

THE MANAGEMENT OF PUBLICLY FUNDED TREATMENT SERVICES IN THE UNITED STATES

Prepared for:

Executive Office of the President
Office of National Drug Control Policy
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EXECUTIVE SUMMARY

The 1997 National Drug Control Strategy¹ calls for the promotion of effective, efficient, and accessible drug abuse treatment to reduce the social and health costs associated with illicit drug use. In an effort to provide information on current availability of alcohol and other drug (AOD) treatment services, CSR, Incorporated, conducted a study to determine what publicly funded AOD treatment services are offered in each State, to identify the major funding sources for those services, and to assess gaps in the range of treatment services available. The study also attempted to explore the impact of the shift to managed care on the provision of publicly funded drug treatment.

A review of the current literature and conversations with informants in State and other types of agencies yielded the following key findings:

- The two primary public treatment funding sources for provision of drug abuse treatment for the medically indigent are Medicaid and the Federal Substance Abuse Prevention and Treatment Block Grant.
- Most States provide Medicaid coverage only for children, mothers of young children, and the disabled who meet income eligibility guidelines. The “average” male drug abuser or addict is not eligible for coverage under Medicaid unless he has an additional long-term physical or psychiatric disability or is solely responsible for a dependent child.
- States limit the types of chemical dependency treatment services available under Medicaid. For example, inpatient treatment may only be covered if there is another primary psychiatric diagnosis that requires acute care treatment.
- As a result of the limits on Medicaid coverage for the uninsured drug addict, the Federal Substance Abuse Prevention and Treatment Block Grant is a major source of funding for drug abuse treatment services.

¹Office of National Drug Control Policy (ONDCP). *The National Drug Control Strategy, 1997*. Washington, DC: ONDCP, 1997a.

- Many States report that the Block Grant mandates and set-asides constrain their ability to allocate funding in a manner appropriate to their clients' characteristics.
- Publicly financed drug treatment is being affected by the recent widespread shift to managed care in the health care system. Many States are seeking "waivers" from the Health Care Financing Administration (HCFA) that permit the enrollment of Medicaid beneficiaries in managed care organizations such as health maintenance organizations (HMOs). Furthermore, many States have introduced managed care technologies into the network of publicly financed behavioral health programs supported by the Block Grant.
- Changes are taking place State by State at varying speeds and with varying levels of inclusiveness. For example, some States are putting all of their Medicaid services under a managed care plan, some are placing most medical treatment under managed care but leaving behavioral healthcare in the traditional fee-for-service system, and others are exploring managed care options but have not yet made significant changes in their Medicaid systems.
- Some States are contracting with private managed care companies to provide Medicaid services as well as behavioral healthcare funded through Block Grant and other State monies. Consumer advocates and AOD professionals are concerned that the availability and accessibility of treatment services will be diminished as dollars that could be used to provide treatment go to profits or as a result of financial losses incurred because contracts were initially underbid. In addition, currently funded public sector and nonprofit agencies that have expertise providing treatment for the medically indigent drug abuser/addict often are not able to compete with large, private managed care companies.
- A recent trend is the transfer of authority from the State AOD agency to the local level. In some States, local boards are responsible for determining the services that will be provided in their areas. The State AOD agency may play an advisory or technical assistance role only.

- The rapid shift to managed care taking shape in many of the States raises questions about changes in the availability of drug treatment services. While there is widespread agreement on the need to control costs, improve case management, and widen access to care, there is concern that managed care contracts may not include adequate and appropriate AOD treatment and that utilization management systems can inappropriately limit treatment access. Drug treatment is considered to be particularly vulnerable to marginalization in managed care programs as there are fewer advocates for these services within healthcare systems.
- Many informants expressed concern that managed care organizations are tightening admissions and length-of-stay criteria, which may result in undertreatment. Both of these potential pitfalls are frequently mentioned in the literature and were echoed by key informants in many States.
- Currently, the full continuum of AOD treatment services (i.e. detoxification, methadone maintenance, inpatient treatment, residential rehabilitation, day treatment, outpatient treatment, and continuing care) is offered in most States (although services may not always be accessible). Some of the public sector networks either directly fund or reimburse for additional specialty services such as long-term residential care and transitional housing programs.
- Although most types of AOD treatment services may exist in any given State, the treatment may not be available or accessible to the drug abuser/addict seeking help. Problems reported that serve as obstacles for those who need and desire help for an addiction include transportation problems, lack of child care, limits on the number of treatment slots available, long distances to travel for treatment, and lack of transitional housing or other community supports. (Managed care admissions criteria and limits on length of stay may also be obstacles to successful outcomes.)

- All sources of information emphasized that the public health systems under discussion are in transition and that the information itself is therefore subject to change. Hence, it is not yet possible to reach conclusions about the impact of these changes on publicly funded drug treatment.

Providers and advocates throughout the country are voicing serious concerns about the changes occurring with the rapid shift to managed care, the possible short-sighted tradeoff between immediate treatment cost savings and the longer term social and health costs associated with undertreatment of drug abuse and addiction. Continuous monitoring of changes in AOD funding mechanisms and treatment systems in each State and dissemination of reported findings are imperative to help States avoid pitfalls as they restructure healthcare service delivery systems.

INTRODUCTION

In the *National Drug Control Strategy, 1997*, the Office of National Drug Control Policy (ONDCP) emphasizes the social and health costs of illicit drug use and calls for the promotion of effective, efficient, and accessible drug treatment to reduce those costs.¹ The prevalence of alcohol and other drug (AOD), abuse, dependency, and related problems is frequently high among uninsured populations; however, many low-income and indigent persons cannot obtain AOD treatment on their own. They depend on publicly financed services, which vary tremendously among the States in terms of availability, specific services or modalities provided, and the funding mechanisms that support the services.

Determining what treatment may be accessed by the needy is complicated, because publicly funded drug treatment programs are financed by a variety of Federal, State, and local funding streams. The numerous agencies that manage those funds have various treatment eligibility requirements, which result in inevitable overlaps and gaps in services. Although data on client admissions to treatment are regularly collected, until recently no systematic effort had been undertaken either to monitor access to services in each State at the service delivery level or to assess the effects of changes in service delivery models, especially the increasing use of managed care.

CSR, Incorporated, set out to identify what publicly funded AOD treatment services are available in each State, how they are administered and funded, and what, if any, gaps in service exist. This project also explored the effect of the public sector's shift to managed care on the provision of AOD treatment. This report presents the findings of the project. We include discussions of the two primary public sector systems of financing treatment, the management of treatment services, gaps in the continuum of care, and policy implications of the data. A table summarizing the state of services follows. Detailed State-by-State summaries also are included for reference.

¹Office of National Drug Control Policy (ONDCP), *The National Drug Control Strategy, 1997*. Washington, DC: ONDCP, 1997a.

INFORMATION-GATHERING METHODS

This work drew on a number of printed resources—several of which were made available as the research progressed—as well as conversations with informants in State and Federal AOD agencies and, on some occasions, State divisions of Medicaid. CSR corroborated findings as much as possible through reports by the Substance Abuse and Mental Health Services Administration and by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Not all information provided was corroborated, but we expect a high level of accuracy based on conversations with relevant contacts and other sources.

Information Sources

Of critical importance to assembling this report was *FY 1994 State Resources and Services Related to Alcohol and Other Drug Problems: An Analysis of State Alcohol and Drug Abuse Profile Data*, compiled by NASADAD.² The report includes information from each of the State AOD agencies on funding levels and sources, client demographics, injection drug use, top policy concerns, major unmet needs, emerging trends, and changes in treatment and prevention.

The NASADAD report provides useful information on the Substance Abuse Prevention and Treatment Block Grant (referred to in this report as the Block Grant) mandates and set-asides and the difficulties many States face in meeting these federally established requirements. These requirements include funding allocations of 35 percent for alcohol treatment services and 35 percent for other drug treatment services; a minimum 5-percent set-aside for treatment services for pregnant and parenting women, including prenatal care and child care; enforcement of tobacco regulations aimed at underage youth; maintenance-of-effort mandates; and other stipulations. As reported by NASADAD, many States report frustration over the limits these requirements place on their ability to allocate funding in a manner appropriate to the reality of their clients' characteristics. For example, a State that has few injecting drug users or pregnant women needing treatment may experience difficulty in fully utilizing the required allotment; meanwhile, the treatment needs of

² National Association of State Alcohol and Drug Abuse Directors (NASADAD). *State Resources and Services Related to Alcohol and Other Drug Problems for FY 1994: An Analysis of State Alcohol and Drug Abuse Profile Data*. Washington, DC: NASADAD. 1996.

other populations in the State remain unmet. These States are finding the Block Grant to be more akin to categorical funding than to a true block grant, which can be tailored to meet the particular needs of a State's treatment clientele.

CSR's research also tapped three recently released documents that reflect the result of substantial efforts to evaluate the effect of managed care on public sector behavioral health programs, including mental health and AOD services. SAMHSA has established the Tracking and Monitoring System for Managed Behavioral Healthcare in the Public Sector. This system, which focuses on 24 States, "monitors the impact of managed care on public mental health and AOD providers, the people they treat and their linkages to the general healthcare sector by tracking both promising and problematic managed behavioral healthcare developments."³ A recent report provides a useful overview of Medicaid managed care programs in the 24 States. The discussion of the role of the State AOD agencies in providing treatment services to clients ineligible for Medicaid, however, is less complete.⁴

Another report, released by the Center for Substance Abuse Treatment (CSAT),⁵ provides an overview of State Section 1115(a) and 1915(b) waivers for chemical dependency services. Based on lessons learned in 12 States, the report recommends strategies to other AOD agencies facing the challenge of managed care system and contract design. In addition, the Institute of Medicine recently developed a review of managed behavioral healthcare delivery systems and quality assurance challenges.⁶ The report discusses the changing healthcare system of both the public and private sectors and offers a detailed review of current managed care trends and their projected

³Substance Abuse and Mental Health Services Administration (SAMHSA). *Tracking and Monitoring System: Managed Behavioral Healthcare in the Public Sector*. First Quarterly Report. Rockville, MD: SAMHSA, 1996a.

⁴Substance Abuse and Mental Health Services Administration (SAMHSA). *Managed Care Tracking System*. Second Report. Rockville, MD: SAMHSA, 1996b.

⁵Center for Substance Abuse Treatment (CSAT). *Alcohol and Other Drug Services Systems: State Transitions to Managed Care—Lessons from Experience*. Draft Report. Rockville, MD: CSAT, 1996.

⁶Institute of Medicine. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington, DC: National Academy Press, 1997.

impact on behavioral health services. Much of the report's contents was confirmed by CSR's contacts in the field.

To develop the most complete picture of the demand for publicly funded treatment services, CSR attempted to include criminal justice and incarcerated populations in this study. SAMHSA is currently conducting a State-by-State analysis of the drug treatment services that are available through State corrections bureaus. As of this writing, the report is not yet available. Some information on collaborative efforts between State corrections and AOD agencies was obtained through CSR's information-gathering efforts and is included in the State summaries. In general, according to information reported by NASADAD, many States' treatment systems are being overwhelmed by referrals from corrections departments.

ORGANIZATION OF STATE PROFILES

This report draws together information on publicly funded treatment modalities available in the 50 States, the District of Columbia, and Puerto Rico and provides a summary profile for each State (see Appendix A). The summary profiles are organized into sections as follows:

- *Services/Modalities*: AOD treatment modalities that are available, with particular attention to programs for special populations and salient provisions or limitations on care;
- *Financing*: Funding streams that support service delivery and the role of Medicaid in reimbursing drug treatment costs;
- *Management of Services*: Agencies that are responsible for managing programs and contracts with providers; and
- *Managed Care Systems*: Information on whether the State AOD or Medicaid agency has converted to a managed care delivery system, the extent to which drug treatment services are part of the package of healthcare services provided, and the managed care model used.

The information from the State summaries has been organized into a summary table for purposes of comparison, presenting a picture that changes dramatically from State to State (see Exhibit 1). The client profiles vary among States; rural States, for example, have a much lower incidence of

Exhibit 1

Overview of Publicly Funded AOD Treatment Services

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
AL	✓			✓		Block Grant supplies 80% of the funding for AOD treatment. The State AOD agency contracts with providers on a FFS basis. There is no managed care system for AOD services.	
AK		✓		✓	Other Federal grants	The State AOD agency uses some managed care methods but has not converted to managed care. Changes to system are under discussion. Medicaid reimburses some treatment.	Subject to availability of services by location.
AZ	✓		1115 waiver implemented	✓		Block Grant supplies about one-half of the funding for AOD treatment. Funding is allocated to five Regional Behavioral Health Authorities (RHBAs), which determine what services to offer and contract with local providers on either a capitated (HMOs) or FFS basis. Non-Medicaid clients pay on a sliding-scale basis. Under an 1115 waiver, the entire State Medicaid program is capitated managed care; AOD services are limited to medically necessary. RHBAs assist eligible clients with enrolling in Medicaid HMOs.	
AR	✓			✓		Treatment is funded primarily by Block Grant. No AOD services are reimbursed by Medicaid (a policy that is under review). Services are FFS. No managed care.	Clients may be refused treatment if provider's contract funds are exhausted.
CA	✓			✓	Other Federal grants	Block Grant supplies about one-third of the funding for AOD treatment. Medically necessary treatment is provided to Medi-Cal (i.e., Medicaid) clients through contracts with counties and private providers. Interagency agreement between AOD and Medicaid administers program. State is planning for conversion to managed care; currently AOD contracts are FFS.	The State-operated program has very long waiting lists for treatment slots. Medicaid does not cover inpatient detoxification.

AOD = alcohol and other drug(s); FFS = fee for service; FPL = Federal poverty level; HMO = health maintenance organization; MCO = managed care organization.

Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
CO	✓			✓		Block Grant supplies about one-third of the funding for AOD treatment. The State AOD agency contracts with providers and reimburses 40 to 50% of treatment costs (more in some areas). Other sources of funding cover the balance. The State is moving to managed care (i.e., managed care organizations will contract with providers). Medicaid covers almost no AOD treatment (i.e., only for pregnant women and the dually diagnosed).	
CT	✓		1915 waiver implemented 1115 waiver proposal under development	✓		Block Grant provides only about one-fifth of the funding for AOD treatment. Most of the State is served by community-based programs under contract with the State AOD agency, which is developing regional networks in preparation for a shift to managed care. The Department of Social Services manages both Medicaid and State-funded AOD programs. Under a 1915 waiver, Medicaid clients access all care through HMOs, some of which subcontract for behavioral health services. An 1115 waiver under development will bring all Medicaid services (including SA) under capitation.	There is no State funding for methadone treatment; funding comes from communities). There is a long waiting list for treatment slots.
DE	✓		1115 waiver implemented	✓		Block Grant provides about one-half of the funding for AOD treatment. The State has an 1115 waiver under which Medicaid clients (and the uninsured below 100% of the FPL) receive AOD treatment through managed care. A minimum level of care is required; each MCO determines the package of services provided. In general, services funded through the State AOD agency are capitated up to a limit, then are FFS. Programs bill the State.	Chronic relapse may result in termination of service provision. Managed care plan requires minimal level of care for AOD services.
DC	✓			DC revenue (i.e., Federal appropriation)		Block Grant provides only about 12% of the funding for AOD treatment. The District contracts directly with providers on a FFS basis. Services used to be free but now are offered on a sliding-fee scale. The AOD agency has recently begun to bill Medicaid for some AOD treatment. The District is exploring managed care models and waiver requirements.	The District and Medicaid programs do not cover hospital inpatient treatment. Medicaid does not cover inpatient detoxification.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
FL	✓		1915 waiver implemented	✓		Block Grant provides about one-half of the funding for AOD treatment. Medicaid billings are low due to narrow eligibility and to providers not seeking reimbursements. The State has a 1915 waiver for high-risk pregnant women. Health and Human Services boards in 15 districts contract with public, nonprofit providers. Managed care elements are being introduced into the State treatment system.	There is a long waiting list for treatment slots.
GA	✓		1115 waiver proposal on hold	✓		Block Grant provides about one-third of the funding for AOD treatment. Responsibility for services is with 19 local boards that do not report to the State. Boards contract directly with providers and make decisions about services offered. The State AOD agency is being downsized and is losing authority. Community Services Boards (formerly community mental health centers [CMHCs]) are now forced to compete with the private sector for contracts, and no State funding is on hand to cover losses. Services reportedly are declining.	There is no long-term (i.e., >28 days) inpatient treatment and no inpatient treatment in DeKalb County, which includes the city of Atlanta. Medicaid does not cover hospital detoxification; most detoxification is now 24-hour crisis stabilization.
HI	✓		1115 waiver implemented	✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency contracts with private, nonprofit providers who are licensed and accredited by the AOD agency. Services are provided to residents with incomes up to 300% of the FPL who have no other way to pay. The State has an 1115 waiver that carves out behavioral health services; the State Medicaid agency contracts with five medical plans, which serve as gatekeepers.	There are long waiting lists for treatment slots.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
ID	✓			✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency contracts with regional contractors to provide AOD treatment services and serve as case managers. The State sets the rate for each service and will pay up to 95%. Income eligibility is 250% of the FPL or below. The client generally is asked to pay 5% and the provider pays whatever portion of the costs is uncovered by either the client or the State. Medicaid reimburses for very little treatment. A task force is looking into managed care.	No methadone treatment is available through the State or Medicaid programs. The level and availability of services vary across the State. Medicaid coverage is limited to hospital-based treatment (an uncommon setting for AOD treatment in this State).
IL	✓		1115 waiver proposal submitted	✓		Block Grant provides about one-third of the funding for AOD treatment. The State AOD agency funds treatment facilities, where clients receive services and are charged fees on a sliding-scale basis. Medicaid covers outpatient services, group therapy, and residential day treatment programs. An 1115 waiver that would incorporate a managed care system with a mental health and AOD carve-out has been submitted.	No inpatient hospital or outpatient methadone treatment is covered through Medicaid.
IN	✓					Block Grant provides 85 to 90% of the funding for AOD treatment. AOD service providers under contract with the State AOD agency now are required to become managed care providers. Service agencies form panels and apply to the State for recognition, rather than the State using an MCO. Payment is a capitated prepay each year to 29 managed care networks in the State (including 30 CMHCs). A Medicaid rehabilitation option is accessible to mental health centers, but a very small proportion of revenue comes from Medicaid.	There is a moratorium on enrollment in networks (as of 1/97) due to exhaustion of funds. New clients are placed on a waiting list. Medicaid only covers outpatient services, and only for the dually diagnosed.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
IA	✓		1115 waiver implemented	✓	Other Federal, State, county, and local resources	Block Grant provides about one-fourth of the funding for AOD treatment. The entire State public health system is under managed care. Under a three-way contract with the department of human services (Medicaid), the department of public health (AOD), and an MCO, providers receive a contractually set payment to serve anyone who requests treatment. (Clients with incomes over 400% of the FPL pay a sliding-scale fee). Under an 1115 waiver, Medicaid-eligible clients are served by the same system.	No medical detoxification is available through the State-operated program. Clients require MCO approval for some levels of treatment.
KS	✓		1115 waiver proposal under development	✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency contracts with a management organization, which contracts with providers. All clients are first assessed at Regional Alcohol and Drug Assessment Centers (RADACs). The RADAC determines the modality and length of treatment on a case-by-case basis. Minimal Medicaid coverage exists for AOD; the State is developing an 1115 waiver.	No publicly funded medical detoxification is available in the State. Most inpatient treatment is 14 days; most treatment accessed is outpatient. Medicaid covers only selected services at residential programs for women.
KY	✓		1115 waiver being implemented	✓		Block Grant provides almost two-thirds of the funding for AOD treatment. Funding has been allocated to 14 regional boards, who contract for services on a FFS basis; providers try to collect a copayment from clients with incomes above 200% of the FPL, and the State pays the remainder of the costs. Services will be capitated in about 2 years, once an 1115 waiver is fully implemented. Currently Medicaid covers only hospital detoxification and some adolescent care under mandatory Early Periodic Screening, Diagnosis, and Treatment services. The State is conducting a feasibility study on Medicaid coverage for more modalities of care.	The level and availability of services vary across the State. Medicaid covers only selected services for special populations.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
LA	✓		1915 waiver proposal under development	✓		Block Grant provides more than one-half of the funding for AOD treatment. The AOD agency contracts with nonprofit providers; some services are provided through State-owned and -operated facilities. Medicaid covers detoxification and outpatient services for AFDC-eligible clients. A small case-management pilot is operating in one region, and a waiver is under development that would carve out behavioral health as FFS.	Medicaid coverage is limited to detoxification and outpatient services for AFDC-eligible clients. There are waiting lists for treatment slots.
ME	✓	✓	1915 waiver proposal submitted; 1115 waiver proposal under development	✓		Block Grant provides about one-third of the funding for AOD treatment. The State AOD agency contracts directly with providers on a FFS basis. Medicaid reimburses for treatment and case management. The State has applied for a 1915 waiver to manage methadone services and is developing an 1115 waiver to shift Medicaid clients into managed care.	Only one methadone program exists in the State, so some clients must travel long distances.
MD	✓		1115 waiver approved but not yet implemented	✓		Block Grant provides about one-third of the funding for AOD treatment. The State AOD agency contracts directly with providers on a FFS basis. Medicaid covers a very small proportion of billed services. The State has been approved for an 1115 waiver, which will bring eligible beneficiaries into managed care. AOD treatment will be carved in, and all MCO applicants will be required to cover it.	No detoxification services are available through the State or Medicaid programs.
MA	✓		1915 waiver implemented 1115 waiver approved but not yet implemented	✓		Block Grant provides almost one-half of the funding for AOD treatment. The State AOD agency purchases services on a FFS basis. The State has a 1915 waiver that purchases behavioral health services through a carve-out. Capitated MCOs contract with providers on a modified FFS basis. An 1115 waiver, which will expand eligibility and fully capitate services, has been approved.	There is a long waiting list for treatment.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
MI	✓		1915 waivers implemented	✓		Block Grant provides more than 40% of the funding for AOD treatment. The State AOD agency contracts with 16 regional, quasi-governmental organizations (i.e., Coordinating Agencies), which authorize payments and subcontract with local providers for basic services; the Coordinating Agencies also contract with Central Diagnostic and Referral Agencies for assessment of need for intensive services. Acute care detoxification, methadone, and outpatient services may be reimbursable by Medicaid. Two 1915 waivers have placed most Medicaid beneficiaries in managed care, and a pilot in five counties carves in behavioral health care. The State is contemplating a behavioral health managed care plan for non-Medicaid clients.	Hospital inpatient services are not covered by the State program. Nonhospital residential treatment is not covered by Medicaid.
MN	✓		1115 waiver being implemented	✓	Local funds (required county match)	Block Grant provides about one-third of the funding for AOD treatment. Localities following Minnesota's Rule 25 place clients in one of three State treatment programs, based on Medicaid eligibility, county of residence, and other factors. The State's 1115 waiver is converting all AOD treatment services for Medicaid clients to a managed care plan. Another State-funded program also is in the process of converting to managed care. The third program funds services for clients ineligible for the other two programs, is fee-for-service, and is managed by the localities (i.e., counties and Indian reservations), which are required to contribute part of the funding (i.e., a 15% match).	Detoxification and aftercare are funded by counties, not the State.
MS	✓		1915 waiver implemented	✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency contracts with private, nonprofit organizations to provide AOD services and charge clients on a sliding-scale basis. Under a 1915 waiver, a pilot program provides mental health and AOD services through voluntary primary care case management programs in 11 counties only. Otherwise, Medicaid does not reimburse AOD services because they are provided in mental health centers throughout the State.	There are long waiting lists for treatment slots. Minimal Medicaid coverage (i.e., waiver pilot program only) exists. No methadone treatment is available.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
MO	✓	✓	1915 waiver implemented 1115 waiver proposal submitted	✓		Block Grant provides about one-third of the funding for AOD treatment. The State AOD agency contracts with private, nonprofit organizations to provide AOD services. All non-Medicaid and many Medicaid clients are means-tested to determine their fee share. Services are provided on a fee-for-service basis, except for the one-third of Medicaid clients who participate in mandatory managed care under a 1915 waiver. The State has applied for an 1115 waiver to expand Medicaid managed care statewide.	There are treatment limits for some covered services under the State and Medicaid programs. Detoxification and inpatient treatment are limited to 5 days. Nonmethadone outpatient detoxification is not available, nor is formal aftercare.
MT	✓				Earmarked State tax on sale of alcoholic beverages	Block Grant provides about one-fifth of the funding for AOD treatment. The State AOD agency manages most AOD services and contracts with private, nonprofit organizations to provide services on a FFS basis. Funds from the earmarked tax are controlled by the counties. Most services are provided on a sliding scale, although providers are not allowed to refuse services based on client inability to pay. No program operates solely on public funds; the State requires that group insurance plans cover AOD services. No managed care exists for AOD services. Medicaid covers treatment services for adolescents only.	Limits on inpatient detoxification were recently instituted. No publicly funded methadone treatment is available.
NE	✓		1915 waiver implemented	✓		Block Grant provides about one-half of the funding for AOD treatment. Localities are required to provide a 10% match to receive State funds. The State AOD agency coordinates with six regional Board of Supervisors to manage AOD services, with each region contracting independently with local service providers. New procedures will require State approval of service providers before reimbursement with State funds. Under a 1915 waiver, Medicaid-eligible adults are covered under a behavioral health managed care plan. All other clients (i.e., Medicaid-eligible children under age 19 and all State-funded clients) are provided services on a FFS basis.	Outpatient and inpatient treatment under the State and Medicaid programs are limited to medically necessary. No aftercare services are available.

AOD = alcohol and other drug(s); FFS = fee for service; FPL = Federal poverty level; HMO = health maintenance organization; MCO = managed care organization. Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to verify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
NV	✓			✓		Block Grant provides more than one-half of the funding for AOD treatment. The State accredits and contracts with 24 local service providers for a designated number of treatment slots. The providers, none of whom are funded solely by the State, currently are required to treat eligible clients regardless of the funding level, although the State is considering changing to a FFS model. In one area, the State is developing a pilot Medicaid managed care program to provide intensive outpatient services for youth.	No coverage exists for hospital inpatient services through the State program.
NH	✓		1115 waiver being implemented	✓		Block Grant provides nearly one-half of the funding for AOD treatment. No local funds regularly support AOD treatment. The State contracts with private local agencies to provide services to all who request it; under State law, no person can be committed to any AOD treatment involuntarily. Medicaid reimburses services for adolescents and women. The State plans to move all AOD services to managed care in the future; managed care currently exists only in some adolescent programs. The State also has in process an 1115 waiver that would implement a statewide managed care plan for pregnant women and children in families with incomes up to 170% of the FPL.	No publicly funded medical detoxification is available in the State. Methadone treatment is available only for pregnant women.
NJ	✓			✓	Earmarked State alcohol tax	Block Grant provides more than 40% of the funding for AOD treatment. The State has two separate systems for AOD treatment: a county system and a State system. The counties receive alcohol tax revenue and contract directly with the providers. The State system funding (including the Block Grant) covers the costs associated with treating Block Grant priority populations. The State anticipates developing a managed care waiver within 1 year.	There is a long waiting list for treatment slots.

AOD = alcohol and other drug(s); FFS = fee for service; FPL = Federal poverty level; HMO = health maintenance organization; MCO = managed care organization.

Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
NM	✓			✓	DWI fund provides funding to counties	Block Grant provides about one-third of the funding for AOD treatment. A DWI fund provides program funding to the counties. All contracts and service provision decisions are handled by the State AOD agency. Medicaid covers 12 hours of outpatient treatment per year and medically necessary treatment for minors. The State system functions somewhat like managed care in that providers receive a fixed amount to serve the indigent and cannot turn away clients; however, the State is contemplating formal conversion to managed care.	There is a long waiting list for treatment slots. The level and availability of services vary across the State.
NY			Several 1915 waivers implemented 1115 waiver proposal submitted	✓	Clients' counties of residence share the cost of treatment	Block Grant provides only about one-ninth of the funding for AOD treatment; more than one-third comes from the State Division of Medicaid (which operates Home Relief), and less than one-third comes from the State AOD agency. The State AOD agency contracts with local service providers primarily on a fee-for-service basis. Home Relief, funded entirely by State and local revenues, serves indigent clients who are not Medicaid-eligible under the Federal program. The State has applied for an 1115 "mega waiver" to create a comprehensive managed care system for the Federal and State Medicaid populations (except for some special-needs clients) under the oversight of proprietary MCOs.	There is a long waiting list for treatment slots. Medicaid does not generally cover counseling or therapeutic communities.
NC	✓	✓	1915 waiver implemented 1115 waiver proposal submitted	✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency provides funding to 41 area boards, who either provide AOD services directly or contract with nonprofit providers. In addition, a public-private partnership ensures that there are no waiting lists for eligible clients when public facilities are full. Facilities bill the State on a fee-for-service basis for adults. Private facilities bill Medicaid through the area boards for services for children age 18 and below, which are provided through a managed care plan under a 1915 waiver. The State is awaiting approval for a proposed waiver for adult services to be covered under a managed care plan.	Medicaid does not cover room and board for adult residential treatment.

AOD = alcohol and other drug(s); FFS = fee for service; FPL = Federal poverty level; HMO = health maintenance organization; MCO = managed care organization.

Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by QNDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
ND	✓	✓		✓		Block Grant provides almost one-half of the funding for AOD treatment. AOD services are available primarily through the one State hospital and eight regional Human Service Centers (HSCs), which are allocated State resources for the provision of services. A State provision also allows each HSC to bill Medicaid directly for the reimbursement of covered costs. No publicly funded managed care system exists within the State, and there are no plans to develop one.	No methadone treatment is available. Frequent relapsing may result in noncoverage of services.
OH	✓		1115 waiver being implemented	✓		Block Grant provides about 30% of the funding for AOD treatment. The State AOD agency contracts with local service boards to implement community AOD treatment programs, which are provided on a fee-for-service basis. An 1115 waiver being implemented will move many AOD services into a separate, capitated AOD category managed by the State AOD agency, which is in the process of selecting a statewide MCO with which it will contract for services.	There are long waiting lists for treatment slots in parts of the State.
OK	✓		1115 waiver implemented	✓		Block Grant provides more than 40% of the funding for AOD treatment. The State AOD agency contracts with 54 private nonprofit agencies and one State-operated agency to provide treatment services, which are funded on a FFS basis. Under an 1115 waiver (called "SoonerCare"), AOD services in urban areas are under managed care and must be included in services offered by MCOs; rural areas are under traditional FFS Medicaid for AOD services.	State-funded methadone treatment not available outside of Oklahoma City. In rural areas, Medicaid coverage for adult inpatient treatment is limited to 12 days per year for all hospitalizations (i.e., not just AOD).
OR	✓		1115 waiver implemented	✓		Block Grant provides about one-sixth of the funding for AOD treatment. In 1995, the State implemented a statewide Medicaid reform program which expanded eligibility for health care and incorporated AOD treatment; service providers are mandated to screen every client for chemical dependency.	

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Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
PA	✓		1915 waiver implemented	✓		Block Grant provides nearly 30% of the funding for AOD treatment. The State AOD agency provides funding to Single County Authorities, who provide (or contract for) and manage services. Except for some Medicaid clients, AOD services are provided on a FFS basis. Under a 1915 waiver, a Medicaid managed care program has been implemented in part of the State; in this program, behavioral health services are carved out and counties contract for behavioral health services on a capitated basis with the Department of Public Welfare or with commercial behavioral health plans.	Frequent relapsing may result in suspension of treatment. All detoxification is inpatient/residential.
PR	✓		Medicaid clients being brought into managed care with HCFA approval (i.e., no waiver)	✓		Block Grant provides about one-half of the funding for AOD treatment. Under health reform, 61 of the Island's 78 municipalities provide all health care (including behavioral health care) through managed care plans. The Puerto Rico Health Insurance Administration (an independent State agency) contracts with insurance companies, who contract with providers on a capitated basis. The payments are made up of State and Medicaid funds. Under health reform, AOD services to Medicaid clients are covered, with HCFA approval, without a waiver.	Duration of treatment limits have recently been tightened. Few residential slots for women exist.
RI	✓		1115 waiver implemented	✓	Drug education fund for offenders; DWI program	Block Grant provides about 40% of the funding for AOD treatment. All publicly funded AOD treatment is managed by the State AOD agency, which contracts with primarily nonprofit providers and sets standards for treatment. Services are provided FFS based on a sliding-fee scale. The State has an 1115 waiver that covers AOD treatment for Medicaid clients. The State is contemplating placing limits on services.	

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 Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
SC	✓		1115 waiver approved; implementation has been slowed	✓	Local funds	Block Grant provides about one-fourth of the funding for AOD treatment. The State AOD agency contracts with 34 private agencies and 4 county agencies to provide all modalities of treatment. No client can be turned away due to inability to pay. Most AOD personnel are employees of private agencies under contract to the State, and much of the funding, decision-making, and program development occurs at the local level. Due to high costs, the State has slowed the implementation of a Medicaid managed care program which has begun on a voluntary enrollment basis in designated areas. All medically necessary services are capped at \$1000 and then are FFS.	
SD	✓			✓		Block Grant provides about one-half of the funding for AOD treatment. The State AOD agency develops and monitors all treatment contracts. The State has no managed care component for publicly funded AOD treatment and no plans to shift to managed care.	No methadone treatment services are available. Adult males must have medical or mental condition in addition to SA. Medicaid is available for youth only.
TN	✓		1115 waiver implemented	✓	Private sources (e.g., United Way, foundations)	Block Grant provides more than one-half of the funding for AOD treatment. The State AOD agency contracts with 55 nonprofit organizations and pays each agency a flat sum to provide AOD treatment services. This funding covers approximately 50% of the total costs of providing services, and the remaining resources are gathered by the agencies from sources such as United Way. Under an 1115 waiver, Medicaid clients receive medically necessary services (including AOD treatment) through 11 managed care organizations. The State plans to merge the State-funded and Medicaid programs in the next 2 years so that both are part of a managed care program.	The State program does not include nondetoxification hospital inpatient or aftercare services.

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Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
TX	✓		1915 waivers implemented 1115 waiver proposal submitted	✓		Block Grant provides one-half of the funding for AOD treatment. The State AOD agency contracts with local, private, nonprofit treatment providers by purchasing a total number of treatment slots. The local providers assess clients and admit them when treatment slots are available. Medicaid covers outpatient chemical dependency services for children and youth. Under 1915 waivers, four multicounty areas within the State have enrolled their Medicaid population in HMOs, which may use cost savings resulting from managed care to provide AOD treatment. One of those HMOs provides inpatient and outpatient detoxification. A pending 1115 waiver would bring a basic array of behavioral health services under capitation; HMOs would be eligible (but not required) under that waiver to provide AOD services.	Clients are wait-listed if treatment slots are unavailable in the State program. Medicaid coverage is limited to youth. There is no Medicaid coverage for AOD treatment for most of the adult population.
UT	✓		1915 waivers implemented 1115 waiver proposal submitted	✓	Local funds	Block Grant provides about one-third of the funding for AOD treatment. The State AOD agency contracts with 13 local authorities statewide to provide (or to contract with local providers to provide) AOD treatment (excluding inpatient treatment) on a FFS basis. Under a 1915 waiver, most Medicaid clients access detoxification through HMOs in a capitated plan. A pending 1115 waiver would bring AOD services into managed care statewide and expand eligibility.	
VT	✓	✓ (AOD can be primary diagnosis)	1115 waiver implemented	✓		Block Grant provides more than one-fourth of the funding for AOD treatment. The State AOD agency contracts directly with local service providers, all of whom are MCOs; under an 1115 waiver, both the State-funded and the Medicaid programs operate under managed care systems. The State has a special provision that allows Medicaid reimbursement for AOD treatment as the primary diagnosis.	No nonmedical detoxification, methadone treatment, or aftercare services are available. Medical necessity is a prerequisite for services in the State programs. Medicaid coverage is limited to acute services in a managed care facility.

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State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
VA	✓			✓		Block Grant provides more than one-fourth of the funding for AOD treatment. The State AOD agency provides funding and technical assistance and monitors the operations of 40 local quasi-governmental Community Service Boards (CSBs). The CSBs develop treatment protocols for clients; several of them have managed care contracts for their areas. The CSBs are required to provide emergency services for AOD and mental health treatment for all who need it and are unable to pay. The State currently is investigating managed care systems for AOD and mental health services.	Medicaid coverage is limited to those with dual diagnoses.
WA	✓			✓	Dedicated State tax	Block Grant provides almost 30% of the funding for AOD treatment. The State AOD agency contracts with counties and local, nonprofit, service providers. The counties contract for outpatient treatment and the State contracts for residential services. Medicaid covers medically necessary detoxification and outpatient services and two youth and women's residential programs. The AOD agency uses some managed care principles but does not contract with MCOs. Medical services for AFDC-related and children under 19 below 200% of the FPL are capitated; the SSI population gradually is being brought under managed care.	There are long waiting lists for treatment slots and variable availability of services throughout the state.
WV	✓			✓		Block Grant provides more than 40% of the funding for AOD treatment. The State AOD agency provides annual allocations to 14 Behavioral Health Services Centers across the State, which manage the delivery of publicly funded AOD treatment. Most of the Centers provide services on a FFS basis, charging on a sliding scale. The State is in the process of converting all behavioral health benefits into managed care plans.	There are long waiting lists for treatment slots. No methadone treatment is available in the State. Due to tight budgets, sparsity of slots, and focus on priority populations, services for adult males are very limited.

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Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

State	Significant Funding Sources					Summary of Services and Systems	Gaps in Services
	Federal Block Grant	Traditional Medicaid	Medicaid Waiver	State General Funds	Other		
WI	✓		1915 waiver being implemented	✓	Local funds (i.e., required county match)	Block Grant provides about one-fifth of the funding for AOD treatment. The State provides county-designated boards with annual funding based on a formula to provide services or to contract with providers. The boards/providers charge clients a sliding-scale fee and then bill the State on a FFS basis up to the amount of the annual allocation. Medicaid covers medically necessary services except for nonhospital residential treatment. Under a 1915 waiver, Medicaid is shifting to managed care and behavioral health is provided by 19 HMO providers in the system. Six managed behavioral health care programs will be piloted.	
WY	✓			✓		Block Grant provides about one-third of the funding for AOD treatment. The State contracts with and oversees local private, nonprofit providers. The State provides each program with \$20,000 and negotiates for caps on what can be billed to the State. The provider must provide services even after billing up to the contract cap. The State views its AOD treatment needs as too small to justify implementing managed care.	No detoxification or aftercare services are available in the State. Medicaid reimbursement is rare and only exists for the dually diagnosed.

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 Due to the complexity of information contained in this table and the data collection method, CSR, Incorporated, recommends that an attempt be made to reverify data with each State before release or publication of State-specific information by ONDCP.

injection drug use than States with large metropolitan centers. These “urban” States have more complex behavioral healthcare systems and, in general, longer waiting lists for treatment slots. Likewise, the proportions of pregnant and parenting women needing treatment and the prevalence of injection drug use change from State to State, along with the following other factors:

- Standards of care;
- Contracting practices;
- Applicability of Block Grant mandates and set-asides;
- State Medicaid program provisions and eligibility rules;
- Income eligibility for publicly funded services;
- AOD agency relationships with other agencies (including Medicaid), providers, managed care organizations, and local governments; and
- The impact of the shift to managed care on AOD benefits in many States.

OVERVIEW OF PUBLICLY FINANCED TREATMENT SYSTEMS

Two State-level agencies are the primary funders of publicly financed AOD treatment. One agency is the State mental health/substance abuse authority (increasingly a single agency, referred to in this report as the State AOD agency or single State agency), typically funded by a combination of Block Grant and State appropriations. The other is the State Medicaid agency.

These two agencies support what are, in some respects, two independent systems of care. Medicaid *reimburses* limited AOD services (under generic categories such as “clinic services” or “rehabilitative services”) for Medicaid-eligible clients, who generally are low-income women, children, and persons with disabilities. Each State plan describes whether and how any particular type of treatment might be reimbursed. No two plans are alike.

The State AOD agency, on the other hand, *directly funds* AOD treatment programs and services that, in most States, may be accessed by anyone who walks in the door. Programs that receive funding range from private, nonprofit recovery centers to community health clinics. In most cases, the State AOD agency contracts directly with providers on a fee-for-service basis. Services typically

are offered on a sliding-fee scale or are free to those who can prove income eligibility (generally a designated percentage of the Federal poverty level). Programs funded by State AOD agencies may be able to apply to the State Medicaid office for reimbursement, depending on the State plan requirements and on whether an established mechanism for billing exists.

Availability of Services

Most State AOD agency-managed (and in some States, locally managed) service networks offer a full continuum of treatment services—detoxification, methadone maintenance, inpatient treatment, residential rehabilitation, day treatment, outpatient treatment, and continuing care. Some networks offer special services, such as therapeutic communities, transitional housing, or long-term residential care. Other networks stress outpatient over inpatient treatment. Some States do not provide any methadone programs and may provide very little continuing care beyond referrals to Twelve-Step programs.

Although most types of AOD treatment may exist in a State, limits on the number of treatment slots available, insufficient lengths of stay, transportation problems, lack of child care, or long distances to travel for treatment may limit access. For example, a State may offer a methadone detoxification program. However, the program may only be offered as an outpatient program in one location in the State, making it inaccessible for clients in other localities.

The Shift to Managed Care

The shift to managed care for Medicaid-funded healthcare services has been rapid. Between 1991 and 1996, the proportion of Medicaid recipients enrolled in managed care programs jumped from 9.5 percent to just over 40 percent (see Exhibit 2, following this page). State Medicaid agencies and State AOD authorities increasingly are looking to managed care to control costs, improve case management, and widen access to care. However, whether managed care contracts will include adequate and appropriate AOD treatment among their covered healthcare services and whether utilization management systems will inappropriately limit treatment access have become concerns of AOD treatment professionals, consumers, and advocates nationally. The impact of the recent shift to the managed care model has not yet been fully assessed by the States. (For background

Exhibit 2

National Summary of Medicaid Managed Care Programs and Enrollment

June 30, 1996
Managed Care Trends

	Total Medicaid Population	FFS Population	Managed Care Population	% Managed Care Enrollment
1991	28,280,000	25,583,603	2,696,397	9.53
1992	30,926,390	27,291,874	3,634,516	11.75
1993	33,430,051	28,621,100	4,808,951	14.39
1994	33,634,000	25,839,750	7,794,250	23.17
1995	33,373,000*	23,573,000*	9,800,000*	29.37*
1996	33,241,147	19,911,028	13,330,119	40.10

*Indicates approximate numbers. Total Medicaid population was provided by the Office of the Actuary, which used 2082 data to calculate average Medicaid enrollees over 1995.

Note: The managed care population differs from the 11,619,929 reported in the 1995 report, because the number represented the enrollment of some beneficiaries in more than one plan. The 1996 total Medicaid population data were collected by States simultaneously as the managed care enrollment numbers were collected, rather than using 2082 data, as had been done in previous years.

Source: www.hcfa.gov/medicaid/omc1.htm

information on managed care models and current issues, including benefits and potential problems, see Appendix B.)

Because the shift to managed care constitutes a reconfiguration of many public health systems throughout the United States and is a recent development, data gathering in this area is difficult and often speculative. Often, information gathered in the course of this project was incomplete because programs were in the design phase or proposed legislation authorizing changes had not yet been passed. Therefore, it must be emphasized that the current mutability of these public sector healthcare programs means that what is true at the time of this writing may not remain so for long.

THE MANAGEMENT OF PUBLICLY FUNDED AOD TREATMENT

As indicated above, the structural relationships between the State AOD agency, the State Medicaid agency, and other authorities (e.g., child welfare or corrections agencies) differ in each State. In some States, a linkage may exist—formal or informal—between the AOD and Medicaid agencies (e.g., Arizona, Florida, Iowa, Maine, Massachusetts, Ohio, and Pennsylvania). For the most part, however, State AOD agencies do not have a formal collaborative relationship with the State Medicaid agencies, and each agency operates independently.

The Role of Medicaid and Limits on Reimbursement

Under Medicaid law, all States must offer coverage for mandatory medical services, such as hospital and physician services. However, States also may offer coverage under a broad range of generic optional service categories, such as clinic services, community-based care, or rehabilitation. Whether these categories of care are available for AOD treatment varies from State to State. For example, States may reimburse counseling at public health clinics under Medicaid's clinic option or cover outpatient treatment under the rehabilitation option. Screening and case management services might be covered under rehabilitation. In other words, each State may cover a particular menu of services under different optional benefit categories. Reimbursement also may be influenced by the degree of coordination between the AOD and Medicaid agencies, statutory limits on what may be reimbursed, and even the AOD agency's understanding of how to handle the claims for those services. For example, in one State, the contact indicated that the AOD agency had had some

difficulty navigating the reimbursement system and, therefore, had not billed Medicaid for services for some time.

Federal Medicaid guidelines do not mandate coverage for AOD treatment services. States may include AOD treatment in their Medicaid program through one of the optional service categories or under a Medicaid managed care model, but reimbursement might still be denied for the following reasons, among others:

- Treatment is not clearly medically necessary (i.e., the client does not present with symptoms of an acute medical episode, such as overdose or withdrawal);
- The client is not Medicaid eligible; or
- The treatment facility is too large (Federal law prohibits reimbursement for care of persons ages 22 to 64 in an institution for mental disorders with more than 16 beds, and the Health Care Financing Administration [HCFA], the Federal agency administering Medicaid, includes AOD abuse as a mental disorder).

In addition, under HCFA policy, counseling provided by nonlicensed personnel as the primary method of care is not considered medical treatment and is therefore not eligible for Federal Medicaid reimbursement. However, even in States that reported no Medicaid coverage for AOD treatment, Medicaid-eligible clients requiring acute treatment for AOD-related medical problems would likely be detoxified and treated, and the care might be covered by Medicaid under medical treatment. Thus, in most States, clients requiring acute care for a coexisting physical or mental disorder may receive services covered by Medicaid, but these services will not be billed as AOD treatment.

In 1992 the George Washington University Intergovernmental Health Policy Project, at the request of the Robert Wood Johnson Foundation, prepared *A Fifty-State Survey of Medicaid Coverage of AOD Services*, a survey of the range of AOD services covered by each State's Medicaid program

and the categories under which those services were billed.⁷ Because of the way States' Medicaid services tracking systems have been developed, the researchers found it difficult to capture information on Medicaid reimbursement for AOD services. Categories for Medicaid financing are based on type of service (e.g., inpatient hospital care or outpatient counseling) and not necessarily on diagnosis. Thus, most States' computer systems are designed to track monies spent for a particular type of service and not for a specific diagnosis (e.g., alcohol dependency or schizophrenia). The researchers found that most States did not have mechanisms for tracking AOD services for Medicaid recipients without reviewing each case for diagnosis, provider type, or service code. As pointed out by the researchers, the Medicaid program is designed to be a financing mechanism and not a service delivery system. However, they found that Medicaid programs have provided a focal point for innovative project development through various initiatives.

Federal Medicaid Waivers

Federal Medicaid waivers permit States to deviate from certain provisions of Federal Medicaid law, enabling them to be more flexible with their Medicaid programs. Waivers recently have become the primary means of enrolling the eligible uninsured in managed care and have presented an opportunity to widen the availability of AOD treatment services. Applications for waivers are reviewed and approved by HCFA.

Two categories of waivers have been widely used to allow States to experiment with new models of care: Section 1915(b) (also known as "freedom of choice" or "managed care" waivers) and Section 1115(a) ("research and demonstration") waivers.⁸ The 1915(b) waiver is the more limited of the two. It allows the State to waive certain statutory requirements—namely, the freedom to choose one's provider, statewide availability of programs, and comparability of services offered by different providers—in order to lock in groups of beneficiaries to managed care systems.

⁷Robert Wood Johnson Foundation. *A Fifty-State Survey of Medicaid Coverage of Substance Abuse Services*. Princeton, NJ: Robert Wood Johnson Foundation, 1992.

⁸Section numbers refer to sections of Title XIX of the Social Security Act of 1965.

Section 1115(a) waivers, on the other hand, are being used to facilitate sweeping healthcare reforms through major restructuring of State Medicaid programs. More than 12 States have implemented these waivers; other States' waiver applications are under review. Some States are implementing 1115(a) waivers that not only enroll Medicaid beneficiaries in managed care or case management programs but also use projected savings to expand eligibility and, possibly, widen the array of healthcare services covered.

Thus, AOD treatment services provided to eligible clients might be covered by Medicaid FFS plans or Medicaid-funded managed care in States with waivers. States may opt to offer Medicaid coverage to clients not Medicaid-eligible under Federal guidelines; however, the States will not receive Federal matching funds (i.e., the Federal share of a State's Medicaid costs) for those services (i.e., the costs would be borne entirely by the State).⁹ For example, males between ages 22 and 64 are not covered by Medicaid unless they are blind, disabled, or solely responsible for a dependent child. These clients must seek care from providers under contract to the State AOD agency.

Some States have implemented waivers that include some Medicaid-ineligible clients in the Medicaid managed care plans. However, savings have not always been as substantial as originally projected. In addition, the Federal Government has raised the question of whether presumed savings from waivers should accrue to the Federal Government rather than to State governments.

The State AOD Agency: Payer of Last Resort

The State AOD agency receives funding from a number of sources, including the Block Grant; State general revenue; other Federal and State sources (e.g., discretionary grants, third-party payments, fees for drinking under the influence, and earmarked taxes); and local sources, such as matching funds. These funds are pooled and disbursed by the agency. For many States, Block Grant funding covers a large proportion of AOD services, ranging from 50 to more than 80 percent of the

⁹With respect to minors, the mandatory Early and Periodic Screening Diagnosis and Treatment services for children under age 21 requires that a child be treated for any condition uncovered by screening, including those that require treatment not considered "medical," that may include AOD abuse. However, treatment centers designated under this provision of the law may not offer the appropriate services or may not be easily accessible.

treatment budget. After collecting client fees (assessed on a sliding scale), third-party reimbursements, and grants-in-aid, the State covers the balance of the costs. Most publicly funded AOD treatment services are provided through this mechanism.

The Devolution of Authority to the Local Level

A common trend occurring in the States surveyed is the devolution of responsibility from the State AOD agency to the local level. In some States, local boards (in one case, comprised of nonprofessional volunteers) are responsible for determining the services that will be provided in their geographic areas. The State AOD agency may merely play an advisory or technical assistance role and have little formal authority for oversight of AOD services, giving oversight responsibility to the local entity. Some State-level contacts expressed concern about the commitment of local decisionmaking bodies to giving AOD treatment the same importance as behavioral or physical healthcare.

GAPS IN THE CONTINUUM OF CARE

The gaps in the continuum of care for State- or locally managed AOD treatment services that were reported by informants tend to be less a clear-cut omission of a modality in a State and more a situation of the following: (1) geographic location of programs relative to clients who need to access them, (2) limits in available treatment slots, (3) limits on access for various categories of clients, and (4) limits on lengths of stay in appropriate treatment modalities. This section describes the primary gaps uncovered in the course of this research effort, some of which were believed by State informants to reflect the changes and/or restraints created by utilization management's medical necessity criteria and other access issues related to managed care programs. (See Appendix B for discussion of utilization management programs and other issues raised by the move to managed care.)

Geographic and Population Distribution Obstacles

In many locations, clients regularly face geographic obstacles to compliance with treatment requirements. For example, in large, sparsely populated States, geographic and climatic conditions can make reaching a treatment site nearly impossible. States with large Native American

populations who require AOD treatment often find it difficult to transport clients from reservations to treatment centers. In some States (e.g., Alaska, Idaho, and Kentucky), some treatment modalities are offered in a limited number of locations; clients living great distances from these sites find it difficult or impossible to access treatment.

Waiting Lists

Many States reported long waiting lists for limited treatment slots (e.g., California, Connecticut, Florida, Hawaii, Indiana, Mississippi, New Mexico, New York, and Washington). North Carolina has resolved its waiting list problem by developing "public-private partnerships," which ensure that when public sector programs are full, private sector programs provide services. These services are paid for with State funds at a negotiated price below that charged by private sector providers for other clients.

Detoxification Services

Several States noted that they do not offer publicly funded detoxification, because it is considered a revolving door with no link to treatment. Some State AOD agencies believe that many clients enter the program to "dry out" when they feel the need, then return to their addictive behavior when they feel better. As noted earlier, in some States (e.g., Georgia and Florida), detoxification services have been restructured into "crisis" programs that are only available in metropolitan areas and are shorter than is generally thought necessary to truly detoxify a client (e.g., 1 day instead of 5 days).

Residential/Outpatient Services

Some States limit the availability of residential treatment and rely primarily on outpatient services (e.g., Arizona). Some States place limits on lengths of stay for both modalities; others have no limits, and the decision about treatment duration is made on a case-by-case basis.

Priority Populations

In accordance with Block Grant requirements, virtually all States reported having special programs and/or priority placement for designated high-risk populations, such as pregnant and parenting women and injection drug users. Most States attempt to place these priority clients into treatment

slots immediately; however, this is not always feasible. Under administrative rules in some States, certain clients for whom no treatment slots are available must be placed in "interim services." In many cases, this modality is not truly a treatment service, but rather a means of keeping in contact with clients to ensure that they do not forgo an opportunity for treatment once a slot opens up.

In some States, budgetary constraints make providing crucial wraparound services for women—such as case management, child care, prenatal care (or referrals for prenatal care), and transportation—difficult or impossible. Conversely some States have designated slots for pregnant and parenting women to comply with Block Grant requirements and cannot fill these slots to capacity.

Continuing Care

Many States offer limited or no continuing care services beyond referrals to community self-help groups. Some States do provide links to job training, housing programs, or some form of "relapse prevention" services. Several contacts in State AOD agencies bemoaned the lack of funding for these services, believing them to be critical to reintegrating recovering chronic AOD abusers into society. In the absence of social supports, these clients are at high risk for relapse.

Impact of the Criminal Justice Population

In some States, service referrals from criminal justice agencies are overwhelming. For example, Florida estimates that 70 percent of its AOD treatment program clients are such referrals. In other States, little or no involvement by the State AOD agency occurs in delivering services to this population, or no coordination exists between that agency and the Department of Corrections.

As noted earlier, SAMHSA currently is assessing AOD treatment in State prison systems. In the Federal prison system, inmates who have an AOD problem may be placed in a drug treatment unit if a slot is available. Within the Federal system, four types of drug treatment are available: drug education; nonresidential (i.e., psychological services) programs, including Twelve-Step and Rational Recovery groups, residential programs, and community transition programs. If an inmate is in the custody of the Bureau of Prisons, the Bureau covers the costs; if an inmate is in the custody

of the Probation Office, that office is responsible for payment and for ensuring compliance. Once inmates are released, however, they must use whatever services are available to the general uninsured population in their State.

POLICY IMPLICATIONS AND FURTHER RESEARCH

CSR's study of publicly financed State AOD treatment services identified rapid shifts taking place in treatment service delivery systems. Many of these changes mirror the complexity of change occurring in all aspects of publicly funded healthcare. As a result of the information gathered in this study, CSR foresees a number of policy implications and provides recommendations for further research as follows:

- A shift to managed care could result in a variety of changes in AOD services, such as greater attention to behavioral healthcare (including AOD treatment), possible expanded coverage to populations above current Medicaid income eligibility (or expanded eligibility for Medicaid coverage of adult males), or limitations on the types of services provided. To avoid a weakening of services, States could be encouraged to develop standard statewide criteria for the placement into and continued receipt of AOD services. Model contract language should be developed to ensure that AOD services are part of managed care contracts, to optimize AOD treatment access, and to include safety net providers in treatment networks.
- Changes in AOD services provided to uninsured persons in the States may be less a factor of whether the State provides services through a managed care model or traditional Medicaid reimbursement and more an issue of whether changes in the Federal Block Grants occur or States move their Block Grant and State funds into managed care systems. The overwhelming majority of States still rely on the Block Grant to serve uninsured populations, regardless of the level of services provided.
- Community-based treatment often is provided by recovering addicts in outpatient settings. These providers generally do not fit the Medicaid definition of a medical provider, but they can and do provide crucial services. Goal 3, objective 4, of ONDCP's 1997 National Drug Control

Strategy emphasizes the importance of community-based treatment providers.¹⁰ Feedback from a number of States strongly supports the need to develop a credentialing system for these providers that includes them in managed care networks and to make them an integral part of the publicly funded continuum of care.

- In the 1997 National Drug Control Strategy, the ONDCP stressed the need for ongoing and up-to-date information on the status of drug treatment in the United States.)¹¹ Given the major shifts in the structure of service management and provision under healthcare reform, up-to-date information about the effects of waivers, managed care, and other changes in service delivery would be extremely useful to States contemplating major changes as well as to Federal policymakers. Well-designed program evaluations, distinguishing a number of variables that may identify the differences in services delivered, access to services, and populations served (as well as outcomes) between traditional Medicaid-reimbursed services and services delivered through a managed care arrangement, are crucial.
- Greater coordination between State AOD, Medicaid, and corrections agencies would improve access to services and reimbursement for high-risk criminal justice populations.
- Access to some types of AOD services has been limited simply because of administrative issues. For example, States report that the public AOD service providers are not always skilled in accessing Medicaid reimbursement and must therefore confine services to State-funded provisions.
- Dissemination of creative approaches to handling long waiting lists for treatment services, such as North Carolina's public-private partnership, would be useful to States with shortages of treatment slots.

¹⁰Office of National Drug Control Policy (ONDCP). *The National Drug Control Strategy, 1997*. Washington, DC: ONDCP, 1997a.

¹¹Office of National Drug Control Policy (ONDCP). *The National Drug Control Strategy, 1997: Budget Summary*. Washington, DC: ONDCP, 1997b.

- AOD treatment systems are changing rapidly, and the healthcare system is becoming increasingly complex. New systems are developing; service providers are beginning to contract directly with purchasers; nonprofit hospitals and clinics are forming networks; and public sector programs, including Medicaid and Medicare, are being privatized. Multiple and complex issues abound related to (1) behavioral healthcare funding mechanisms, (2) managed care program structures, (3) AOD treatment issues, (4) privatization of other public sector agencies in the wraparound service network, (5) the interface between AOD treatment services and general medical care, and (6) the legislative actions that continue to shape managed care service systems. These issues and the unprecedented pace of change have the potential to significantly affect availability and access to AOD treatment services. Continuous monitoring of changes in each State and dissemination of reported findings could help States avoid pitfalls as they re-engineer their AOD service delivery systems.

APPENDIX A
STATE SUMMARIES

ALABAMA

SERVICES/MODALITIES

The following publicly funded services are available:

- Crisis residential adult programs and crisis residential adolescent programs, which are highly structured, short term, and intensive;
- Residential rehabilitation services, which are long-term therapeutic programs;
- Residential detoxification services, which are acute care medical detoxification programs;
- Residential rehabilitation pregnant women programs, which include child care and ancillary services;
- Intensive outpatient adult programs;
- Intensive outpatient adolescent programs;
- Specialized services (including case management) for pregnant women/women with dependent children that augment the intensive outpatient and residential programs; and
- Methadone detoxification (21 days) and maintenance (beyond 21 days) (there are very few injecting drug users in Alabama).

SPECIAL POPULATIONS

Women: Specialized services for pregnant and parenting women recently have been implemented.

Dually diagnosed: The Department of Mental Health is in the process of developing treatment and prevention services for the dually diagnosed.

PROVISIONS/LIMITATIONS

None.

FINANCING

State AOD Agency

Financing through the Substance Abuse Services Division is 80 percent Substance Abuse Block Grant funding. The balance is State revenue and a small amount of other Federal funds.

Medicaid

Medicaid reimbursement for substance abuse is minimal—about \$1.1 million for substance abuse services (both State and Federal share).

MANAGEMENT OF SERVICES

The State funds providers on a fee-for-service basis through the Substance Abuse Services Division.

MANAGED CARE SYSTEMS

There is no managed care program for substance abuse services.

ALASKA

SERVICES/MODALITIES

The following services are offered by the State to the indigent on a sliding fee scale, including room and board:

- One inpatient detoxification program is offered at a specialized hospital and one residential non-hospital-based detoxification program is provided at a freestanding facility.
- Inpatient care is available at hospitals or in other medical settings for acute substance abuse-related illnesses.
- Residential rehabilitation programs are offered in three modalities:
 - Intermediate care, which is up to 90 days of fully or partially residential treatment (there is limited medical provider availability of this type of care);
 - Long-term care, which is 6 months to 2 years of a spectrum of services, from transitional care to therapeutic community services (there is one therapeutic community in Anchorage); and
 - Transitional care, which is 1 to 6 months of intermediate (i.e., inpatient or intensive outpatient) care at a halfway house.
- A variety of outpatient services are provided:
 - Primary services, drug-free or methadone, on a scheduled basis;
 - Emergency care on a 24-hour basis; and
 - Across-the-board aftercare services.

The State ensures treatment for all. Those ineligible for Medicaid are charged on a sliding fee scale. Mental health services are also available through the Division, and a dual diagnosis is not required in order to receive treatment.

SPECIAL POPULATIONS

Women: Pregnant women receive priority.

PROVISIONS/LIMITATIONS

The level and availability of services vary across the State.

FINANCING

State AOD Agency

A small proportion (1 to 15) of financing is Substance Abuse Block Grant funding. The Division also is supported by two major Federal grants and Federal discretionary money (a Center for Substance Abuse Treatment [CSAT] Women and Children grant and Rural and Remote Culturally Distinct and Special Populations funds). Many people are covered by the Indian Health Service. A high proportion of the population is military.

Medicaid

The Medicaid agency (i.e., the Division of Medical Assistance) is not a managed care organization, but it performs some of the functions of a managed care organization (e.g., determines eligibility, negotiates rates with providers, and pays bills). The following substance abuse services have been eligible for Medicaid reimbursement since 1994: assessment and diagnosis; individual, family, and group counseling; care coordination services; rehabilitation services; intensive outpatient services; intermediate services; and medical services.

MANAGEMENT OF SERVICES

The Division of Alcoholism and Drug Abuse within the Department of Health and Social Services manages State-funded substance abuse services.

MANAGED CARE SYSTEMS

The State currently is considering broad changes in its Medicaid program.

ARIZONA

SERVICES/MODALITIES

The publicly funded services/modalities that are available in each area of the State are determined by five Regional Behavioral Health Authorities (RBHAs), which contract with local providers to create a network of locally available services:

- Residential treatment (typically 30 to 90 days) is available, although intensive outpatient (individual, family, or group) treatment is utilized more often;
- Ten psychiatric health facilities statewide each have one or two substance abuse beds;
- Detoxification usually is provided through intensive outpatient services;
- There are 10 to 15 methadone providers (public and private) statewide, including some in rural areas (There is a large heroin problem in the State—many people in need of injecting drug use treatment who previously went to California are now served in Yuma.);
- Crisis response and stabilization services may include hospitalization;
- Day treatment is a separate modality;
- Aftercare services include counseling and group support;
- Substance abuse treatment through therapeutic groups and foster care programs are available for youth; and
- Maricopa County has a special grant to provide relapse prevention services.

Services can be paid for on a sliding fee scale or by Medicaid for eligible populations. There are three categories of clients: (1) Medicaid clients receiving Medicaid-reimbursed services, (2) Medicaid clients receiving State-funded (not Medicaid-reimbursed) services, and (3) non-Medicaid clients receiving State-funded services.

SPECIAL POPULATIONS

Native Americans: A combination of Indian Health Service and State/Federal funds cover treatment for Native Americans. Only 4 of the 17 tribes participate in the State system.

Criminal justice population: State prisons receive some Center for Substance Abuse Treatment (CSAT) criminal justice money for treatment.

PROVISIONS/LIMITATIONS

None.

FINANCING

State AOD Agency

Financing through the Division of Behavioral Health Services (within the Arizona Department of Health Services) is approximately 50 percent Substance Abuse Block Grant funds and 50 percent State appropriations. Two discretionary grants go directly to providers; these grants include a pregnant/postpartum women's grant in Tucson and a CSAT criminal justice grant in Maricopa County for adults on probation (the latter grant funds Treatment Alternatives to Street Crime [TASC] case management services provided through a private nonprofit agency).

Medicaid

Behavioral health services are covered for Medicaid-eligible populations (i.e., recipients of Aid to Families with Dependent Children) if the services are deemed medically necessary. If an eligible client is not enrolled in an RBHA and presents in a hospital emergency room in need of detoxification, Medicaid will pay for the first 3 days. The client is then switched to the State-funded network. If a client's income is at or below 30 percent of the poverty level, Medicaid will reimburse for counseling services. The RBHAs assist eligible clients in enrolling in the Medicaid health maintenance organization (HMO).

MANAGEMENT OF SERVICES

There are five RBHAs for the six State regions. RBHAs are nonprofit companies that use Government funds to create a network of behavioral health services available to people in the region for little or no cost. These companies determine the array of behavioral health services the State provides for the public. The RBHAs work locally and contract with providers for treatment services.

MANAGED CARE SYSTEMS

Under a section 1115 waiver, the entire State Medicaid program is now a capitated managed care system called AHCCCS, in which Medicaid clients access services through an HMO. All mental health and substance abuse care is fully capitated for adults and children. The RBHAs are capitated on Medicaid clients and receive an allocation of the Substance Abuse Block Grant funds from the State each month. The local providers who have contracts with the RBHAs either are capitated or paid on a fee-for-service basis.

ARKANSAS

SERVICES/MODALITIES

A full spectrum of publicly funded services may be accessed, including detoxification, residential, and outpatient treatment. The State also supports Chemically Free Living Centers where homeless clients can live for up to 6 months after treatment.

- Hospitals contract on a regional basis for medical detoxification for limited services (3 days, with additional days requiring prior agency approval). Observation detoxification includes monitoring, on a 24-hour-per-day basis for 2 days, a client undergoing mild withdrawal in a residential setting.
- Residential programs are offered to clients who are not ill enough to require medical or observation detoxification but who need more intensive care in therapeutic settings with supportive living arrangements. There is no cap on the number of days. During billing audits, the State ensures that services are justified but sets no caps.
- Outpatient services vary across the State. They may involve individual, family, or group counseling. The State mandates that people leave treatment with a maintenance plan.
- Intensive outpatient programs use a holistic approach with many different treatment methods.
- Interim services are provided a person is admitted to a substance abuse treatment program.
- There are two methadone programs in Arkansas. One is a private, for-profit program that does not serve the uninsured. The other is a private, nonprofit program at the University of Arkansas in Little Rock that the State partially funds.
- Partial day treatment care is provided for a minimum of 4.5 hours per day (including, but not limited to, counseling, therapy, and recreational therapy).
- For aftercare services, programs may make referrals to other programs, such as Alcoholics Anonymous and Narcotics Anonymous, or may provide services themselves.

SPECIAL POPULATIONS

Women: There are five Pregnant and Parenting Women Living Centers where women and their dependents can stay for up to 2 years.

Homeless: Clients who are homeless can live in Chemically Free Living Centers for up to 6 months after treatment.

PROVISIONS/LIMITATIONS

According to the Bureau of Alcohol and Drug Abuse Prevention (ADAP) Policies and Procedures manual, as long as a provider has ADAP funds available, no client may be refused treatment. However, when a provider has exhausted the reimbursable amount of the contract, clients may be refused treatment due to their inability to pay.

FINANCING

State AOD Agency

The ADAP funds substance abuse treatment services primarily using Substance Abuse Block Grant funding. Private nonprofits (community-based organizations, such as Mental Health Centers) conduct intakes and require that patients provide proof of their inability to pay. If a client is poor, the services are provided free to the client and the State is billed; otherwise a sliding-scale fee is required.

Most services are provided on a fee-for-service basis. Some programs—mainly special programs, such as Pregnant and Parenting Women Living Centers—are budget based, because they were implemented as pilot programs and could not afford to operate on a fee-for-service basis.

Medicaid

No substance abuse services are reimbursed by Medicaid in Arkansas. This is under review.

MANAGEMENT OF SERVICES

Services are provided on a traditional fee-for-service basis; the State is billed by the providers.

MANAGED CARE SYSTEMS

Arkansas has a statewide 1915 waiver under which Medicaid recipients must select a primary care physician who acts as a gatekeeper. In addition, a selective contracting waiver governing obstetric care exists in two counties.)

CALIFORNIA

SERVICES/MODALITIES

Indigent, uninsured clients may self-refer to substance abuse services and pay on a sliding fee scale or not at all. The following publicly funded services are available with no limitations or caps:

- Outpatient drug-free programs;
- Outpatient methadone maintenance;
- Outpatient detoxification;
- Drug-free programs;
- Inpatient hospital detoxification;
- Freestanding residential detoxification; and
- Residential drug-free programs.

Outpatient methadone treatment is available for up to 21 days. Aftercare services can be provided as part of the outpatient services.

SPECIAL POPULATIONS

Women: Addicted women are a priority in placement in perinatal programs (which include prenatal care). As of May 1996, 148 pregnant clients were on the waiting list for the perinatal programs.

PROVISIONS/LIMITATIONS

Inadequate resources limit the availability of treatment slots. At any time, approximately 14,000 clients were on the waiting list; the wait can be longer than 30 days, depending on the service needed.

FINANCING

State AOD Agency

The Substance Abuse Block Grant is the largest source of funding; "other" sources are the next largest, followed by other Federal funding and State appropriations.

Medicaid

An interagency agreement between the Department of Alcohol and Drug Programs (ADP) (the State alcohol and other drug [AOD] agency) and the Department of Health Services (DHS) (the State agency administering Medicaid) enables medically necessary substance abuse treatment services to be provided to eligible Medi-Cal beneficiaries through contracts with counties and private providers. The services offered through the program, known as Drug/Medi-Cal (D/MC), are limited to the following:

- Outpatient detoxification;
- Outpatient methadone maintenance;
- Daycare habilitative (intensive outpatient) services for pregnant and postpartum women and youth under age 21;
- Residential services for pregnant and postpartum women and youth under age 21;
- Naltrexone treatment (including counseling, medications, and medical monitoring); and
- Outpatient drug-free services.

Inpatient detoxification is not covered by D/MC.

MANAGEMENT OF SERVICES

Through the interagency agreement with DHS, ADP administers, manages, and finances D/MC through contracts with counties and local providers. The State is exploring managed care for State-funded services; currently ADP has fee-for-service contracts with counties and providers.

MANAGED CARE SYSTEMS

According to the National Association of State Alcohol and Drug Abuse Directors State Resources report, the State is anticipating and preparing for State AOD services to be incorporated into a managed care system. At this time it appears that a managed care system will be put in place within the next 5 years. The State is grappling with the need to shift its AOD services and fee-for-service funding mechanisms into a managed care system. Counties are concerned about the survival of social model programs during the development of the managed care system, particularly in light of the growth of the medical model D/MC program.

COLORADO

SERVICES/MODALITIES

The State provides a full range of publicly funded services to about 70,000 to 80,000 clients per year, including the following:

- Case management programs for chronic clients;
- Residential detoxification programs in which the average length of stay is a few hours to several days;
- Medical detoxification, which includes residential or outpatient care for withdrawal symptoms that require medical supervision;
- Intensive residential treatment, which involves at least 40 hours and 6 days per week of therapeutic activity in a residential setting, with an average length of stay of 2 to 6 weeks;
- Transitional residential treatment, which is provided in halfway and three-quarterway houses and includes 10 to 20 hours of therapeutic contact, 6 days per week, in a residential setting for persons transitioning to or from more intensive residential or outpatient treatment, and with a flexible length of stay that normally does not exceed 120 days;
- Long-term support (i.e., domiciliary), providing 24-hour, 7-day supportive care for dysfunctional clients who cannot benefit from treatment, with a length of stay that may be indefinite;
- Therapeutic community programs, which provide long-term, highly structured residential treatment, 24 hours per day, 7 days per week, with a length of stay of 3 months to 3 years and an average of 1 year;
- Outpatient treatment, with a minimum of one contact per 30 days and a variable length of stay (i.e., an average of 3 months);
- Intensive outpatient treatment, which covers more visits and longer counseling times than outpatient treatment; and
- Narcotic treatment involving substitution therapy, in which the length of stay may be several years.

SPECIAL POPULATIONS

Dually diagnosed populations: Outpatient and day care services, detoxification, and residential and outpatient services are provided for the dually diagnosed.

PROVISIONS/LIMITATIONS

None.

FINANCING

State AOD Agency

The funding is about one-third Substance Abuse Block Grant, one-fifth State revenue, one-fourth "other" sources, and the balance from other Federal and State sources.

Medicaid

There is almost no Medicaid reimbursement for substance abuse except for some services for pregnant women and for dually diagnosed clients.

MANAGEMENT OF SERVICES

The State Department of Public Health and the Environment contracts with providers and reimburses them approximately 40 to 50 percent of treatment costs (this proportion may be larger in some areas) on a fee-for-service basis. The balance of approved costs of treatment services may be covered through other sources, including but not limited to county and municipal appropriations, direct Federal grants and contracts, other State contracts, client fees, third-party payments, philanthropic foundation grants, and cash donations.

MANAGED CARE SYSTEMS

The State is moving to managed care. Under a Request for Proposals being developed, the State will contract with six managed care entities that will contract with providers, rather than the State contracting directly with numerous local providers.

The State has a 1915(b) waiver to provide capitated mental health services to Medicaid-eligible clients. This arrangement does not include substance abuse services except as they overlap with mental health services.

CONNECTICUT

SERVICES/MODALITIES

Treatment programs are required to take the medically indigent and cannot discriminate based on ability to pay, number of times in treatment, or motivation. The following publicly funded services are available:

- Medical detoxification is available through freestanding residential programs, both State-operated (a 99-bed facility) and community-funded, nonprofit managed services (12 beds). There are also 143 community-based ambulatory detoxification slots.
- Community-based residential treatment is available through 725 funded slots providing intensive residential, intermediate residential, and residential drug (longest term) treatment.
- Methadone maintenance is available through 2,141 outpatient slots entirely funded by the communities (no State funding).
- Intensive outpatient treatment is available through 230 slots, all of which are community based.
- Drug-free outpatient treatment is available through 3,744 slots.
- Long-term care is available through 130 slots. Clients formerly sent to State detoxification programs from emergency rooms (frequently chronic recidivists) are now sent to long-term care programs. These clients often are homeless. Alcoholics Anonymous programs are available in the long-term care services.

SPECIAL POPULATIONS

Women: Pregnant women are prioritized for admission. There are 57 slots for pregnant/parenting women. Women are referred for prenatal care (which is covered by Medicaid).

Dually diagnosed: There is one comprehensive program for the dually diagnosed.

PROVISIONS/LIMITATIONS

A waiting list of 1,586 was reported to the National Association of State Alcohol and Drug Abuse Directors (with an average wait of 2 months).

FINANCING

State AOD Agency

The major share of funding is State revenue, with another large piece from "other sources" and a smaller share from the Substance Abuse Block Grant.

Medicaid

The same State agency, the Department of Social Services, manages both Medicaid and State-funded programs.

Medicaid clients access all medical care through health maintenance organizations (HMOs). Some of the HMOs subcontract with behavioral health agencies for substance abuse services.

MANAGEMENT OF SERVICES

Most of Connecticut is served by community-based programs under contracts with the State.

MANAGED CARE

The State is developing regional networks of providers in order to establish a State-operated managed care program. Contracts with the networks will be capitated. A client will be able to call an information line to find out where to access care.

DELAWARE

SERVICES/MODALITIES

The following publicly funded services are available:

- Residential treatment, both short term (up to 28 days) and long term (over 28 days);
- Methadone detoxification;
- Two outpatient methadone maintenance programs;
- Outpatient treatment; and
- Aftercare (which is not a formal modality; many programs offer aftercare services but do not bill separately for them).

SPECIAL POPULATIONS

Criminal justice population: The Department of Corrections funds quarterway and halfway houses with limited outpatient services and three or four long-term inpatient jail programs.

Women: Two targeted full-spectrum programs are available, the Perinatal Program and the First Step Program.

Dually diagnosed: Four programs are available that feature a continuous team approach and have no caps on length of stay, although the usual length of stay is about 1 year. The programs each have a capacity of 40 clients and offer very intensive services.

Children and youth: The Department of Services to Children, Youth and Their Families (not the Department of Health and Social Services, the State alcohol and other drug [AOD] agency) funds the following services:

- Residential treatment: Clients are sent to facilities in Maryland or Pennsylvania, and the State covers the costs.
- Day treatment: There is one program in Newcastle County, one in Sussex County, and one being implemented in Kent County. (These three counties comprise the entire State.)
- Intensive outpatient, afterschool services: There are four programs—two in Newcastle County and one each in Sussex and Kent Counties.
- Detoxification: There is no program specifically for youth. They may receive services in two adult detoxification centers, or they may go to the hospital (which

Medicaid covers). Some youth on heroin receive detoxification treatment at out-of-State facilities; Medicaid reimburses some of this at a capitated State rate for child mental health.

- Aftercare: Programs provide continuing care, but 12-step programs may not be provided due to uncertainty about their age appropriateness.

PROVISIONS/LIMITATIONS

There is no cap on length of stay for State-funded services. A utilization review committee reviews requests for residential services, but probably would not refuse treatment until after several (probably five) episodes of treatment have failed, when the oversight team would terminate treatment.

Capitated services covered by Medicaid generally are limited to 30 units of outpatient services for children and 20 units of outpatient services and 30 units of inpatient services for adults. Beyond that, services are on a fee-for-service basis.

FINANCING

State AOD Agency.

Funding is approximately 50 percent Substance Abuse Block Grant and 50 percent State revenue.

Medicaid

Delaware has an 1115 Medicaid waiver under which Medicaid clients (as well as uninsured people with incomes at or below 100 percent of the Federal poverty level) receive inpatient and outpatient mental health and substance abuse services through a managed care plan. The two categories of Medicaid services are as follows:

1. Diamond State Health Plan, which covers all Medicaid-eligible clients (with a few exceptions) as well as uninsured noncategorical clients with incomes below 100 percent of the Federal poverty level. This is a managed care program with combined substance abuse/mental health services covering inpatient, outpatient, partial hospitalization, detoxification, and methadone treatment. A minimal level of care is required; however, each managed care organization (MCO) individually determines the services provided.
2. Fee-for-service for clients exempt from the other category. This category does not include substance abuse services.

MANAGEMENT STRUCTURE

A few targeted programs (including those for pregnant and parenting women and for the homeless) receive grants. In general, however, State-funded services are capitated up to limits, and then are

on a fee-for-service basis. Programs bill the State, which reimburses with a mixture of Federal and State funds.

Services provided by MCOs under the Diamond State Health Plan are fully capitated. Some general health MCOs contract out substance abuse services to behavioral health MCOs, and others handle them within their own panel.

MANAGED CARE

Under an 1115 waiver, Delaware provides a fully capitated managed care plan designed to provide a basic set of health care benefits to current Medicaid beneficiaries as well as uninsured people whose incomes fall below 100 percent of the Federal poverty level.

DISTRICT OF COLUMBIA

SERVICES/MODALITIES

The following publicly funded services are available:

- Freestanding, nonhospital, short-term residential detoxification (from 5 to 7 days) with a referral to long-term treatment;
- Short-term (up to 28 days) or long-term (up to 4 months) residential treatment;
- Transitional living programs with life skills training for 6 months, which include safe house supervised living (these programs formerly were for the general addictions population but now focus on homeless women and children);
- Outpatient drug-free programs, with no cap;
- Outpatient methadone programs, with no cap; and
- Aftercare services consisting of support groups, counseling, and ancillary services.

SPECIAL POPULATIONS

Women: Residential and intensive day treatment are available for pregnant and parenting women. Residential social detoxification treatment is available for women with up to two children. Supervised living programs (for up to 6 months) are available for mothers with up to four children.

Criminal justice population: The District has received a grant from the Center for Substance Abuse Treatment to improve the criminal justice system for drug treatment service provision.

PROVISIONS/LIMITATIONS

Caps on treatment are noted above. Medicaid does not cover inpatient detoxification or other hospitalization in connection with substance abuse.

FINANCING

State AOD Agency

The majority of funding is from the alcohol and other drug (AOD) agency (allocated by Congress to the D.C. budget). A very small proportion of funding is from the Substance Abuse Block Grant.

Medicaid

The District is beginning to obtain Medicaid reimbursement for substance abuse services. The District Medicaid program does not specifically address substance abuse. There have been some problems identifying which services are billable.

MANAGEMENT OF SERVICES

The District contracts directly with providers who invoice the District on a fee-for-service basis. A sliding fee scale has just been phased in (all services formerly were free).

MANAGED CARE SYSTEMS

The District currently is exploring managed care models and is leaning toward a behavioral health managed care model with mental health and substance abuse under one umbrella. Medicaid reform would be part of this initiative, and the District is reviewing waiver requirements to determine what would be required.

FLORIDA

SERVICES/MODALITIES

A range of publicly funded services is available. The *Administrative Rule* defines levels of treatment as follows:

1. Residential levels 1, 2, 3, and 4; residential host family (for adolescents); supported housing.
2. Detoxification
 - a. Residential
 - b. Outpatient
 - c. Methadone detoxification
 - d. Addiction receiving facilities (ARFs)
3. Nonresidential (outpatient day/night)
4. Intervention
 - a. Community
 - b. Employee assistance program
 - c. Treatment Alternatives for Safer Communities (TASC)
5. Prevention
6. Specialized services
 - a. Methadone maintenance
 - b. Licensed inmate programs in State jails

Medical detoxification is available in the large metropolitan areas. There are State-funded detoxification facilities called crisis stabilization units (which are public nonprofit) where, for example, the police might bring an acute case for anywhere from 24 hours to 7 days. Usually, funded detoxification programs are multilicensed facilities where clients can be transitioned to rehabilitation services. Outpatient emergency screening and treatment are available for adults and youth.

For outpatient intensive treatment—also called day/night—clients spend 5 hours per day for at least 4 days per week for 7 weeks (perhaps from 6:00 to 10:00 p.m. 4 evenings per week, sometimes afternoons) participating in treatment services.

Aftercare is a licensed category under the new *Administrative Rule*. It is considered a specialized service and is provided through separate contracts between the Health and Human Service (HHS) boards and local providers. It can include telephone counseling or true aftercare services (defined by the *Rule*).

Many types of community interventions are provided, including utilizing community people to “do an intervention” with an abuser; Alpha/Beta programs in schools for-at-risk youth; and a midnight basketball league for substance abusers, which is a program to reduce substance abuse in a formalized and monitored manner.

SPECIAL POPULATIONS

Women: Pregnant women are prioritized for treatment. The State of Florida designed a comprehensive package of services for pregnant and postpartum women that meets the Substance Abuse Block Grant requirements and is contracted for at the district level. If there is no inpatient slot available, the women are placed in a special “interim service” (i.e., outpatient service) until appropriate inpatient service is found. Specialized holistic services for women and dependent children include residential and day treatment and ancillary services.

Criminal justice population: Most people (about 70 percent) in publicly funded substance abuse treatment are criminal justice referrals. If a judge orders treatment, then placement is a priority. Police officers bring adolescents into Juvenile Assessment Centers, which are affiliated with law enforcement agencies (funded through State general revenues and Juvenile Justice grants, with local sheriffs and/or police departments providing staff). Every juvenile who intersects with law enforcement has a TASC assessment; providers are available statewide to assess juveniles for treatment needs and to serve as case managers. (TASC workers also may provide services to adult criminal justice clients with substance abuse problems.) ARFs are semisecured facilities that conduct assessments and provide detoxification and stabilization services. ARFs serve both adult and juvenile offenders.

Dually diagnosed: Both residential and outpatient services are available to the dually diagnosed.

PROVISIONS/LIMITATIONS

Approximately 1,000 people are on waiting lists for treatment every month.

FINANCING

State AOD Agency

The State has \$50 million through the Substance Abuse Block Grant—about 50 percent of the total spending. The balance comes from the State legislature and has local matching requirements. The funds are allocated to district offices with some set-asides.

Medicaid

Any provider under contract with a State-funded agency can enroll as a Medicaid provider and then bill Medicaid (which is handled by the State Agency for Health Care Administration). Substance abuse billings are not high, because eligibility is narrow (i.e., recipient of Aid to Families with Dependent Children) and many providers do not seek reimbursement. Room and board for

residential care is not reimbursed. Covered services include medical evaluations, individual counseling, and group therapy by mental health professionals.

The State has an 1115 waiver covering women at risk of giving birth to low-birthweight infants. This effort is a multidisciplinary intervention involving risk identification and reduction.

MANAGEMENT OF SERVICES

The Governor appoints one HHS board in each of 15 districts covering the State. The HHS boards allocate the funding for each district. They cannot deviate from Federal mandates (without waivers) but can deviate from State mandates.

The districts contract with public nonprofit entities (there are approximately 125 of them and one private methadone clinic). Services are rendered according to the contracts. The *Administrative Rule* defines requirements for providers of services to public clients.

MANAGED CARE SYSTEMS

Managed care elements are being introduced into the Medicaid system (such as utilization review, preauthorization of inpatient care, and concurrent review of high utilizers). An 1115 waiver has been approved but not yet implemented; the waiver will bring mental health and substance abuse services under managed care.

GEORGIA

SERVICES/MODALITIES

Responsibility for the oversight and administration of services was transferred to 19 local boards in 1991. All substance abuse programs in State hospitals have been closed down, and services were scheduled to be moved to community programs. In general, the following services are provided, but the availability varies among the local areas:

- **Detoxification:** A few programs still offer standard detoxification, but some programs have been transformed into 23-hour crisis stabilization units. In some counties, inpatient detoxification may be available if the client consents to receive treatment in a psychiatric unit.
- **Inpatient:** Long-term inpatient treatment is not available; 28 days is the maximum, and most inpatient services are being eliminated to provide crisis stabilization for the mentally ill. Inpatient treatment is not available in Dekalb County (metropolitan Atlanta).
- **Outpatient services:** Some services are specific to substance abuse, and others are generic mental health outpatient services.
- **Methadone:** Available in five cities. One clinic in Atlanta recently closed and its services have been transferred to the community hospital.
- **Aftercare:** Some programs provide aftercare services. A publicly funded program for chronic recidivists has been eliminated.

There are no minimum program requirements, only quality standards to certify for Medicaid reimbursement. Before 1991 every service area (in every region) had easy access to detoxification and outpatient treatment (with some intensive outpatient), and there was adequate nonhospital long-term care. Day treatment programs for the dually diagnosed have been turned into programs for low-functioning mentally ill with a small substance abuse component.

SPECIAL POPULATIONS

Adolescents: There are a few publicly funded, freestanding adolescent residential treatment programs in the State.

Women: Three programs for pregnant women are still in operation.

Homeless: Two residential programs funded by the Center for Substance Abuse Treatment that provide services to homeless women and children will be closed in 1 year.

PROVISIONS/LIMITATIONS

Long-term inpatient treatment does not exist. Most inpatient services are being eliminated. Inpatient treatment is not available in Dekalb County (metropolitan Atlanta).

FINANCING

State AOD Agency

One-third of funding comes from the Substance Abuse Block Grant and one-half from State revenue. Substance abuse, mental health, and mental retardation programs are centralized in one agency, and substance abuse receives little financing.

Medicaid

Medicaid reimburses some substance abuse services. It no longer reimburses for treatment at State hospitals (where detoxification and long-term treatment formerly were provided), because substance abuse clients are no longer treated there. A clinic option in the State Medicaid program covers some outpatient services. The State division currently is awaiting approval for a waiver (see below).

MANAGEMENT OF SERVICES

A few years ago, the service delivery system was completely reorganized. Nineteen regional boards (composed of unpaid nonprofessional volunteers) were established, and authority for developing and implementing policies and programs were transferred from the State agency to the boards. Each board develops its own policies and subcontracts to providers. The State agency has little oversight or communication with the boards; its role and personnel are being downsized and it is serving more of a technical support role. Money is funneled to the boards on a fee-for-service basis. (Services are reportedly declining, and clients are reported to be calling the State agency at an unprecedented rate to complain of being denied services, at times because they were unable to pay an admission fee.) The former Community Mental Health Centers are now Community Service Boards, and they compete with the private sector for contracts. They are still nonprofits, but their standing in the State system is like private for-profits: State funding is not available to cover losses incurred in treating low-income, uninsured, or indigent clients.

MANAGED CARE SYSTEMS

The State developed a waiver proposal to bring all three disability services (i.e., substance abuse, mental health, and mental retardation) into managed care to include all Medicaid clients as well as non-Medicaid clients who rely on State and Federal funds for services. Under the waiver, capitated Medicaid payments would be pooled with uncapitated State and Federal funds; the State then would contract directly with providers to deliver services. However, that waiver proposal (which has not been approved) is on hold, with no plans for implementation.

HAWAII

SERVICES/MODALITIES

A comprehensive range of publicly funded services is available, including detoxification, hospital inpatient services, outpatient services, residential services, and methadone services (both medication and treatment). Aftercare is not covered, but it can be built into treatment. Insufficient resources and treatment slots are a major problem: Generally 100 to 200 people are on a waiting list at any time.

SPECIAL POPULATIONS

Youth: The Alcohol and Drug Abuse Division of the State Department of Health pays for school-based treatment for students in 22 high schools in the State by contracting with private agencies to provide group and individual counseling, screening, and referrals in the schools. About 100 students per year receive treatment through that program.

Women: A pregnant and parenting women's initiative provides a residential and day program for women and their children, and pregnant women receive priority in treatment throughout the State. The "Baby Safe" program provides outreach, case management, and treatment for pregnant, addicted women.

Native Hawaiians: Hawaii's Federal block grant has a set-aside for Native Hawaiians, and in all the division's contracts, a certain percentage of the budget must be devoted to Native Hawaiians. About 38 percent of the State's admissions to treatments are Native Hawaiians.

Criminal justice population: Probation and Parole purchases services and operates a drug court program using the same providers that the Alcohol and Drug Abuse Division licenses and accredits.

PROVISIONS/LIMITATIONS

Under Medicaid, substance abuse and mental health benefits are merged and provided through a carved-out managed care plan. Both are limited to medically necessary services with the following additional limitations:

- Inpatient hospital treatment: 30 days per year (which can be exchanged for community-based residential treatment or intensive outpatient treatment at the rate of 2 inpatient hospital days for 1 intensive outpatient day).

- Outpatient visits: 24 per year.

There is no limit to detoxification services.

FINANCING

State AOD Agency

The Alcohol and Drug Abuse Division pays for services for people who do not have Medicaid or private insurance coverage. Most of these services are funded through Federal block grant funds and State appropriations, which are administered by the Alcohol and Drug Abuse Division. Out of a treatment budget of about \$9 million, one-half is from a Federal block grant and one-half is State funding.

Medicaid

Medicaid services are the responsibility of the State Department of Human Services. Hawaii has a statewide 1115 waiver, QUEst, which pays for services for residents with incomes up to 300 percent of the Federal poverty level. It provides a comprehensive range of services, including methadone. The program excludes residential substance abuse treatment; however, there are five separate QUEst plans, and most purchase community-based residential services instead of hospital beds to stabilize clients.

MANAGEMENT OF SERVICES

The Alcohol and Drug Abuse Division negotiates fees and establishes contracts with private nonprofit agencies who conduct the screening, referrals, and treatment for eligible clients on a fee-for-service basis. The division licenses and accredits these providers (none of which are hospitals), then purchases substance abuse services for all residents with incomes up to 300 percent of the Federal poverty level who have no other way to pay. Currently the division contracts with 15 adult and 8 adolescent service providers. Medicaid services are provided through a managed care plan (see below).

MANAGED CARE SYSTEMS

The statewide QUEst Medicaid waiver is a managed care plan. The Medicaid agency contracts with five medical plans to serve as gatekeepers: three of these are insurance plans, one is a closed-panel health maintenance organization that also provides services, and one both provides services directly and operates a network.

IDAHO

SERVICES/MODALITIES

The following publicly funded services are available:

- **Detoxification:** Clients may be referred by the police and other types of agency and program staff to an emergency room for detoxification. However, the primary detoxification modality is social (i.e., nonmedical) detoxification in a residential setting, typically for 3 to 5 days.
- **Residential stabilization:** The average stay is 7 to 14 days (maximum 30).
- **Nonhospital residential (i.e., halfway house):** The average stay is about 1 month. Clients participate in outpatient continuing rehabilitation.
- **Outpatient continuing rehabilitation:** As the primary modality of treatment, it provides screening, assessment, counseling, therapy, family and systems assessment, case management, and so forth.
- **Aftercare:** Clients are taught during treatment to access and utilize "continuing" care; 12-step or self-help services are not incorporated into treatment methods as billable units.

SPECIAL POPULATIONS

Women: The State funds one substance abuse program for women with children.

PROVISIONS/LIMITATIONS

Methadone is not available from the public health system in Idaho.

Because Idaho is a rural State, many regions lack the population density to justify placing a special program there.

FINANCING

State AOD Agency

Funding is approximately 50 percent Substance Abuse Block Grant and 50 percent State revenue. All substance abuse services are contracted on a fee-for-service basis. Each contract is for a specified amount of money that gets billed out as it gets used. The State sets a rate for each service under the contracts and will pay up to 95 percent. The amount charged to a State client is established by the terms of the contract between the State and the provider. Income eligibility is

250 percent of the poverty level or below. The client is generally asked to pay 5 percent of the cost of services, and the provider must cover the remainder.

Medicaid

Medicaid reimburses for very little substance abuse treatment, because only hospital-based treatment is eligible and very little drug treatment is provided in hospitals.

MANAGEMENT OF SERVICES

The State has seven regions (and regional directors), each of which is responsible for disbursements. The State contracts with providers (i.e., private nonprofit), and regional contractors serve as case managers.

MANAGED CARE SYSTEMS

Idaho has a 1915 waiver that does not cover substance abuse. A task force currently is reviewing the system, and the State has not yet decided whether to move to managed care. There may be one State agency to manage substance abuse services based on outcomes, not on caps or maximums.

ILLINOIS

SERVICES/MODALITIES

The State Department of Alcoholism and Substance Abuse (DASA) provides the full spectrum of substance abuse services, from prevention programs to aftercare, including the following:

- Detoxification programs;
- Long-term rehabilitation (90 days);
- Short-term rehabilitation (30 days);
- Outpatient programs (25 hours);
- Intensive outpatient programs (75 hours); and
- Residential aftercare programs, which include unlimited case management; methadone treatment; recovery homes that may or may not provide intensive treatment; and sanctuary programs, which are community-based facilities providing long-term residential care in which residents can receive necessary detoxification services.

SPECIAL POPULATIONS

Women: Illinois had a commitment to specialized services for women long before these were imposed by Federal mandates. The State maintains several specialized treatment centers for women and many gender-specific outpatient services. In addition, the Department of Child and Family Services has specialized treatment programs for abusing and neglectful mothers that include case management and intensive outpatient services. DASA has developed a "welfare project" in which substance-abusing, Aid to Families with Dependent Children mothers who do not show up for screening or comply with treatment programs are financially sanctioned. The project has requested a waiver to impose the sanctions, but is currently operating without an approved waiver.

Dually diagnosed and other special populations: Many special populations, including mentally ill substance abusers, are handled through case management that is tied to the clients' specific needs. Services are developed through the specific agencies corresponding to the identified needs.

Ethnic groups/migrants: DASA provides funds to local communities for ethnic-specific programs (e.g., a Latino project or a Polish alliance). Migrants are eligible for specific services that receive targeted funding from the State (local agencies can design programs for State support).

Criminal justice population: DASA provides treatment in collaboration with the Department of Corrections. An institutionally based system was developed to ease the treatment load of

community-based programs. DASA conducts the programs within prisons and then provides residential and aftercare programs in the community.

PROVISIONS/LIMITATIONS

Technically no limitations are imposed on people needing substance abuse treatment. People are screened using the American Society of Addictive Medicine (ASAM) placement criteria; once they are ASAM certified, individuals are placed in the most appropriate program. Those people who are certified and overstay the treatment timeframes are considered to have been misplaced and are redirected or extended as necessary; non-ASAM-certified individuals do not receive extended stays. Because approximately 52 percent of treatment admissions have no previous admissions and only 8 percent of the admissions have four or more previous admissions, the State believes that the certification process has been effective in the placement of clients. It was noted, however, that as welfare programs are eliminated, more clients seek substance abuse treatment as a way of obtaining basic food and shelter.

FINANCING

State AOD Agency

State funds for substance abuse come from the State's general operating revenue, as well as from several different funds created with the monies derived from fines (e.g., drunk driving fines or the 12½ Percent Solution Fund). The State also seeks competitive awards, such as grants from other Federal sources and from national and State foundations. The State does not expect to be the total funding source for all local treatment programs, but it operates to ensure the availability of services by developing both treatment facilities and actual treatment programs.

All public funding for substance abuse flows through DASA. Treatment is available at State-funded facilities on a sliding-fee scale for services.

The State has local taxing bodies called "708 Boards" and "553 Boards" that provide funding for local treatment providers with local tax money.

Medicaid

Medicaid funds can be used for outpatient services, group therapy programs, and residential day treatment programs. Outpatient methadone services were dropped from the Medicaid program.

MANAGEMENT OF SERVICES

DASA is a cabinet-level department of the State. It shares decisionmaking power regarding the types of services available and how they are operated (e.g., targeting special populations) with local providers. Mental health services are administered by a separate cabinet-level department.

MANAGED CARE

The State has a modified managed care system; substance abuse treatment and mental health services are carved out of this system. The State has moved back from fee-for-service programs to primarily grant-in-aid programs. DASA is moving toward implementing a network based on geography and need. Case management will be handled through the network as a way of streamlining access to needed services. DASA is considering implementing programs that target people early in order to cut down on the number of people in more advanced treatment.

An 1115 waiver has been submitted but not yet approved. It would incorporate a managed care system with a mental health and substance abuse carve-out.

INDIANA

SERVICES/MODALITIES

Indiana has established managed care provider (MCP) networks to deliver mental health and addiction services. Every provider must make a continuum of services available to eligible clients. The modalities provided are as follows:

- Treatment planning;
- Evaluation and monitoring;
- Case management;
- Twenty-four-hour crisis intervention, including detoxification (publicly supported detoxification is only available within networks);
- Outpatient treatment;
- Intensive outpatient treatment;
- Residential treatment;
- Transitional residential treatment;
- Halfway houses; and
- Family support services.

To be eligible for State-supported services, clients must be at or below 200 percent of the Federal poverty level, although providers can, at their discretion, provide services to clients above the poverty level.

Currently (as of January 1997) there is a moratorium on enrollment—new clients cannot access services. On July 1, 1996, the State approved the use of 60 percent of funds (in 1 month), and the system has been shut down. The enrollment waiting list far exceeds the balance of funds.

SPECIAL POPULATIONS

Women: There are special services for pregnant and parenting women.

Criminal justice population: The incarcerated population cannot access network services. Those on parole can receive treatment if they meet the network eligibility requirements.

PROVISIONS/LIMITATIONS

Detoxification is only provided by the State if the client is enrolled in a network. For example, the Salvation Army once provided detoxification services under contract with the State but now, under managed care, cannot provide that service to a client who is not enrolled in the system.

FINANCING

State AOD Agency

The Substance Abuse Block Grant provides 85 to 90 percent of funding. The balance is State funding from various line items (such as a dedicated tax fund). Funding streams formerly were managed independently but are now consolidated.

Medicaid

A Medicaid rehabilitation option is accessible to mental health centers. Adults with mental illness and children and youth with serious emotional disturbances may have outpatient, intensive outpatient, and case management services reimbursed by Medicaid. If a substance abuse client fits the above categories, some services are reimbursable. A very small portion of the State revenue base supports this system.

MANAGEMENT OF SERVICES

Since the 1980s the Division of Mental Health has provided support for services delivered through nonprofit organizations. Originally the nonprofit organizations formed a statewide system of community mental health centers (CMHCs); subsequently freestanding addiction service providers joined the system.

Since 1994 legislation has required that mental health and addiction services contracting with the division become MCPs. Thus, rather than the State using a managed care corporation, service agencies form managed care panels and apply to the State for recognition. The MCP networks are required to enroll all persons for treatment who meet eligibility requirements (i.e., financial needs and criteria diagnosis of the *Diagnostic and Statistical Manual*, fourth edition). Payment is attached to the individual (i.e., capitated) and made prospectively (i.e., \$2,700 per client per 12 months of care; pregnant women/women with children are at a higher rate of \$3,375). Enrollment is for 1 year; clients must be re-enrolled each year. A total of 30 CMHCs and many private nonprofit agencies comprise the 29 MCP networks in the State.

State behavioral hospital bed usage is being reconfigured, with responsibility for beds "assigned" to CMHCs based on the respective percentages of low-income clients in catchment areas. This is designed in order to maintain availability of this more intense level of care while building in an incentive to contain its use.

MANAGED CARE SYSTEMS

The State treatment system has been converted into a managed care system (see previous section).

IOWA

SERVICES/MODALITIES

The full spectrum of services is available with the exception of inpatient detoxification. There are seven levels of treatment as follows:

1. Continuing treatment;
2. Halfway house;
3. Extended outpatient treatment;
4. Intensive outpatient treatment;
5. Residential treatment;
6. Medically monitored residential treatment; and
7. Medically managed inpatient treatment (which is the most intensive level and is available for Medicaid clients only).

Levels 1–3 can be accessed through self-referral, and there is no limit on the services. Levels 4–7 must be authorized by the managed care plan (i.e., the Iowa Managed Substance Abuse Care Plan [IMSACP]).

SPECIAL POPULATIONS

Women: Three mothers and children programs are accessed traditionally rather than through IMSACP.

Dually diagnosed: Dual diagnosis services are available from health maintenance organizations serving Medicaid clients and can be arranged for non-Medicaid clients.

Criminal justice population: Collaborative relationships with substance abuse service delivery personnel in the courts and corrections systems are under development. Court liaison services for juvenile and adult district courts are offered.

PROVISIONS/LIMITATIONS

Inpatient detoxification services are not available to non-Medicaid clients.

FINANCING

State AOD Agency

Substance abuse treatment services receive funding from the Substance Abuse Block Grant (about one-fourth of the funding); State revenue (about one-fourth); and other Federal, State, county, or local resources (one-half).

Medicaid

Iowa has an 1115(b) waiver. Medicaid eligible clients are covered by IMSACP. Intensive outpatient, primary or extended residential, medically monitored residential, and medically monitored inpatient services require treatment authorization. IMSACP processes and pays claims.

MANAGEMENT OF SERVICES

IMSACP is a new program (implemented in September 1995) administered by a managed care organization under contract with the Iowa Department of Human Services (Medicaid) and the Iowa Department of Public Health (single State agency). The managed care organization has a contract with a provider of managed behavioral health services. The providers receive a contractually set payment to serve anyone who walks in. Thus, services are provided under a capitated three-way contract.

Eligible non-Medicaid clients include those whose income is below 400 percent of the Federal poverty level. They are served on a standardized sliding-fee-scale basis.

MANAGED CARE SYSTEMS

The Iowa State public health system is under managed care. The State has an 1115 waiver, and both Medicaid and non-Medicaid clients are served under the same system and the same guidelines for substance abuse care delivery. Medicaid clients accessing levels 4-7 must be connected with an IMSACP crisis care manager.

KANSAS

SERVICES/MODALITIES

Clients may be charged according to a sliding fee scale or not at all for the following publicly funded services:

- Detoxification: Social detoxification is available in some areas. Publicly funded acute/medical detoxification is not available.
- Inpatient: Very little long-term inpatient treatment is available. Short-term treatment of 14 days is available.
- Outpatient: Most treatment is provided on an outpatient basis.
- Methadone: Services are available at two sites.
- Aftercare: Continuing care guidelines are under development.
- Halfway house: There are reintegration centers in a case management setting for people leaving primary treatment.

Over three-fourths (77 percent) of admissions are for alcohol addiction.

SPECIAL POPULATIONS

Criminal justice population: The agency funds programs in youth correctional facilities. The Department of Corrections handles adults.

Women: There are seven women and children's programs that are full-spectrum residential.

Youth: There are both residential and outpatient youth programs. The agency funds alcohol treatment units in the group homes for youth whose parents have lost custody.

PROVISIONS/LIMITATIONS

None.

FINANCING

State AOD Agency

The financing is approximately 50 percent Substance Abuse Block Grant funding and 50 percent State revenue, with a small amount of additional Federal funding.

Medicaid

There is minimal Medicaid coverage for substance abuse—only for some services in residential programs for women.

MANAGEMENT OF SERVICES

The State alcohol and other drug (AOD) agency contracts with a management organization, which then contracts with providers. An assessment arm of this structure establishes Regional Alcohol and Drug Assessment Centers (RADACs). All clients are assessed by a RADAC using the Kansas client placement criteria. The RADAC assigns the client to a program/modality (the client can file a grievance if he or she is unhappy with the decision) and determines length of treatment on a case-by-case basis. The management organization tracks utilization. Treatment programs are divided into RADAC areas with separate budgets that are reviewed every quarter.

MANAGED CARE SYSTEMS

The State currently is applying for a demonstration waiver.

KENTUCKY

SERVICES/MODALITIES

The following publicly funded services are available:

- Detoxification: Twelve nonmedical, freestanding facilities (two or three are detoxification only, and the rest are both detoxification and treatment);
- Residential (nonmedical) treatment based on the Minnesota model (269 beds);
- Long-term residential recovery programs: Six-month programs targeted for adolescents, and long-term treatment for pregnant and parenting women (eight sites);
- Two methadone maintenance programs, one each in Lexington and Louisville;
- Individual outpatient programs (these programs do not have caps—clients are encouraged to stay as long as needed);
- Psychiatry outpatient services;
- Intensive outpatient services (step-down model);
- Transitional halfway houses (largely for homeless clients, although two are aftercare facilities for women to sustain recovery); and
- Aftercare programs.

The duration of each modality of care is decided on by the provider. More services are available in the metropolitan areas. A large proportion of the services provided are part-time outpatient.

The primary facilities are the 14 community mental health centers (CMHCs) in the State, many of which have primary residential or intensive outpatient drug treatment programs. These CMHCs may subcontract with affiliate agencies (i.e., private, nonprofit chemical dependency agencies) to provide special services, such as halfway houses for homeless men or residential programs for women and children.

SPECIAL POPULATIONS

Dually diagnosed: One program is available.

Women: Residential and outpatient programs for pregnant and parenting women are available.

PROVISIONS/LIMITATIONS

Injecting drug users in rural areas must drive long distances to methadone clinics in the two cities, go to private clinics, or go out of State.

FINANCING

State AOD Agency

The Substance Abuse Block Grant provides almost two-thirds of the financing of substance abuse treatment services, and most of the balance is covered by State revenue.

Medicaid

Kentucky does not have Medicaid reimbursement for substance abuse except for (1) up to 14 days of acute care detoxification in a hospital for people who are eligible for Aid to Families with Dependent Children or are disabled and (2) services for adolescents as a result of early periodic screening, diagnosis, and treatment referrals. The State had a statewide 1915 waiver (KenPAC) case management program that was subsumed by an 1115 waiver. To date, this program has provided the Medicaid population with a primary care physician/gatekeeper. The State is trying to get Medicaid to cover more than detoxification and is doing a feasibility study on covering substance abuse. There may be a State cost-sharing provision with the Medicaid office in order to give more substance abuse care to that population. The State has applied for a 1915(b) waiver to carve out behavioral health services.

MANAGEMENT OF SERVICES

Funding is allocated to 14 regional boards according to prevalence and utilization rate data. This structure will be changed for mental health and subsequently for substance abuse once the 1115 is implemented. At the moment, contracts are fee-for-service, but will be capitated in about 2 years. There is a sliding fee scale for services and providers trying to collect a copayment from clients above poverty level (according to a liberal estimate, approximately 200 percent of the Federal poverty level). If a client cannot pay, 100 percent is charged to the State contract. Some centers may provide more services than they are reimbursed for and, consequently, may find themselves in a deficit situation.

The State is developing a capacity management system with a screening and assessment component that will be used for placing and prioritizing pregnant women and injecting drug users.

MANAGED CARE SYSTEMS

In addition to the Medicaid waiver program, which places Medicaid-eligible clients in a managed care system, the State plans to capitate all publicly funded service contracts.

LOUISIANA

SERVICES/MODALITIES

The following publicly funded services are available through programs funded by the Office of Alcohol and Drug Abuse within the State Department of Health and Hospitals:

- Social detoxification in nonhospital settings;
- Medical detoxification;
- Residential services provided in short-term (30 days or less) and long-term (over 30 days) treatment;
- Outpatient clinics providing treatment/day treatment/recovery/ aftercare or rehabilitation services (27 clinics have an average length of stay of 6 months);
- Methadone;
- Primary inpatient (with an average length of stay of 25 days, but the length of stay is flexible);
- Halfway houses (with an average length of stay of 3 months);
- Therapeutic communities providing a minimum of 12 months of residential treatment; and
- Aftercare or continuing care provided in outpatient and some inpatient clinics.

SPECIAL POPULATIONS

The State has declared the following groups as priority populations: injecting drug users, people who are HIV+, people with sexually transmitted diseases or tuberculosis, homeless people, and people who gamble.

Women: There are several residential programs for women, including a program for pregnant women and women with dependent children; a program for dually diagnosed women with children; and a program for women with high-risk pregnancies.

Adolescents: There are two programs for adolescents.

Criminal justice population: The agency operates two corrections programs. The Blue Walters program is a large, 140-bed prerelease program for all adult male inmates identified with a substance abuse problem. They are referred prior to release. The Impact Program is a collaborative effort between the Department of Corrections and the agency to improve and enhance the referral

system in order to facilitate treatment referrals for both incarcerated and released offenders. This program is a formalization of what previously had been an informal system. The current administration is attempting to increase networking and collaboration between the Department of Corrections and the State alcohol and other drug (AOD) agency and also is looking into establishing drug courts.

PROVISIONS/LIMITATIONS

According to the National Association of State Alcohol and Drug Abuse Directors, the waiting period is about 17 days for outpatient and 18 days for inpatient services, and 713 people were on the waiting list for AOD treatment. According to personal communication with the State AOD agency, these numbers are substantially smaller.

FINANCING

State AOD Agency

Approximately \$19 million of the treatment budget is from the Substance Abuse Block Grant, about \$13 million is from State revenue, and the balance (a small portion) is Federal pass-through funding to target cities and rural services.

Medicaid

The Medicaid portion of substance abuse financing covers detoxification and outpatient services for clients who are eligible for Aid to Families with Dependent Children.

MANAGEMENT OF SERVICES

Services are provided through a combination of State-owned and -operated facilities and contracts with nonprofit providers.

MANAGED CARE SYSTEMS

Currently, a Medicaid case management pilot project in one region of the State has adopted elements of managed care (such as utilization review).

The State is developing a 1915(b) waiver that would bring Medicaid services into managed care, although behavioral health and substance abuse services would still be on a fee-for-service basis.

MAINE

SERVICES/MODALITIES

The State agency contracts with providers on a fee-for-service basis to provide the following publicly funded services:

- Freestanding inpatient detoxification for 2 to 7 days;
- One methadone program in the State (clients must travel);
- Short-term residential rehabilitation services for 30 days or less;
- Extended care on a long-term basis (6 months to 2 or 3 years, and usually over 180 days), primarily for long-term alcoholics;
- Extended shelter, transitional services that provide less care than the extended care programs and primarily offer structured therapy for those out of detoxification who need to develop a network of social support and a link with services;
- Long-term transitional residential programs (i.e., a community-based, peer-oriented halfway house for men and women, with an average length of stay of 6 months);
- Adolescent residential rehabilitation programs, primarily long-term (2 to 3 years), with services that vary among the programs;
- Intensive outpatient services with no cap that include substance abuse evaluation, diagnosis, and treatment, usually provided in day-long programs (the clients return home at night);
- Nonintensive outpatient programs with no cap that provide fewer hours and days of treatment than the intensive programs;
- Psychoeducational group therapy, cofacilitated by substance and mental health professionals and with 8 to 25 clients per group;
- Relapse prevention group therapy with no cap;
- Emergency shelter provided in 12-bed overnight shelters (where staff try to get clients into detoxification) or freestanding residential programs with onsite detoxification;
- Case management services (primarily for the Women's Project); and
- Motivational therapy (a new modality).

SPECIAL POPULATIONS

Dually diagnosed: There is an entire parallel set of services for the dually diagnosed.

Women: The Women's Project provides interim case management for pregnant women and women with dependent children. The project assesses whether prenatal care has been obtained, but does not provide the prenatal care itself, which is paid for by Medicaid or other insurers. The program has a voucher system for child care, but major funding gaps exist.

PROVISIONS/LIMITATIONS

None.

FINANCING

State AOD Agency

The funding largely comes from State revenue, with about 35 percent from the Substance Abuse Block Grant.

Medicaid

Medicaid reimburses for substance abuse treatment and case management. The State has applied for a 1915 waiver for methadone only (to cap the services and contain very long-term methadone use). Currently, the State has only one program, and many clients must drive long distances to receive methadone. Another program may open.

MANAGEMENT OF SERVICES

The State agency contracts with service providers and manages the contracts.

MANAGED CARE SYSTEMS

The State currently is applying for an 1115 managed care waiver for the entire State Medicaid program.

MARYLAND

SERVICES/MODALITIES

The following publicly funded services are available:

- A halfway house program, which is a transitional living program providing time-limited services to alcohol and other drug (AOD) abuse clients who have been evaluated or treated for their addiction, with a duration of 90 days to 6 months;
- An intermediate care facility providing short-term intensive treatment, ostensibly with a 28-day limit but flexible (usually 2 to 6 weeks);
- Outpatient services, generally less than 6 hours per week;
- Intensive outpatient services, highly structured "step-down" treatment for a minimum of 6 hours per week;
- Methadone provided through nonresidential treatment;
- One therapeutic community in the State in which clients can receive services for up to 1 year; and
- Aftercare services provided through 12-step programs that clients are required to attend as part of treatment (no other aftercare services are available through the State).

SPECIAL POPULATIONS

Pregnant women and adolescents are a priority. There are special residential and outpatient programs for women and pregnant women, but gaps exist in the continuum of care in several regions of the State. Residential care is not reimbursable through the Substance Abuse Block Grant or Medicaid, and the State covers the costs.

Criminal justice population: The State agency coordinates substance abuse evaluations and case management of offenders through Maryland's criminal justice and treatment system.

PROVISIONS/LIMITATIONS

There are no detoxification services. The State previously offered nonhospital detoxification services, but the programs have been closed.

FINANCING

State AOD Agency

The funding is 33 percent Substance Abuse Block Grant and 45 percent State revenue.

Medicaid

Many addiction services are not reimbursable, and Medicaid is not a big funder of substance abuse services. The State once had State-only Medicaid, but that program no longer exists.

MANAGEMENT OF SERVICES

The State contracts with providers who invoice the State on a fee-for-service basis.

MANAGED CARE SYSTEMS

The State has been approved for an 1115 demonstration waiver that was scheduled to go into effect in February 1997. This waiver will bring all Medicaid clients (except those dually eligible for Medicaid and Medicare) into managed care. The waiver will authorize a "carve-in" of substance abuse services; all managed care organization applicants will be required to offer the appropriate level of individualized care.

MASSACHUSETTS

SERVICES/MODALITIES

The following publicly funded services are available:

- Residential programs, including:
 - Acute inpatient treatment, a freestanding, nonhospital, medically monitored trilevel model with the following levels:
 1. Detoxification,
 2. Alternative step-downs (minimal nursing), and
 3. After-planning;
 - Three models of residential rehabilitation:
 1. Recovery home,
 2. Therapeutic community, and
 3. Social model;
 - Youth residential programs; and
 - Residential services for families.
- Ambulatory services, including:
 - Traditional outpatient assessment and treatment (individual and group);
 - Acupuncture detoxification;
 - Methadone (or other substitution therapy, such as LAM); and
 - Criminal justice (a variation on core outpatient drug-free services).
- Wrap-around services provided by community support programs, which include:
 - Some child care (outpatient);
 - Some case management models;
 - HIV risk reduction;
 - Three public inebriate shelters; and
 - Supportive housing.

SPECIAL POPULATIONS

Women: Residential treatment programs are available for pregnant and parenting women. They include detoxification, outpatient treatment, child care at some sites, and referrals for prenatal care.

PROVISIONS/LIMITATIONS

There is a long waiting list (approximately 2,500) for treatment.

FINANCING

State AOD Agency

Funds are administered by the State Department of Public Health. The majority of funding is split between the Substance Abuse Block Grant (somewhat less than 50 percent) and State revenue (slightly more); the balance is from "other" State and Federal streams.

Medicaid

In 1992 the State implemented a 1915 waiver to purchase mental health and substance abuse services (acute services only) through a carve-out. Under the 1915 waiver, a full continuum of care is provided.

MANAGEMENT OF SERVICES

The State purchases all non-Medicaid services on a fee-for-service basis. The State is the payer of last resort.

MANAGED CARE SYSTEMS

Under the 1915 waiver, the State pays managed care organizations (MCOs) capitated rates; the MCOs contract with providers on a modified fee-for-service basis. The State has been approved for an 1115 demonstration waiver that has not yet been implemented; that waiver will expand the populations eligible for services under the 1915 waiver and fully capitate services through a carve-out.

MICHIGAN

SERVICES/MODALITIES

The State Department of Community Health provides a comprehensive continuum of care for clients ineligible for Medicaid, including the following:

- Up to 5 days of "social detoxification";
- Nonhospital, short-term (30 days or less) residential treatment;
- Outpatient rehabilitation services;
- Intensive outpatient services;
- Methadone; and
- Aftercare.

Medicaid reimburses for the following:

- Acute care medical detoxification inpatient services (usually the person presents at an emergency room and the hospital bills Medicaid directly);
- Outpatient rehabilitation services; and
- Intensive outpatient services.

Hospital inpatient services are not covered by the State, and nonhospital residential treatment is not covered by Medicaid. Aftercare services are usually provided at outpatient rehabilitation centers and include group therapy and some individual therapy.

SPECIAL POPULATIONS

Women: Pregnant women receive priority in treatment.

Criminal justice population: Inmates receive substance abuse treatment services through the Department of Corrections, with little formal involvement from the Department of Community Health.

PROVISIONS/LIMITATIONS

Medicaid treatment limits are as follows:

- Up to 40 visits for outpatient rehabilitation per treatment year;

Up to 45 sessions for intensive outpatient rehabilitation per treatment year; and

Up to \$100 per month for methadone medication (counseling sessions are billed as part of the outpatient or intensive outpatient rehabilitation).

In addition, the State requires that intensive outpatient rehabilitation for Medicaid clients not covered by a managed care plan be approved by the Central Diagnostic and Referral Agencies (CDRs) (see below).

FINANCING

State AOD Agency

About 68 percent of the State's total treatment budget is from Federal sources (over 40 percent is from the Substance Abuse Block Grant). The remaining funds are from State appropriations. Treatment funds are funneled to local providers through coordinating agencies (see below).

Medicaid

Acute care detoxification, methadone, and outpatient services are reimbursable by Medicaid. Residential services for children and adolescents are covered if referred through an early periodic screening, diagnosis, and treatment (EPSDT) screening. Participation in managed care is mandatory.

MANAGEMENT OF SERVICES

The State contracts with 16 regional, quasi-governmental organizations across the State called coordinating agencies. The coordinating agencies are responsible for authorizing payments for treatment services and for acting as liaisons between the State and local providers. The agencies agree to a flat annual fee for the provision of substance abuse treatment services and subcontract with local providers for services and with CDRs to conduct assessments and screenings of clients for "intensive services" (i.e., methadone and residential services).

MANAGED CARE SYSTEMS

Under two 1915 waivers, over 95 percent of Medicaid clients (including those receiving substance abuse treatment) are enrolled in managed care plans. A pilot program in five counties in southeast Michigan requires that all recipients go through a health maintenance organization for medical, mental health, and substance abuse treatment services. In addition, the State is developing a pilot plan to include all non-Medicaid clients in a managed care program covering behavioral health services.

MINNESOTA

SERVICES/MODALITIES

Six levels of publicly funded care are offered through the State:

- Outpatient;
- Combination inpatient-outpatient;
- Inpatient;
- Extended care;
- Halfway houses; and
- Case management (in some areas).

Detoxification and aftercare are funded by the counties, not by the State.

SPECIAL POPULATIONS

The State targets pregnant women, adolescents, methadone and cocaine users, and intravenous drug users for substance abuse treatment.

PROVISIONS/LIMITATIONS

When conducting client assessments and placement, each locality must follow Minnesota Rule 25, which establishes statewide criteria for placement in a treatment program. All people who are eligible for Medicaid or State general assistance who are not enrolled in prepaid health plans are eligible for the Consolidated Chemical Dependency Treatment Fund (CCDTF), which combines funding streams from several sources (both Federal and State) to cover drug and alcohol treatment for low-income residents. People who are ineligible for Medicaid and who have income less than 60 percent of the State median income also are eligible for CCDTF as long as funds are available (currently estimated to be sufficient to cover income-eligible people who are either minors, adults responsible for minors living in their households, or pregnant).

FINANCING

State AOD Agency

The Department of Human Services, which is the State alcohol and other drug (AOD) agency, funds substance abuse treatment through State revenue (about one-half of the total amount of treatment funding), the Substance Abuse Block Grant (about one-third), and county and other Federal sources (the balance). State funds cover substance abuse treatment through CCDTF (a fee-

for-service program) and through MinnesotaCare, a State health insurance program for clients who are ineligible for Medicaid but who cannot afford treatment. MinnesotaCare is in the process of switching to a managed care system.

Medicaid

Under an 1115 waiver, Medicaid clients are being enrolled in a managed care plan called Prepaid Medical Assistance Program (PMAP), which provides substance abuse treatment through a carve-in. Eventually all Medicaid-covered substance abuse services will be provided through PMAP, but those clients who are still fee-for-service currently obtain substance abuse treatment through CCDTF.

MANAGEMENT OF SERVICES

CCDTF funds are distributed to county social service agencies and Indian reservations based on a statutory formula. The localities (i.e., counties and reservations) have a 15-percent match requirement and act as case managers in determining the appropriate intensity of services needed by each client and restricting the client to receiving those services from a specified provider. Each locality is responsible for assessing and placing clients, determining clients' financial eligibility, establishing contracts with service providers, and billing the State for services provided on a fee-for-service basis.

For the prepaid managed care plans (i.e., MinnesotaCare and PMAP), the State contracts with health maintenance organizations (HMOs) to provide substance abuse services (or the HMOs contract with providers). All of the HMOs except one also have contracts with private insurers and therefore do not rely solely on public funds.

MANAGED CARE SYSTEMS

The State has an 1115 waiver and is in the process of switching Medicaid clients to the prepaid capitated program PMAP. In addition, the State is in the process of converting MinnesotaCare (a non-Medicaid State plan for low-income residents) to managed care.

MISSISSIPPI

SERVICES/MODALITIES

The State has a network of services that are available to anyone on a sliding fee scale. There are 15 mental health regions, each of which offers a core of services:

- Residential treatment may be from 30 days to 6 weeks, depending on need. Clients then may be referred to transitional care.
- Transitional services provide up to 60 days of transitional care, depending on need (the average is 30 to 35 days).
- Detoxification services are primarily social. Each residential facility has the opportunity to conduct an affiliation agreement with a medical facility for which the State would pay approximately \$800 to \$900 per visit (1 to 5 days).
- Outpatient services are not capped. The schedule is "free flowing" and depends on the client's needs. There is some intensive outpatient treatment (15 weeks, 3 days per week, up to 135 hours).
- Outreach/aftercare services vary, but they provide an ongoing process of followup and information dissemination.

SPECIAL POPULATIONS

Women: Three programs for pregnant women and their dependents are under contract: prenatal care, child care, and transitional services.

Adolescents: There are some special services for pregnant adolescents.

PROVISIONS/LIMITATIONS

According to the National Association of State Alcohol and Drug Abuse Directors, the waiting list includes over 2,000 people; in Fiscal Year 1994, the total number of admissions was 6,300 for "Alcohol" and 5,107 for "Other Drug."

FINANCING

State AOD Agency

The Substance Abuse Block Grant supplies about 60 percent of the funding; the balance is provided from State revenue, which supports the main residential programs, and some other Federal moneys.

Medicaid

In general, Medicaid does not reimburse mental health centers, through which substance abuse treatment can be accessed; therefore, participation is minimal. Under a 1915 waiver, a pilot project in 11 of the 82 counties provides mental health and substance abuse services through voluntary primary care case management programs.

MANAGEMENT OF SERVICES

The State agency contracts with private nonprofits under the rubric of mental health to create a network of alcohol and other drug (AOD) services that are available to anyone on a sliding fee scale. These contracts take a limited managed care approach; for a given amount of funding, a provider will see a given number of clients.

MANAGED CARE SYSTEMS

Currently the State is not operating any managed care programs except for the limited Medicaid pilot project in 11 counties, discussed previously.

MISSOURI

SERVICES/MODALITIES

Publicly funded substance abuse treatment is available through the State alcohol and other drug agency (AOD) agency (i.e., the Division of Alcohol and Drug Abuse). There are three categories of clients: (1) pregnant women and women with dependent children, (2) adolescents, and (3) general adults. Most clients (all non-Medicaid clients and many Medicaid clients) are means-tested to determine their fee share; eligibility for services is based on income and a copayment may be required. Services for these clients are provided on a fee-for-service basis. About one-third of Medicaid clients participate in mandatory managed care.

The following three detoxification modalities are available:

- Social-setting (nonmedical) detoxification, with a nurse available and a doctor on call;
- Modified medical and nonmedical (inpatient) treatment at State-owned medical facilities, primarily for mental patients; and
- Hospital (medical) detoxification.

Long-term residential treatment (30 days to 1 year) and short-term residential treatment (less than 30 days) are available.

The following two categories of outpatient treatment are available:

- Clinical intervention (very intensive), with a duration of 3 to 5 weeks; and
- Outpatient (less than 10 hours per week) and intensive outpatient (more than 10 hours per week), with a duration of up to 1 year.

Methadone detoxification, maintenance, and counseling are available on an outpatient basis.

SPECIAL POPULATIONS

Women: The State offers comprehensive residential and outpatient services to pregnant and postpartum women and their children. Transportation services and referrals for primary health care are available.

PROVISIONS/LIMITATIONS

Nonmedical detoxification, inpatient treatment, and medical detoxification have 5-day caps.

Nonmethadone outpatient detoxification is not provided. Aftercare services as such are not provided, but outpatient counseling and ancillary services may be covered; providers decide what is needed.

Under the Medicaid managed care plan, there is a limit of 20 outpatient days and 30 inpatient (hospital) days for adults; beyond the limit, services may be provided on a fee-for-service basis if they are within the fee-for-service limitations. There is no limit for children.

FINANCING

State AOD Agency

About one-half of the financing is from State revenue; another one-third comes from the Substance Abuse Block Grant. The remainder is from other State and Federal revenue.

Medicaid

Medicaid reimburses for detoxification, methadone, outpatient treatment, inpatient treatment, group counseling and education, codependency education, day treatment, and community support services. Local providers deliver and bill Medicaid for many substance abuse treatment services, including rehabilitation services (both residential and outpatient), special skill-building and education programs, and case management.

MANAGEMENT OF SERVICES

The State contracts directly with private nonprofit providers (purchase of service) who then invoice the State. The State agency monitors services and authorizes payment.

MANAGED CARE SYSTEMS

Currently a 1915(b) waiver in part of the State places eligible clients (about one-third of the Medicaid population) in mandatory managed care. The State has applied for an 1115 waiver to expand managed care statewide; that waiver proposal is under review.

MONTANA

SERVICES/MODALITIES

Publicly funded substance abuse treatment services are provided primarily through State contracts with treatment providers. Montana provides the full range of treatment programs, including the following:

- Residential treatment programs;
- Social and medical detoxification;
- Outpatient rehabilitation;
- Intensive outpatient rehabilitation (the State's primary treatment modality); and
- Boot camp programs for youth ages 18 to 25.

Detoxification is provided primarily at the Montana Chemical Dependency Center (MCDC), a free-standing residential facility in Billings. Clients needing medical detoxification are either bused to Billings by the service provider or admitted to a local hospital. Montana has residential centers for intravenous drug users and for pregnant women and women with dependent children. Dually diagnosed clients are treated in a hospital attached to the residential center.

SPECIAL POPULATIONS

Women: All programs are required to give priority to pregnant women.

Criminal justice population: The Department of Corrections operates an extensive program within the prison system. This includes programs within the women's prison, a boot camp program for youth ages 18 to 25, prerelease centers, and a community-based probation program for those released back into their communities.

Native Americans: The State has several programs for Native Americans, some of which are funded through the Indian Health Service. The State also has a special contract for substance abuse services for Native American women.

Dually diagnosed: One of the State's next two priorities will be the dually diagnosed.

Youth: The other of the State's next two priorities will be adolescents.

PROVISIONS/LIMITATIONS

All substance abuse services are provided on a sliding fee scale. By State law a person cannot be refused services based on nonability to pay. Level of care and patient placement are based on needs

and other criteria at time of admission. Waiting lists are not a problem because of the sparse population in most parts of the State.

A limitation recently was instituted on providing detoxification on demand, because the system had become a "revolving door." The MCDC intake policy now specifies that a person cannot return for treatment for 6 months following release from the facility. No limits are placed on the amount of treatment and the length of treatment in outpatient programs.

FINANCING

State AOD Agency

Funding for public substance abuse treatment is handled primarily through the State Alcohol and Drug Abuse Division (ADAD). In addition to the Federal Substance Abuse Block Grant, the State funds treatment programs through an earmarked tax levied on the sale of alcoholic beverages. No State funds are appropriated other than the earmarked tax (which originally was used to treat only alcoholism but now treats all substance abuse, because clients rarely seek treatment only for alcoholism). The block grant funds are distributed to counties primarily based on need, and the tax funds are distributed based on population/land area formulas. The State also funds treatment through special programs in the Department of Corrections. For example, a grant recently was provided to the Probations Office to fund a special program for the newly released.

Medicaid

Medicaid funds are used for the treatment of adolescents.

MANAGEMENT OF SERVICES

ADAD funds and controls MCDC and maintains considerable decisionmaking power regarding other treatment programs and contracted services, although ADAD does not control the use of the earmarked tax (the counties control the use of that tax). ADAD has contracts with 31 State-approved programs, primarily private not-for-profit programs except for three programs operated directly by counties. The State reimburses the programs on a fee-for-service basis. No program operates solely on public funds. Since 1987 the State has required that group insurance plans cover substance abuse services; consequently, the programs are reimbursed through private insurance as well as State funds.

The use of the earmarked tax is determined by county commissioners. Depending on need, the counties may provide additional funds or petition the State for additional funds beyond the population-based formulas. To obtain some treatment services, counties have formed alliances to combine funds.

The State maintains a Substance Abuse Task Force that includes ADAD, the Parole Board, the Department of Corrections, and MCDC. One purpose of the task force is to develop protocols for

aftercare services and to provide monitoring for those who have received treatment in a correctional facility.

MANAGED CARE SYSTEMS

Mental health is being brought into managed care; however, that does not include substance abuse services, which are all provided on a fee-for-service basis.

NEBRASKA

SERVICES/MODALITIES

The following publicly funded services are available:

- Detoxification is funded by the State in freestanding residential facilities and by Medicaid as inpatient hospital treatment.

- Rehabilitation is covered by the State when provided through nondetoxification hospital inpatient services or short-term (30 days or less) or long-term residential programs (with frequent use of halfway houses and therapeutic communities).

- The State funds one intensive outpatient rehabilitation program.

- The State funds one methadone program in Omaha (where heroin users are concentrated), although methadone program funds can be used to cover care for heroin addicts who live far from Omaha; local treatment is covered when provided by a local hospital or other methadone treatment care facility (private or public) in the area. Medicaid does not cover methadone treatment.

Aftercare is not covered by either Medicaid or State funds.

SPECIAL POPULATIONS

Criminal justice population: The Department of Corrections handles prison inmate treatment needs. The State Division of Alcoholism and Drug Abuse certifies the Department of Corrections treatment program; this certification is required in order to receive State substance abuse funds.

PROVISIONS/LIMITATIONS

A limited number of treatment slots are available, and waiting lists are established if necessary. Medicaid limits detoxification treatment to 7 days. Outpatient and inpatient treatment under both Medicaid and State-funded programs are limited to medically necessary services.

FINANCING

State AOD Agency

One-half of the State substance abuse treatment resources come from the Substance Abuse Block Grant. The remaining one-half are from State appropriations. In addition, the local Board of Supervisors in each region is required to provide a 10-percent match in order to receive State funds.

Medicaid

Substance abuse services for most Medicaid-eligible adults are covered under a carve-out behavioral managed care plan. For children and youth under age 19, Medicaid services are on a fee-for-service basis in the "Health Check for Youth" program.

MANAGEMENT OF SERVICES

The Division of Alcoholism and Drug Abuse within the State Department of Public Institutions manages substance abuse services. There are 6 regions throughout the State, each consisting of approximately 15 counties. The State funds each region according to need (defined through a formula based on population, income, and drug-use patterns) to manage the provision of local substance abuse treatment services on a fee-for-service basis. Each region is headed by a Board of Supervisors, which coordinates with the Division of Alcoholism and Drug Abuse. The regions contract independently with local treatment service providers, which currently are private nonprofit organizations. However, the State is in the process of implementing new procedures that require local providers to obtain prior approval from the Division of Alcoholism and Drug Abuse in order to be reimbursed by State funds.

MANAGED CARE SYSTEMS

Medicaid-covered substance abuse services for most Medicaid-eligible adults are provided under a carve-out behavioral managed care plan implemented under a statewide 1915(b) waiver.

NEVADA

SERVICES/MODALITIES

The State funds a full spectrum of services, including the following:

- Four "social detoxification" freestanding residential treatment facilities;
- Eleven nonhospital residential rehabilitation facilities (where programs range from 14 days to 1 year);
- An outpatient/intensive outpatient treatment facility in each county;
- A methadone treatment program in Las Vegas;
- Thirty-four drug-free programs; and
- Varying aftercare programs.

The State does not pay for hospital inpatient treatment services (either detoxification or nondetoxification), although Medicaid does cover medically necessary services.

SPECIAL POPULATIONS

Women: The State's highest priority designation is for pregnant intravenous drug users.

Criminal justice population: The State provides technical assistance and coordinates with the Department of Corrections for parolees needing outside placement into the State Bureau of Alcohol and Drug's system with one program that specifically targets felons on parole. This program has both a residential component (approximately 18 beds) and an outpatient component.

Native Americans: Eight percent of the State's total population is of Native American origin. One of the treatment facilities is located on a reservation.

PROVISIONS/LIMITATIONS

The State requires all providers to fully serve the treatment needs of any eligible person who presents. There are no caps or limitations on the level of service.

The total number of substance abuse treatment clients within the State is still small enough that the State Bureau of Alcohol and Drugs is able to monitor individual client-level activity with regard to treatment plan, as well as success within that plan, on an as-needed basis. If a client has a history of continual relapsing, the State is involved in the treatment plan.

FINANCING

State AOD Agency

Substance Abuse Block Grant funds and State General Funds support the treatment programs.

Medicaid

Medicaid covers substance abuse treatment services for clients who present at hospitals with a medical necessity. The State is developing a pilot managed care program targeting intensive outpatient services for youth in a portion of the State.

MANAGEMENT OF SERVICES

The State accredits local service providers and currently contracts with 24 providers for a total number of treatment slots. The providers develop and administer clients' treatment plans (unless an individual case warrants the State's involvement). The providers are required to deliver a full set of services based on client need, regardless of funding level. The State is investigating changing this system to a fee-for-service model to better track State funds and to ensure that they are used only to treat public clients. Because none of the providers are funded entirely by the State, they obtain additional funds through paying clients, the United Way, and so forth. Thus, State funds are mingled with funds from other sources.

MANAGED CARE SYSTEMS

The State is developing a pilot managed care program for Medicaid clients that targets intensive outpatient services for youth in a portion of the State.

The State noted that due to explosive population growth, there is a need to consider the managed care option for additional programs. (Nevada is the fastest growing State in the Nation, and Las Vegas is the fastest growing city.) However, as a designated "frontier State" (i.e., fewer than three people per square mile), the State's ability to provide substance abuse treatment services even under traditional models is constrained by transportation problems.

NEW HAMPSHIRE

SERVICES/MODALITIES

The State Office of Alcohol and Drug Abuse Prevention (OADAP) provides all modalities of substance abuse treatment by contracting with private agencies. The overall treatment philosophy derives from an alcohol-based model. The services available include the following:

- Social detoxification provided through seven crisis intervention sites;
- Two short-term (28 to 30 days) residential treatment programs;
- One long-term (9 months to 2 years) residential treatment program for women with children;
- Methadone maintenance for pregnant women until they give birth, after which they enter a detoxification program (other methadone programs are against State law);
- Residential adolescent programs (3 months);
- Intensive outpatient adolescent programs;
- Alternative sentencing programs;
- Academy programs in minimum-security prisons near time of parole;
- Shock-treatment programs (i.e., boot camps);
- Halfway houses; and
- Aftercare programs, primarily including Alcoholics Anonymous, Narcotics Anonymous, or other community-based group programs.

The State makes no provision for medical detoxification.

The State agency focuses primarily on prevention. It works with the Department of Corrections on alternative sentencing programs (e.g., academy treatment settings), programs provided near the time of parole, shock treatment/boot camp types of programs for adolescents, and halfway houses for former substance abusers returning to their communities.

SPECIAL POPULATIONS

Chronic substance abusers: State law mandates that treatment be available for chronic substance abusers, seriously ill and chronic substance abusers, and formerly ill and chronic substance-abusing adults.

Women: The State recently completed a federally funded demonstration project serving pregnant women and women with children. State financing will continue to provide these services but at a significantly reduced rate than what was available under the Federal grant.

PROVISIONS/LIMITATIONS

State-funded substance abuse treatment programs primarily serve single adult males, but it is not limited to this group. There are no caps on regular treatment, and no one can be denied service. Individual crisis sites, however, may impose restrictions on treatment; this is done at the local level under site-specific guidelines. All services are provided on a voluntary basis; by State law, a person cannot be committed, even for short-term detoxification.

FINANCING

Single State Agency

OADAP receives funding for substance abuse treatment from both the Substance Abuse Block Grant and the State operating budget. No local funds are regularly committed to treatment.

Medicaid

Medicaid funds are used to provide treatment for adolescents and women.

MANAGEMENT OF SERVICES

OADAP contracts for treatment and services with private local agencies and makes all decisions regarding the types of services available and which agencies will be contracted to provide these services. In early 1996 the State underwent a massive reorganization and OADAP merged with the Mental Health Division. The functions and operational style of both programs are still being developed.

MANAGED CARE SYSTEMS

The State has an 1115(b) waiver in process that would implement a statewide managed care plan for pregnant women and children with incomes up to 170 percent of the Federal poverty level. State services are not currently provided through managed care, except for some programs treating adolescents. The State plans to move all substance abuse services into managed care plans in the future.

NEW JERSEY

SERVICES/MODALITIES

A full spectrum of services is available through the State Department of Health, Division of Addiction Services, including the following:

- Detoxification (both hospital inpatient and freestanding residential);
- Long-term (1 to 2 years) residential programs, such as therapeutic communities;
- Short-term (28 days) residential programs, such as halfway houses;
- Extended care programs (providing supported housing services rather than intensive substance abuse treatment), such as the Salvation Army Shelter;
- A hybrid youth comprehensive care program (combining school and substance abuse treatment services);
- Outpatient rehabilitation and intensive outpatient rehabilitation;
- Methadone treatment; and
- Aftercare services (as part of the outpatient drug-free programs).

Statewide, approximately 20 alcohol and drug abuse clinics have been approved by the Division of Addiction Services and about 100 mental health clinics have been approved by the Division of Mental Health Services. These clinics are qualified for Medicaid reimbursement for services provided to Medicaid clients.

SPECIAL POPULATIONS

The State follows the provisions specified in the Substance Abuse Block Grant.

Criminal justice population: The Department of Corrections runs its own substance abuse treatment service programs both within the facilities and through halfway houses. There is a coordinated effort between the Department of Corrections and the Division of Addiction Services called the "Modified Assistance Program (MAP)." This program, which has separate facilities for youth and adult offenders, takes early release inmates and filters them into the existing State substance abuse treatment system. There is a memorandum of agreement allowing the Department of Corrections to purchase treatment slots at the same discounted rate that the Division of Addiction Services receives.

PROVISIONS/LIMITATIONS

There are no limitations placed on the provision of county or State services.

If a county spends all the money allocated by formula from the State before serving all needy people, or if a State-run program is filled, then the people are wait-listed. Usually there are insufficient residential treatment slots for indigent clients.

FINANCING

State AOD Agency

The Division of Addiction Services has two separate systems for the provision of publicly funded substance abuse treatment: (1) a county-operated system and (2) a direct purchase of services system operated by the State. The county-operated program is funded through a special State alcohol tax that provides a portion of the revenue to the treatment of substance abuse. The formula for determining the allocation of these funds is based on estimated need, population size, and per capita income over the last 3 years. Each of the State's 21 counties are entitled to these funds, which are funneled through county social service agencies. The county agencies are then free to determine their substance abuse treatment plans and enter into delivery contracts with providers as needed. Some of the larger counties also have their own treatment facilities, which are partially funded by this revenue. In addition, the State contracts directly with some providers (such as hospitals) to provide services to priority clients.

The State-operated program derives its revenue from three funding streams: (1) Substance Abuse Block Grant funds; (2) State general fund allocations; and (3) the "Uncompensated Care Trust Fund," a line item in the State's budget that was established to fund all indigent hospital care needs (i.e., medical, mental health, and substance abuse).

Medicaid

To be eligible for Medicaid reimbursement, substance abuse services must be medically necessary and must be provided by or through qualified providers (such as physicians, psychologists, and State-approved alcohol and other drug (AOD) abuse clinics and mental health clinics).

MANAGEMENT OF SERVICES

The State funnels resources to 21 social service agencies within each of the counties. It also separately contracts with 143 providers to serve priority clients; these providers include hospitals, county treatment facilities, or other private nonprofit agencies.

MANAGED CARE SYSTEMS

The State is reviewing managed care options for its Medicaid program and anticipates developing a waiver within 1 year.

NEW MEXICO

SERVICES/MODALITIES

The New Mexico Division of Substance Abuse (DSA) contracts with 43 substance abuse treatment agencies to provide a full continuum of services, including the following:

- Inpatient medical detoxification;
- Outpatient rehabilitation;
- Intensive outpatient rehabilitation;
- Short-term residential;
- Long-term residential; and
- Methadone maintenance clinics.

Some programs (i.e., those treating only substance abuse) are conducted in freestanding facilities, and others are conducted in mental health facilities. Those treatment programs conducted in mental health facilities are for both the dually diagnosed as well as those without psychiatric problems. All contracts are on an annual basis, and all decisions are made at the State level.

New Mexico also has a range of prevention programs that are conducted through DSA.

SPECIAL POPULATIONS

Native Americans: The State meets the needs of Native American residents by contracting for services with tribal governments; a full range of services are provided for this population.

Women: New Mexico has one residential treatment program for women with dependent children, which is located in the southwestern part of the State; there are no provisions to serve women in other areas, and most facilities have long waiting lists.

Criminal justice population: Substance abuse treatment for the inmate population is handled through the Department of Corrections.

PROVISIONS/LIMITATIONS

Agencies contracting with the State cannot refuse service to the medically indigent; the agencies receive a fixed amount to serve this population and are expected to provide services on demand. The State currently is in the process of determining whether there will be any provisions or limitations on service. Because the number of facilities under contract are limited and many forms of treatment are available only in some areas of the State, access to service is somewhat limited.

Large waiting lists at most treatment facilities (e.g., over 200 on the waiting list for medical detoxification) limit the number of people actually receiving treatment.

FINANCING

State AOD Agency

All substance abuse treatment funding goes through the New Mexico Department of Health, Behavioral Health Services, DSA. Treatment programs and services are funded primarily by the Federal Substance Abuse Block Grant with the addition of some State funding.

The State also has a \$4 million driving-while-intoxicated fund that provides substance abuse program funding to the counties. These funds are administered by the Department of Finance and are not coordinated or connected in any way with DSA.

Medicaid

Medicaid only reimburses hospital detoxification and 12 hours of outpatient treatment per year. Minors under 21 (or under 18 in some areas) may receive medically necessary treatment.

MANAGEMENT OF SERVICES

All contracting and service provision decisions are made by DSA. The State issues an annual Request for Proposals for service providers and awards 1-year contracts for substance abuse treatment services.

MANAGED CARE SYSTEMS

The State is moving toward managed care, but plans are not specific at this point. Because treatment facilities are provided with a fixed amount each year to serve the medically indigent and contracted agencies cannot refuse service, the State currently operates much like a managed care system.

NEW YORK

SERVICES/MODALITIES

The following publicly funded services are available:

- Hospital inpatient detoxification;
- Freestanding residential detoxification;
- Drug-free residential programs (primarily the therapeutic community model);
- Drug-free outpatient services (medically supervised);
- Drug-free day services (more intensive than outpatient services, providing treatment 3 days per week for several hours);
- Methadone maintenance (primarily on an outpatient basis, although there is some residential methadone treatment as well);
- Aftercare services provided primarily through referral, although some programs have aftercare components; and
- Therapeutic communities, which are not covered by third-party reimbursement.

SPECIAL POPULATIONS

Youth: Residential chemical dependency programs are available for youth.

Women: Residential treatment programs are available for pregnant and parenting women.

Dually diagnosed: Residential treatment programs are available for mentally ill chemical abuser clients.

PROVISIONS/LIMITATIONS

The waiting lists for treatment in New York are enormous. Clients generally must wait several months for methadone maintenance; in some areas, the wait for residential treatment is 4 months or more.

FINANCING

State AOD Agency

The Substance Abuse Block Grant supplies about one-ninth of the total funding, and the State agency supplies less than one-third. The biggest share (over one-third) comes from the State Medicaid agency (see next section).

Medicaid

The State Division of Medicaid (Home Relief) plays a very large role in substance abuse treatment. In New York State, Home Relief (similar to MediCal) acts like a parallel benefit system for indigent clients who are not Medicaid-eligible under the Federal program. There is no Federal match. The program is funded entirely by State and local revenues (the State shares the cost with the client's county of residence). Medicaid-reimbursable services include methadone maintenance (with about 4,300 clients receiving services at any one time); drug-free, medically supervised ambulatory treatment; some inpatient hospital rehabilitation; and some freestanding inpatient nonhospital treatment. (A number of services are not sufficiently medical in nature to qualify for Medicaid reimbursement, such as drug-free counseling, therapeutic communities, prevention programs, and vocational rehabilitation.)

MANAGEMENT OF SERVICES

The State agency contracts directly with providers on a primarily fee-for-service basis. (Some substance abuse services are covered under voluntary managed care programs.)

MANAGED CARE SYSTEMS

There are several 1915 waiver health maintenance organization programs across the State (some voluntary and some mandatory) providing primary care to eligible clients. In addition, the State has applied for an 1115 waiver—a "mega waiver"—to create a comprehensive managed care system for the Federal and State Medicaid population under the oversight of proprietary managed care organizations. Special needs plans (e.g., for clients with AIDS or mental illness) would be separately capitated. The application is under review.

NORTH CAROLINA

SERVICES/MODALITIES

The State of North Carolina is divided into 41 locally operated entities called "area authorities." Each area authority is required to ensure that a full array of substance abuse treatment services is available, including the following:

- Outreach;
- Prevention and education;
- Screening/referral/intervention;
- Detoxification/crisis stabilization;
- Outpatient services, including visits, day treatment programming, and partial hospitalization; and
- Case management, which includes aftercare (although most of the cases are handled by clinicians and are not true case management, except for a perinatal initiative that offers a full array of aftercare, such as child care and transportation).

The following services are provided on a regional basis:

- Detoxification services in freestanding residential facilities;
- Inpatient services;
- Methadone services (nine methadone centers are strategically located to cover the State);
- Residential programs;
- Halfway houses; and
- Treatment Alternatives to Street Crime (TASC) programs.

Hospital inpatient detoxification services are provided by three State-run facilities (called alcohol and drug treatment centers, or ADACs) covering three of the four regions in the State. These hospitals each have 100 beds for detoxification and are funded primarily by the State. The ADACs also offer nondetoxification rehabilitative services on a short-term (maximum 14 days) basis.

There is no waiting list for services; a "public-private partnership" ensures that when public-sector programs are full, private-sector programs provide the services, which then are paid for by State funds at a negotiated price lower than that charged by the private-sector providers for other clients.

SPECIAL POPULATIONS

Women: North Carolina operates a large perinatal initiative for substance-abusing pregnant and parenting women. There are 18 programs across the State, including five residential programs. This program is funded by Federal and State money (i.e., Substance Abuse Block Grant funds and Medicaid).

Native Americans: In the western part of the State, the Cherokee Nation operates its own programs and provides a full array of services.

Criminal justice population: The Department of Corrections, Division of Alcoholism and Chemical Dependency, also operates its own State-funded programs for the incarcerated population. The primary program, called Drug and Alcohol Recovery Treatment (DART), provides 35 days of treatment services within the prisons, incorporating a 7-day orientation followed by a 28-day residential program. Inmates participate in DART at the beginning of their sentences. The program features lectures, demonstrations, group therapy, some individual counseling, and Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings. After completing the DART program, inmates receive DART aftercare: 8 to 10 weeks of weekly group counseling and continuation of AA/NA participation. After completing the aftercare program, inmates continue participating in AA/NA meetings. Currently 8,000 to 10,000 inmates complete the DART program each year. Inmates who complete DART are eligible to participate in a 10-week training program to provide peer counseling to other inmates. (The Division of Alcoholism and Chemical Dependency also is implementing a prerelease program that will provide inmates with specialized services 60 to 90 days before release) Community AA/NA volunteers sponsor the inmates and help them become oriented to life outside the prison. In addition, a State grant funds four "back-end" programs in which inmates receive 6 to 18 months of treatment toward the end of their sentences.

PROVISIONS/LIMITATIONS

There is no maximum or limit for the 0- to 18-year-old population. For adults covered by Medicaid, inpatient services usually are limited to 28 days. Treatment services are covered by Medicaid, but room and board are not.

FINANCING

State AOD Agency

In general, local, State, and Federal funding for mental health, developmental disabilities, and substance abuse services flow through the 41 area authorities, although some Substance Abuse Block Grant money goes directly to institutions providing services. Slightly over one-half of the

funding for substance abuse services comes from Federal sources (primarily the Substance Abuse Block Grant), with most of the rest from State appropriations.

Medicaid

Private entities bill Medicaid through the area authorities. A 1915(b) waiver covers services for children and adolescents ages 0 to 18; the waiver covers medically necessary care, with no specified limits, and the area authorities receive capitation fees for enrollees.

MANAGEMENT OF SERVICES

The 41 area authorities consist of single- and multicounty areas; the multicounty area services are overseen by "area boards," whereas the county governments oversee the single-county area services. The area authorities provide some services directly (especially in rural areas) and contract with nonprofit organizations for other services. Facilities bill the State for services provided to adults on a fee-for-service basis. Services to clients ages 0 to 18 are provided through a managed care program.

MANAGED CARE SYSTEMS

Under a 1915(b) waiver, Medicaid services to children and adolescents are capitated. The State is moving to a managed care approach for adults; a proposed waiver for adult services is awaiting Health Care Financing Administration approval.

NORTH DAKOTA

SERVICES/MODALITIES

Publicly funded services are available primarily through the North Dakota State Hospital and eight regional Human Service Centers:

The North Dakota State Hospital in Jamestown provides State-funded inpatient medical detoxification and nondetoxification services. Patients in other parts of the State needing services are usually transported by the local Sheriff's office to the State Hospital.

The eight regional Human Service Centers provide State-funded social detoxification in freestanding residential facilities as well as outpatient rehabilitation services, drug-free communities, and aftercare services.

Indigent uninsured people sometimes present at local hospital emergency rooms with a need for inpatient services, and some hospitals admit them and "write off" the expense.

No publicly funded methadone treatment is available.

SPECIAL POPULATIONS

Women: The Substance Abuse Block Grant provisions are followed, although there is a relatively low demand by pregnant women for substance abuse treatment, as well as a low incidence of intravenous drug use as compared with other substance abuse.

Native Americans: The State has a large alcohol abuse problem, particularly among its Native American population, who represent approximately 10 percent of the overall population but 15 percent of the substance abuse treatment population (and would represent an even higher proportion of the treatment population were it not for the difficulties in transporting clients from reservations to appropriate facilities).

Hispanic migrants: The eastern portion of the State has a growing number of Hispanic migrant workers seeking treatment.

Criminal justice population: The State Penitentiary in Bismark provides inmates with substance abuse treatment services, and the State Division of Alcohol and Drugs provides the penitentiary with technical assistance and licenses the programs. In addition, each of the eight regional Human Service Centers coordinates with the correctional system to provide referrals to treatment for newly paroled inmates who are in need of continuing substance abuse treatment.

PROVISIONS/LIMITATIONS

The State provides treatment services on demand to uninsured substance abusers, without limits on the amount of service they receive once they are assessed as needing treatment. However, if a client continues to relapse or leaves treatment before completion, he or she may be assessed as "not needing treatment" upon return. These decisions are left to the eight regional Human Service Centers.

Uninsured individuals or those without the necessary means are assessed using a sliding fee scale based on their income and family size. The balance is covered by the State.

FINANCING

State AOD Agency

The State's Division of Alcohol and Drugs receives the Substance Abuse Block Grant funds and oversees their allocation to the eight regional Human Service Centers. In addition, each regional center (as part of the State government system) receives a General Fund amount for providing substance abuse services. The formulas for the funding are based on types of substances abused and the demographics of the abusers in each region.

Medicaid

A State provision for substance abuse treatment allows each Human Service Center to bill Medicaid directly for the reimbursement of some costs.

MANAGEMENT OF SERVICES

The State's Division of Alcohol and Drugs is a central administrative office that tracks utilization and other data and acts as a flow-through for the Substance Abuse Block Grant funds to the eight regional Human Service Centers across the State. All eight centers offer crisis counseling, in which a substance abuser enters the system through screening and assessment conducted by a licensed addictions counselor. These counselors develop the substance abuse treatment plans and place the clients into the appropriate social detoxification or residential facilities.

MANAGED CARE SYSTEMS

There is no managed care system in place for the provision of publicly funded substance abuse treatment services within the State, nor is there a clear indication that the State will enter into this type of system in the future.

OHIO

SERVICES/MODALITIES

A wide range of publicly funded substance abuse treatment services are available through the Ohio Department of Alcohol and Drug Addiction Services (ODADAS):

- Detoxification;
- Outpatient treatment;
- Residential programs;
- Methadone services (in urban areas only, which is where heroin use is concentrated); and
- Aftercare (the State encourages providers to offer aftercare services, such as counseling and case management, especially for pregnant and parenting women and criminal justice clients).

The services are available to all medically indigent persons or on a sliding-scale basis for persons with insurance coverage.

Under an 1115 waiver, Ohio has developed a taxonomy of Medicaid Medically Necessary Services, as follows:

Level I: Outpatient Treatment

1. Outpatient
2. Intensive outpatient
3. Day treatment

Level II: Community Residential

1. Nonmedical community residential
2. Medical community residential

Level III: Subacute Services

1. Ambulatory detoxification
2. Observation bed
3. Subacute detoxification

Level IV: Acute Hospital Detoxification

SPECIAL POPULATIONS

Women: The State provides 28 residential programs for pregnant and parenting women funded by the Substance Abuse Block Grant "women set-aside" and State appropriations and, in some cases, Medicaid (for programs with no more than 16 beds; the State will apply for a waiver on the 16-bed limit). The programs had a link with the Job Opportunities and Basic Skills (JOBS) program, both during treatment and for aftercare, to help move women into training and employment and to help cover child care.

Criminal justice population: Ohio recently has begun focusing on developing programs for the criminal justice population and on building closer links between courts and this population. The State is establishing Treatment Alternatives to Street Crime (TASCs), in which an independent contractor handles assessments, referrals, urine screens, and reporting to the courts. This system is accountable to the courts and provides a formalized process for handling the contacts and connections between the courts and the criminal justice population. The TASCs initially were funded through a Federal grant and State funds; they now are funded entirely by the State. The State also is establishing drug courts through county and State funding.

The prison treatment programs follow the therapeutic community model, which emphasizes behavioral change, high structure, assignments, group meetings, and peer pressure. There are currently three programs in prisons, with two more being implemented in 1997. The women's prison has an 80-bed program in a self-contained building, which will expand to 200 beds in 1997; this program is funded by the Department of Alcohol and Drug Addiction Services, which also funds a program in a men's prison that is expanding to 160 beds in 1997. The other existing program, as well as the two programs scheduled for startup later this year, is funded by the State Department of Corrections. On the Federal level, the U.S. Bureau of Justice Assistance is establishing residential substance abuse treatment programs for offenders.

PROVISIONS/LIMITATIONS

Caps include a 30-day limit on residential treatment and a 16-bed limit for Medicaid coverage. Service protocols being developed will include clinical standards relating to special populations that require more intensive/longer/different treatment. In addition, in some parts of the State, residential treatment slots are insufficient and there are waiting lists.

FINANCING

State AOD Agency

Using a Federal Substance Abuse Block Grant as well as other Federal, State, and local resources, ODADAS finances all non-Medicaid substance abuse services by contracting with local service boards to implement community substance abuse programs, which are provided on a fee-for-service basis.

Medicaid

Under an 1115 waiver being implemented, some Medicaid substance abuse treatment services (inpatient hospital detoxification and intensive outpatient treatment) will be provided under a capitated system operated by a statewide managed care organization.

MANAGEMENT OF SERVICES

The 1115 waiver being implemented will move many substance abuse services into a separate alcohol and other drug (AOD) category managed by ODADAS. Some services formerly provided in hospitals and reimbursed through the Department of Human Services (the Medicaid agency) will be funded through ODADAS, which is currently selecting a statewide organization with which to contract for services. As part of the waiver implementation, Ohio is developing service protocols and implementing a new management information system.

Under the waiver, both Medicaid (inpatient hospital detoxification and intensive outpatient treatment) and non-Medicaid treatment services will be provided through ODADAS, not through mental health or medical service provisions. The Department of Human Services currently contracts with ODADAS for all nonhospital treatment services; under the waiver, some medical services also will be transferred to ODADAS.

MANAGED CARE

Under the 1115 waiver being implemented, Ohio will move to a managed care model for hospital treatment and other services. Currently, the only managed care Medicaid program is for prenatal care, which began in July 1996.

OKLAHOMA

SERVICES/MODALITIES

The following publicly funded substance abuse services are available:

- Hospital inpatient detoxification services (hospital inpatient nondetoxification services are not funded by the State);
- Short-term (30 days or less) and long-term (over 30 days) residential rehabilitation programs;
- Outpatient and intensive outpatient (i.e., a minimum of 6 hours per week) programs, which include aftercare services; and
- One methadone program in Oklahoma City (State-funded methadone programs are not available outside of Oklahoma City).

SPECIAL POPULATIONS

Women: Women are a priority as stipulated by Substance Abuse Block Grant provisions.

Criminal justice population: The State has a demonstration grant to conduct up to three drug courts, which are operated by the State substance abuse agency rather than the Department of Corrections; the drug courts assign nonviolent offenders to intensive outpatient rehabilitation services rather than incarceration.

Other State priorities: Included within the State's priorities are intravenous drug users and homeless people.

PROVISIONS/LIMITATIONS

Treatment service contracts are based on a sliding fee scale, with no limitations.

FINANCING

State AOD Agency

A majority of the funding comes from the Substance Abuse Block Grant, with the remaining portion from the State's General Assembly.

Medicaid

Limited substance abuse services currently are reimbursable.

MANAGEMENT OF SERVICES

The State contracts with 54 private nonprofit agencies and one State-operated agency to provide substance abuse treatment services, which are funded on a fee-for-service basis.

MANAGED CARE SYSTEMS

In July 1997 the State plans to begin a managed care pilot project to provide substance abuse treatment services to the eastern part of the State (which includes one-fourth to one-third of the total substance abuse treatment population). As part of that project, the State is forming an administrative service organization that will link mental health and behavioral health services; produce an assessment instrument that will be used for all cases; and perform utilization management, claims processing, and information management functions. This grouping of services is seen as particularly important, because an estimated 30 percent of the substance abuse clients are dually diagnosed with mental illnesses. The State anticipates moving to a statewide managed care system if the pilot project is a success. In addition, the State plans to develop provider networks in all regions so that it can contract with networks rather than with individual providers.

OREGON

SERVICES/MODALITIES

In 1995 Oregon implemented a statewide Medicaid reform program, the Oregon Health Plan (OHP), which expanded eligibility for comprehensive health care beyond Medicaid boundaries and incorporated substance abuse treatment. The OHP was designed to achieve the goals of universal access to high-level health care at an affordable cost. As part of the basic benefits package for all members, the OHP provides the following:

- Outpatient services;
- Intensive outpatient services;
- Outpatient methadone services; and
- Substance abuse prevention programs.

Prevention and early intervention of substance abuse also is written into the basic managed care contract, and service providers are mandated to screen every OHP client for chemical dependency.

Residential treatment including detoxification is not covered by the OHP. Residential treatment is provided with State funds; the State "buys" a specific number of beds in local residential treatment facilities that are then available for OHP members.

SPECIAL POPULATIONS

All designated special populations (e.g., adolescents, women, minorities, and people involved with the criminal justice system) and people diagnosed as difficult to treat have been incorporated into the OHP.

PROVISIONS/LIMITATIONS

Prepaid health plans must be able to strongly link substance abuse treatment to physical medical services as well as to mental and public health services. Nonhospital detoxification and residential services can begin immediately, before a person has been declared eligible and enrolled in the OHP; outpatient services must wait until the person is determined eligible and enrolled.

The OHP covers all Medicaid-eligible clients as well as those families who have income up to 133 percent of the Federal Poverty Level and have either pregnant women or children under age 6. During the demonstration program (4/1/93 through 12/31/98), Oregon does not apply categorical restrictions in determining eligibility.

Those who receive Medicare may not be eligible for OHP coverage.

FINANCING

State AOD Agency

All funding of the OHP goes through the Office of Alcohol and Drug Abuse Programs (OADAP). In addition to Medicaid funds, the State provides funds from the general operating budget and from the Federal Substance Abuse Block Grant to managed care organizations to implement the OADAP goals of prevention, early intervention, and comprehensive treatment for low-income State residents.

Medicaid

The OHP was developed under an 1115(b) Medicaid waiver and is funded to a significant extent with Medicaid funds.

MANAGEMENT OF SERVICES

Substance abuse treatment is made available through the OHP, which falls under the auspices of the Oregon Department of Human Resources (DHP). Within the DHP, the OADAP maintains responsibility for planning, contracting, and regulating Oregon's publicly funded substance abuse prevention, intervention, and treatment services. All decisions regarding treatment, including type of services, standards, rates, and other requirements, are set at the State level.

MANAGED CARE

The OHP is a managed care program that was phased in during a two-phase demonstration project. The goal of the OHP has been to develop a fully integrated service delivery system for substance abuse and physical and mental health services. Health care providers within the OHP system must meet OADAP criteria for services.

PENNSYLVANIA

SERVICES/MODALITIES

The following publicly funded services are available:

- Hospital inpatient detoxification services;
- Freestanding residential detoxification programs;
- Hospital inpatient nondetoxification services;
- Short-term (30 days or less) and long-term (over 30 days) residential rehabilitation;
- Outpatient and intensive outpatient rehabilitation;
- Methadone treatment;
- Drug-free programs; and
- Aftercare programs (all publicly funded clients are required to have an aftercare plan, which may include outpatient rehabilitation, a halfway house, and so forth, depending on the specific treatment continuum or protocol).

No outpatient detoxification is provided, because of the belief that detoxification is ineffective without the counseling and other services also provided to clients in an inpatient setting.

SPECIAL POPULATIONS

The service priorities follow the provisions of the Substance Abuse Block Grant.

PROVISIONS/LIMITATIONS

Treatment limitations are based on a clinical determination for substance abuse treatment. The recommended (not required) limitation is that if a client frequently relapses (which is common in substance abuse treatment) or terminates treatment early more than twice, the provider should make the decision that the client is not "clinically ready to accept treatment," and no further treatment should be provided.

FINANCING

State AOD Agency

Funding from the Substance Abuse Block Grant and State-appropriated funds are administered by the Department of Health.

Medicaid

To be eligible for Medicaid, adults must meet client placement criteria. Medicaid is administered by the Department of Public Welfare.

MANAGEMENT OF SERVICES

The State's publicly funded substance abuse treatment program is decentralized; single county authorities receive the funding and provide (or contract for) and manage services. The State also provides technical assistance to these local entities. Except for the Health Choices Behavioral Services populations (see below), substance abuse treatment services are on a fee-for-service basis.

MANAGED CARE SYSTEMS

In January 1997, under a 1915(b) waiver, a Medicaid managed care pilot program, the Health Choices Behavioral Services program, was implemented in the southeast part of the State (which includes the city of Philadelphia and a large Medicaid population). Medicaid clients in the rest of the State may voluntarily enroll in the program until July 1997, when it will be mandatory for them to do so also. In this program, behavioral health services are carved out; counties may contract with the Department of Public Welfare to provide behavioral health services on a capitated basis and may subcontract with commercial behavioral health plans.

PUERTO RICO

SERVICES/MODALITIES

The following publicly funded services are available completely free to clients:

- Detoxification: Five freestanding evaluation, detoxification, and stabilization centers (services now limited to 3 to 4 days);
- Residential centers for men (8- to 10-month stays);
- Methadone maintenance centers;
- Acupuncture;
- Outpatient services: Full-day treatment for clients who cannot get into residential treatment (80 percent of clients are referred by courts to residential treatment, but there are insufficient slots to handle all referrals); and
- Aftercare: All programs are required to provide 3 months of aftercare (relapse therapy), primarily delivered by telephone and office visits; Narcotics Anonymous and other community-based groups conduct followups.

SPECIAL POPULATIONS

Women: Outpatient methadone programs are available for pregnant women. There is one residential treatment center for women, which has five rooms for pregnant/postpartum women and their infants. A specialized women's detoxification center admits pregnant women. There are no specialized facilities to treat pregnant adolescents, and the Minor's Law prohibits minors and adults from being treated in the same facilities. The Alcohol Treatment Program provides outpatient treatment for women in outpatient treatment centers, and residential treatment is available (15 beds, with an average stay of 3 to 4 months).

Criminal justice population: Puerto Rico operates a drug court program.

PROVISIONS/LIMITATIONS

Puerto Rico currently is undergoing health care reform, which impacts substance abuse services. For example, 21 days of detoxification formerly was provided at the centers, but under health care reform, that limit was cut back to 3 to 4 days. The centers will continue providing services, but those services may be limited and cut back further.

FINANCING

State (Commonwealth) AOD Agency

The Substance Abuse Block Grant provides about one-half of the total funding, State revenue cover a little over one-third, and most of the balance comes from discretionary Federal grants. Currently, services are completely free to clients; State and Substance Abuse Block Grant funds cover most costs.

Medicaid

In the areas that have been brought into managed care, substance abuse services are covered by the capitated payments, which include Medicaid funds. In the areas that have not yet been brought in, only medically necessary services are reimbursed by Medicaid.

MANAGEMENT OF SERVICES

Under the health care reform, 61 of Puerto Rico's 78 municipalities provide all health care (i.e., primary, mental health, and substance abuse services) under a managed care plan. An independent agency, the Puerto Rico Health Insurance Administration, manages the health care reform; it contracts with insurance companies, who then contract with providers on a capitated basis. The capitated payments come from both State and Medicaid funds.

MANAGED CARE SYSTEMS

Most of Puerto Rico's municipalities (excluding the four major cities) have been brought into managed care under health care reform, and the remainder of the island will be brought in within 4 years. Under managed care, substance abuse services to Medicaid clients are covered, with Health Care Financing Administration approval, although no waiver was developed.

RHODE ISLAND

SERVICES/MODALITIES

The Rhode Island Division of Substance Abuse (DSA) contracts primarily with nonprofit service providers for all modalities of substance abuse treatment, including the following:

- Detoxification;
- Short- and long-term residential treatment;
- Residential treatment for women with dependent children;
- Outpatient rehabilitation;
- Intensive outpatient rehabilitation;
- Methadone clinics;
- Adolescent programs; and
- Outreach and treatment for minority populations.

The State is divided into eight mental health catchment areas, and although many forms of treatment are provided in each catchment area, some services may only be available in one location. However, almost any area of the State is easily accessible (within a 45-minute drive) to any other area. All persons in families with incomes up to 200 percent of the poverty level are eligible.

SPECIAL POPULATIONS

Women: Women are treated primarily through a Rite Care package, which is a comprehensive medical services program for low-income residents. The State conducts special programs for pregnant women and for residents with children who are recipients of Aid to Families with Dependent Children (AFDC).

Adolescents: The State conducts special programs for both male and female adolescents.

Ethnic groups: The State has developed contracts with local agencies to conduct outreach and to provide services to specific populations, such as Hispanics and African-Americans.

Criminal justice population: Although the Department of Corrections has a separate program and financing for the inmate populations, considerable overlap exists between the service provision of the Department of Corrections and DSA. The State agency sets eligibility criteria, determines program standards, and reviews both Requests for Proposals (RFPs) and contracts for the

Department of Corrections; the two agencies collaborate to ensure that all eligible residents are included.

PROVISIONS/LIMITATIONS

Any program that uses Medicaid funding requires prior client approval for treatment, and some consideration must be given to the medical necessity provision in Medicaid-eligibility requirements.

The State currently is considering placing limitations on services. This is being approached on a modality-by-modality basis; methadone treatment programs are being considered first, followed by women's day treatment, residential programs, and outpatient services.

FINANCING

State AOD Agency

All contracting with service providers is conducted by the DSA. Funds primarily come from the State's general operating budget, followed by Federal support from the Substance Abuse Block Grant. Additional State funds are provided from a drug education fund for offenders, a driving-while-intoxicated program, and other unspecified funding sources.

Medicaid

Medicaid funds are used for women and adolescents and in medically necessary cases for those at the poverty level.

MANAGEMENT OF SERVICES

All publicly funded substance abuse treatment is managed through the DSA. The DSA issues RFPs, contracts with agencies, and sets standards for treatment. Except for the RIte Care populations (see below), services are provided on a fee-for-service basis.

MANAGED CARE SYSTEMS

Rhode Island received an 1115 waiver to implement the RIte Care program, which primarily serves AFDC recipients and uninsured mothers and children through health maintenance organizations. This managed care program covers substance abuse treatment as well as all mental health and medical services.

SOUTH CAROLINA

SERVICES/MODALITIES

The State Alcohol and Drug Abuse Services (ADAS) division of the Department of Health contracts with 34 private agencies and four county agencies to provide all modalities of substance abuse treatment. All levels of treatment are available at the local level, including the following:

- Social and medical detoxification;
- Low-intensity outpatient rehabilitation;
- Intensive outpatient rehabilitation for women and adolescents;
- Residential rehabilitation;
- Hospital care, as needed;
- One public methadone clinic (there also are several private clinics); and
- School-based programs for adolescents.

SPECIAL POPULATIONS

Women: There are three residential programs for women with children and specialized intensive outpatient programs with child care; however, no distinction is made for pregnant women. Women, in general, are treated primarily through Medicaid programs.

Migrants: South Carolina has a seasonal migrant labor population that has substance abuse problems; however, they rarely request government services. This population primarily comes into treatment through law enforcement agencies.

PROVISIONS/LIMITATIONS

Currently, the State places no limits on the provision of treatment, and none of the 34 agencies that have contracts with the State can deny services based on inability to pay. A precertification system is designed to help get people into the most effective and appropriate programs based on their condition and needs.

FINANCING

State AOD Agency

ADAS allocates both State funding and Federal Substance Abuse Block Grant funds to the counties for contracting with local service providers. Although each county differs, estimations indicate that

approximately 40 to 60 percent of public substance abuse treatment is funded by this combination of State and Federal funding. The remaining funding comes from the local level.

Medicaid

Medicaid funds are used to treat women and adolescents.

MANAGEMENT OF SERVICES

The management of substance abuse services differs from the management of mental health services. Although South Carolina currently is in the midst of an overall reorganization, mental health and substance abuse services are and will continue to be separate agencies within the State structure. Staff working in the mental health area are State employees, and the largest portion of funds for mental health services are Medicaid reimbursements. In contrast, most of the people who provide substance abuse services and treatment are employees of private agencies working under contract to the State agency. Because much of the funding and program development occurs at the local (i.e., county and community) level, much decisionmaking about the types of programs and facilities to be available also occurs at the local level.

MANAGED CARE SYSTEMS

The State applied for a Medicaid waiver in 1993 under a governor whose intent was to move toward total managed care. A new governor was elected in 1994, and the move toward managed care slowed down. Currently, the State is deconstructing the 1115(b) waiver and implementing managed care in sections on a voluntary basis; 23 of the 34 treatment sites already have begun some form of managed care. One of the primary reasons for the shift away from managed care was the high initial cost associated with implementing a total managed care program. The first goal of the statewide program is to get Medicaid patients into managed care on a voluntary basis, which is being done through marketing. At present, all medical treatment has a \$1,000 general cap; after this cap has been met, treatment/services are provided on a fee-for-service basis. Substance abuse services are included in this general cap.

SOUTH DAKOTA

SERVICES/MODALITIES

The State provides a range of publicly funded services, including the following:

- Two hospital inpatient detoxification programs and three freestanding residential detoxification programs (all of which provide social detoxification services, in which the treatment is managed by a treatment counselor under the guidance of a physician);

- Three nondetoxification residential programs (one in a hospital, one in a nonhospital facility, and one within a State mental hospital);

- Six long-term "transitional care programs," or halfway houses, which are used for postresidential care for clients released from residential care;

- Six "custodial care" programs, in which clients remain in the "transitional care" facilities but with a stepped-down level of treatment;

- Two "day inpatient" programs for adult males who also have medical or mental health treatment needs, which are classified as outpatient services but are provided in a secure environment (i.e., clients are housed in halfway houses or transitional living communities);

- Various outpatient rehabilitation programs (defined as 60 hours of treatment within 6 weeks);

- About 30 drug-free facilities for adults and adolescents; and

- Aftercare services, which typically include weekly group therapy and individual therapy sessions for 6 months (although clients may receive the services for up to 1 year).

No publicly funded methadone programs are available.

SPECIAL POPULATIONS

The State prioritizes according to the stipulations of the Substance Abuse Block Grant. Each of the priority clients is placed in a treatment protocol within 48 hours of seeking treatment.

Criminal justice population: The State Division of Alcohol and Drug Abuse operates substance abuse treatment services within the five State correctional facilities. (The services were operated by the Department of Corrections until 1995, when funding and personnel were moved to the Division of Alcohol and Drug Abuse.) Currently, 30 chemical dependency counselors are within these five

facilities, and each program is accredited by the division. Every inmate who is eligible for parole can seek treatment; however, because of the rapid increases in the prison populations, the inmates closest to parole are served first. In addition, the division manages the parolees placement after they leave the criminal justice system, most often placing them in one of the day inpatient programs described previously.

Native Americans: The State's total population includes 7 percent Native Americans, but 30 percent of the people seeking publicly funded substance abuse treatment are Native Americans. Thus, most of the treatment facilities throughout the State incorporate a Native American cultural sensitivity and identity component. These facilities are not located on reservations, but in the towns and cities closest to them.

PROVISIONS/LIMITATIONS

The State will pay treatment costs for people in families earning up to 185 percent of the poverty guidelines established by the State. However, a priority system exists in which pregnant women and women with dependent children are served first, followed by youth and intravenous drug users (women or children), and finally males with either a medical or mental condition as well as substance abuse problem.

The following caps are defined:

- Detoxification (hospital or residential facility): 3 days;
- Nondetoxification residential (hospital or nonhospital): up to 30 days for adults and 45 days for adolescents;
- Transitional care programs (halfway houses): up to 30 days for adults and 45 days for adolescents;
- Custodial care programs: no limits on length of stay;
- Day inpatient programs: 6 weeks or 45 days of care;
- Outpatient rehabilitation: 60 hours of treatment within 6 weeks; and
- Aftercare services: up to 1 year.

All caps above refer to each time a client seeks treatment, rather than over the client's lifetime. The State will only pay for one residential placement per year.

FINANCING

State AOD Agency

One-half of the State's funds come from the Substance Abuse Block Grant and one-half are appropriations from the General Assembly.

Medicaid

Medicaid coverage is provided only for inpatient and outpatient services for youth.

MANAGEMENT OF SERVICES

The State develops all contracts and monitors compliance. The State contracts with a number of facilities; 45 component contracts exist, but one facility may have several components, such as both a residential and an outpatient component.

The State contracts with 14 core service agencies throughout the State to conduct screening and assessment of the clients' treatment needs. These agencies are private nonprofits that serve as the entry points for all people seeking State-funded treatment. The agencies make treatment recommendations, and then the State reviews and places each client in an appropriate treatment facility.

MANAGED CARE SYSTEMS

The State has no managed care component for publicly funded substance abuse treatment. There are no current plans to move to a managed care system, although the State's private health care system does operate under a managed care system.

TENNESSEE

SERVICES/MODALITIES

Two separate systems exist for publicly funded substance abuse treatment services, one provided through the State Bureau of Alcohol and Drugs and the other (a managed care carve-out program called TENNCARE Partners) for Medicaid clients. The Bureau covers people who are not eligible for TENNCARE Partners, including those who are ineligible for Medicaid, those who have met their lifetime substance abuse treatment caps, the uninsurable, and those with pre-existing conditions who are ineligible for TENNCARE Partners. The State plans to merge the two programs within the next 2 years so that both are part of a managed care program.

The following services are funded through the Bureau:

- Seven hospital inpatient medical detoxification programs;
- Ten freestanding residential social detoxification programs;
- About 20 intensive (30 to 45 days) residential nondetoxification programs;
- About 25 nonintensive (30 to 90 days) residential nondetoxification programs (halfway houses);
- One methadone program in Nashville; and
- Drug-free communities operated by the 29 State-funded Community Mental Health Centers across the State.

The State programs do not include nondetoxification hospital inpatient services or aftercare services.

The following services are available through TENNCARE Partners:

- Inpatient medical detoxification programs (usually covering 3 to 4 days of care) provided at two hospitals;
- Nonhospital residential rehabilitation services for 3 to 7 days; and
- Drug-free communities operated by the 29 State-funded Community Mental Health Centers.

TENNCARE Partners essentially provides only short-term substance abuse treatment, and "medical necessity" is a prerequisite to obtaining those services. The following are not covered: social detoxification provided in a freestanding residential facility; hospital inpatient nondetoxification services; halfway houses; or aftercare services.

SPECIAL POPULATIONS

The Bureau of Alcohol and Drugs follows the provisions specified in the Substance Abuse Block Grant.

Criminal justice populations: The Bureau coordinates with the Department of Corrections and provides technical assistance, but does not directly provide substance abuse treatment to inmates or services or aftercare for recent parolees. Substance abuse treatment within the correctional facilities is limited and only available in certain institutions.

PROVISIONS/LIMITATIONS

The Bureau of Alcohol and Drugs contracts with 55 not-for-profit agencies and pays each agency a flat sum to provide substance abuse services. The Bureau does not specify any limitations or caps, but no further funding is provided beyond the flat sum. This funding covers approximately 50 percent of the total cost of providing treatment services. The remaining resources are gathered by the not-for-profits from a variety of alternate sources, including United Way and private foundations.

TENNCARE Partners caps substance abuse treatment services at 10 days of detoxification and \$30,000 lifetime total costs, regardless of timing, number, or type of treatment.

FINANCING

State AOD Agency

The Bureau uses Substance Abuse Block Grant and State General Assembly funds to finance treatment services (which currently are funded at about \$19 million per year).

Medicaid

TENNCARE Partners provides medically necessary mental health and substance abuse services to Medicaid clients statewide.

MANAGEMENT OF SERVICES

The Bureau contracts with 55 not-for-profits across the State to provide substance abuse treatment services. The facilities are required to follow State specifications for care, which essentially are the Substance Abuse Block Grant provisions.

MANAGED CARE SYSTEMS

Under an 1115(b) waiver, TENNCARE Partners has been in effect since 1994. Medicaid clients receive medically necessary services (including substance abuse treatment) through 11 managed

care organizations. Authorization requirements for substance abuse services are determined by each managed care organization.

TEXAS

SERVICES/MODALITIES

A range of publicly funded services is available, including freestanding residential detoxification, outpatient programs, short- and long-term residential rehabilitation programs, outpatient rehabilitation programs, methadone programs, drug-free programs, and aftercare. Hospital inpatient detoxification is not available for most of the population.

SPECIAL POPULATIONS

The State follows the provisions specified in the Substance Abuse Block Grant.

PROVISIONS/LIMITATIONS

The State pays for a total number of treatment slots; beyond that number, everyone in need of services is wait-listed.

There is no central screening agency within the State. A client presents at a center; if a treatment slot is available, the client is evaluated and receives services. No caps or limitations exist on the services provided if a treatment slot is available.

FINANCING

State AOD Agency

The State Commission on Alcohol and Drugs receives funding from the Substance Abuse Block Grant, the State General Funds, and other discretionary grants.

Medicaid

There is no Medicaid coverage within the State for substance abuse treatment for most of the adult population. Inpatient hospital services are covered, which may incidentally include substance abuse treatment; however, if a facility is deemed by the State to be an Institute for Mental Disease (IMD), Medicaid covers no services for patients ages 22-64. In deciding to classify a facility as an IMD, the State considers the types of patients and staff, the way the facility presents itself, and the facility's overall character. Thus, if a facility begins providing a significant amount of substance abuse-related services, the State classifies it as an IMD and it becomes ineligible for Medicaid.

Any medically necessary care uncovered through early periodic screening, diagnosis, and treatment for children and youth (through age 21) must be provided, including substance abuse treatment. The State licenses chemical dependency treatment facilities to provide a range of outpatient chemical dependency services to children and youth, as recommended by physicians.

MANAGEMENT OF SERVICES

The State Commission on Alcohol and Drug Abuse subcontracts with local private nonprofit treatment providers by purchasing a total number of treatment slots. The local providers assess and admit clients when there are treatment slots available; otherwise, the clients are wait-listed.

MANAGED CARE SYSTEMS

Under 1915 waivers, four multicounty areas within the State have enrolled their Medicaid population in health maintenance organizations (HMOs). Any cost savings resulting from managed care may be used by the HMOs to provide additional services (including substance abuse treatment) beyond those mandated by the Medicaid State Plan. One of those HMOs provides inpatient and outpatient detoxification (but those services are not considered Medicaid services). An 1115 waiver that is pending would bring a basic array of behavioral health services under capitation; HMOs would be eligible (but not required) under that waiver to provide substance abuse services.

UTAH

SERVICES/MODALITIES

A comprehensive range of publicly funded treatment services is available, including the following:

- Detoxification;
- Methadone;
- Inpatient treatment;
- Outpatient treatment;
- Residential programs; and
- Aftercare services.

SPECIAL POPULATIONS

Women: Under a mandate to provide gender-specific treatment, Utah has four residential programs for parenting women and their children and four prenatal case management programs. No waiting lists exist for these programs—they are able to serve all people who need treatment.

Native Americans: No Federal mandate exists to establish programs specifically for Native Americans, but some of the local authorities operate culturally specific programs. The Division of Substance Abuse encourages all local programs to be culturally specific.

Criminal justice population: A prison operates an intensive outpatient program for inmates, and the State recently implemented a drug court in which offenders are offered drug treatment as an alternative to prison.

PROVISIONS/LIMITATIONS

There is no maximum or limitation.

FINANCING

State AOD Agency

The Division of Substance Abuse receives funding for substance abuse services through Federal Substance Abuse Block Grant money, State appropriations, and county and local funds. The Division of Substance Abuse contracts with 13 local authorities statewide to provide (or contract with local providers to provide) substance abuse treatment on a fee-for-service basis.

Medicaid

Under a 1915(b) waiver covering part of the State, substance abuse treatment is covered under a mental health carve-out if a comorbidity exists. For those clients, community mental health centers provide substance abuse services on a fee-for-service basis. Under another 1915(b) waiver, most Medicaid clients in the State access detoxification through health maintenance organizations (HMOs) in a capitated plan.

Because of the Federal welfare reform that eliminated Supplementary Security Income eligibility for drug and alcohol addiction, the Division of Substance Abuse encouraged providers to access Medicaid to pay for treatment.

MANAGEMENT OF SERVICES

The State Division of Substance Abuse provides technical assistance, encourages access to Medicaid, and funnels State and local funding to 13 local authorities who provide or contract for substance abuse services. In some cases, these local authorities are the service providers; in other cases, they contract with local providers for services, or they provide some services (such as assessment) and contract for other services (such as treatment). Except for inpatient services, these local authorities are responsible for all substance abuse services, including methadone treatment and aftercare. They bill Medicaid on a fee-for-service basis for services provided to Medicaid clients. Private hospitals provide necessary inpatient treatment and bill Medicaid for services provided to eligible clients.

MANAGED CARE SYSTEMS

The Division of Mental Health and the Division of Substance Abuse are separate divisions within the Department of Human Services. Mental health services provided through the Division of Mental Health are capitated. Currently, all substance abuse treatment funded by the Division of Substance Abuse is on a fee-for-service basis, although it will move to capitation within 2 years.

Utah has submitted an 1115 waiver, which has not yet been approved. The waiver will incorporate the State's 1915(b) waivers, bring substance abuse services into managed care statewide, and expand eligibility.

VERMONT

SERVICES/MODALITIES

A range of publicly funded services are provided, including hospital inpatient detoxification and nondetoxification treatment, residential short-term and long-term rehabilitation services, outpatient and intensive outpatient rehabilitation services, and drug-free programs. Methadone and aftercare services are not covered. Both State-funded and Medicaid services are provided under managed care plans. The State's public system covers all indigent and low-income clients who are not eligible for Medicaid.

SPECIAL POPULATIONS

The State prioritizes clients according to the traditionally served groups (e.g., pregnant women and women with dependent children, intravenous drug users, people with HIV/AIDS, and adolescents) as well as includes low-income, uninsured adult males on the priority list.

PROVISIONS/LIMITATIONS

No limits exist to the State-funded substance abuse treatment services allowed as long as the treatment has been predetermined as a "medical necessity."

For Medicaid-covered services, the primary limitation is that the managed care facility must only provide acute services (i.e., no supportive care services, such as halfway houses, which the State's public system funds instead). Medicaid clients can self-refer (i.e., obtain services without a physician's referral) for one mental health and substance abuse treatment visit before authorization for a specific treatment plan. The following exclusions apply to the Medicaid coverage:

- Substance abuse treatment services will only be provided through a managed care system.
- No substance abuse treatment services will be provided for the following:
 - Custodial care and treatment of organic conditions that will not improve with said treatment;
 - Treatment services beyond the initial treatment evaluation without a diagnosis, treatment plan, and expected clinical outcome or services that do not lead to continued improvements in the client's condition;
 - Mandated treatment, including court-ordered treatment, unless determined to be "medically necessary" by a State-certified alcohol and other drug abuse (AOD) counselor or the managed care plan; and

—Services outside the State, unless they are necessitated by an emergency or are either provided with the approval of the managed care plan or under contract with the managed care plan.

FINANCING

State AOD Agency

The State's public system is funded through the Substance Abuse Block Grant and the State's General Fund.

Medicaid

The State has a special provision that allows for Medicaid reimbursement for substance abuse treatment services as the "primary diagnosis."

MANAGEMENT OF SERVICES

The State contracts directly with local service providers, all of whom are managed care organizations.

MANAGED CARE SYSTEMS

Both the State-funded and the Medicaid (under an 1115 waiver) programs operate under managed care systems.

VIRGINIA

SERVICES/MODALITIES

A full spectrum of publicly funded services is available, including the following:

- Hospital inpatient detoxification and nondetoxification treatment;
- Residential detoxification programs;
- Short-term and long-term rehabilitation programs;
- Outpatient rehabilitation services;
- Methadone programs;
- Drug-free services; and
- Aftercare services.

Most facilities receiving State funds offer outpatient, intensive outpatient, and/or day treatment. Some facilities also include residential treatment. The services are provided through local agencies called Community Service Boards (CSBs).

SPECIAL POPULATIONS

The State follows the same priorities as the Substance Abuse Block Grant provisions.

Criminal justice population: Some of the State-funded community programs work with correctional institutions in providing treatment services.

PROVISIONS/LIMITATIONS

The State Code requires the CSBs to provide emergency services for substance abuse and mental health treatment for all who need it and are unable to pay. This provision includes Medicaid-eligible clients, who must be dually diagnosed with substance abuse and mental health conditions in order to receive substance abuse services.

FINANCING

State AOD Agency

The State receives funds from both the Substance Abuse Block Grant and State General Assembly appropriations and provides them to the CSBs according to allocation formulas.

Medicaid

To be eligible for Medicaid reimbursement for substance abuse treatment, clients must be dually diagnosed with a mental condition. The State conducts utilization reviews to monitor compliance.

MANAGEMENT OF SERVICES

The State provides funding and technical assistance and monitors the operations of 40 local quasi-governmental CSBs. (The CSBs work for the local governments, not for the State.) Most CSBs encompass a single community, such as Alexandria or Arlington; others cover combined areas, such as Falls Church City and Fairfax County. The CSBs develop treatment protocols for clients and are responsible for designating dually diagnosed clients and developing and administering individual treatment protocols.

MANAGED CARE SYSTEMS

Some of the CSBs have managed care contracts for their areas. The State is not involved in these arrangements.

The State is piloting a managed care initiative in the Tidewater region. In addition, the State's General Assembly recently established a 2-year subcommittee to consider the delivery of publicly funded substance abuse and mental health services (generally including managed care systems) and to investigate the trends, pitfalls, and benefits of such services.

WEST VIRGINIA

SERVICES/MODALITIES

The following publicly funded services are available:

- Inpatient detoxification services are provided in hospitals when other "medical needs" are also present (Because it is unlawful in this State to be a "public inebriate," persons in that condition are brought to shelters for referral to treatment programs for "medically managed detoxification," lasting 12 to 48 hours.);

- Most residential detoxification services are provided in freestanding residential detoxification programs;

- One long-term and four short-term residential rehabilitation programs for adults are available;

- One residential program for the dually diagnosed is available;

- Six transitional living facilities are available;

- Two comprehensive multimodality eight-bed units are available that also handle outpatient treatment;

- Three specialized residential treatment facilities for women are available;

- Several day treatment programs are available; and

- One drug-free program is available;

Outpatient programs are required to have at least one substance abuse specialist/clinician for adolescents as well as at least one prevention service provider.

Although no formalized aftercare services are provided, they often are available as part of the residential treatment programs. The State provides no methadone treatment programs.

SPECIAL POPULATIONS

State priorities follow the Substance Abuse Block Grant provisions. Medicaid priorities within this State include pregnant injecting women, all other women, dependent children and adolescents requiring treatment, and, finally, dually diagnosed adult males. The specialized residential treatment facilities for women technically are provided for pregnant women and women with dependent children (following the block grant provisions), but it is difficult to maintain capacity with this specialized population.

Criminal justice population: The State's Department of Corrections has its own treatment resources; thus, the two State agencies only loosely coordinate and cooperate. Within the correctional facilities, only group therapy/counseling is available to those seeking treatment. The State Division of Alcohol and Drugs provides technical assistance and helps place exiting inmates into residential facilities as needed upon their release.

PROVISIONS/LIMITATIONS

There are no stipulated limitations to the amount or type of care an eligible person can receive. Practically speaking, however, geographic and fiscal factors limit the actual services received. Due to sparsity of services and budgetary constraints (dedication of funding to priority population), services for adult males are limited.

FINANCING

State AOD Agency

The State draws resources from the Substance Abuse Block Grant and the General Fund.

Medicaid

Medicaid covers substance abuse treatment services for adolescents and women with dependent children. The priority list is as follows: first, pregnant injecting women; second, all other women; and third, dependent children and adolescents requiring treatment. Adult males within this State must be assessed as dually diagnosed to be included on the service list.

MANAGEMENT OF SERVICES

Across the State, 14 Behavioral Health Services Centers manage the delivery of publicly funded substance abuse treatment, mental health services, and mental retardation services. The Office of Behavioral Health Services (within the State Department of Health and Human Resources) makes annual allocations to the Health Services Centers to provide services for all non-Medicaid clients. Most of the centers provide services on a fee-for-service basis, charging on a sliding scale. The centers can contract with health maintenance organizations to provide care on a capitated basis, but most do not. The centers also provide services to Medicaid clients (as do other qualified Medicaid providers) and are reimbursed by Medicaid.

MANAGED CARE SYSTEMS

The State is in the process of converting all behavioral health benefits into managed care plans, including Medicaid-reimbursed services. The Office of Behavioral Health Services will cover services for both Medicaid and non-Medicaid clients.

WASHINGTON

SERVICES/MODALITIES

A full continuum of publicly funded services is available, including the following:

- Hospital inpatient detoxification and nondetoxification services;
- Freestanding residential detoxification programs;
- Short- and long-term residential rehabilitation programs;
- Outpatient rehabilitation programs;
- Methadone services;
- Drug-free programs; and
- Aftercare services (provided through outpatient rehabilitation).

Recovery houses provide intensive inpatient treatment, including social, recreational, and occupational therapy. Extended recovery houses provide long-term residential services for substance abusers with profound physical and mental impairment from chronic abuse. In some areas of the State, there are insufficient services and/or slots available to respond fully to the need.

SPECIAL POPULATIONS

The Substance Abuse Block Grant provisions for special populations are also State priority treatment groups.

Criminal justice populations: The Division on Alcohol and Substance Abuse (within the State Department of Social and Health Services) informally coordinates with the Department of Corrections; upon release from correctional institutions, clients receive referral information about available substance abuse treatment.

Dually diagnosed: The State funds a 130-bed MICA (mentally ill chemically abusing) program for the dually diagnosed.

PROVISIONS/LIMITATIONS

Waiting lists and funding gaps have become major issues for the State.

FINANCING

State AOD Agency

The Division of Alcohol and Substance Abuse administers Medicaid-eligible and Medicaid-ineligible substance abuse services in the State. (The State Medicaid agency, the Division of Medical Assistance, administers Medicaid-covered medical care.) State funds for substance abuse services are derived from the Substance Abuse Block Grant (primarily for residential treatment) and from a dedicated State tax for substance abuse treatment (primarily for outpatient treatment). The dedicated tax was established in 1989 to help cover the Medicaid match that cannot be covered using resources from the Substance Abuse Block Grant.

Medicaid

Outpatient substance abuse services are covered by Medicaid. Hospital-based detoxification is covered if it is medically necessary. Two youth residential programs (under 17 beds each) and one women's residential program (under 17 beds) are covered by Medicaid; however, social detoxification (nonmedical) is not covered.

MANAGEMENT OF SERVICES

The State contracts with counties and local nonprofit service providers. Prevention services are contracted to counties and nonprofit organizations with community prevention linkages. Outpatient treatment services are contracted through counties. Funds are allocated based on target population formulas, and counties receive contracts upon submission of a biennial plan for services in that community. Residential services are contracted directly with service providers.

The State certifies the types of modalities that must be made available to needy clients and the treatment facilities themselves and also is authorized to enter into contracts for the delivery of these services. In addition, the State directly allocates, based on a formula that includes population and minority composition data, the funds to counties within each of seven established regions across the State.

MANAGED CARE SYSTEMS

The Division uses managed care principles in managing substance abuse services, but does not contract with managed care companies.

Services covered by Medicaid are provided on both a fee-for-service (for in-hospital care) and a managed care basis. Medical services provided for both Aid to Families with Dependent Children (AFDC) families and for children under age 19 at 200 percent of the poverty level are capitated; in addition, the Supplemental Security Income population is being brought into managed care on a county-by-county basis.

WISCONSIN

SERVICES/MODALITIES

A full continuum of publicly funded services is available, including the following:

- Hospital inpatient detoxification and nondetoxification services;
- Nonhospital residential treatment programs;
- Outpatient treatment;
- Day treatment (i.e., intensive outpatient);
- Nonmedical nonambulatory intoxication monitoring services;
- Ambulatory withdrawal services;
- Medically monitored nonambulatory withdrawal services;
- Methadone treatment; and
- Drug-free programs.

SPECIAL POPULATIONS

The State follows the Substance Abuse Block Grant priorities: Pregnant women and women with dependent children are served first, followed by intravenous drug users and other priority groups.

PROVISIONS/LIMITATIONS

The State has pilot-tested the "Uniform Placement Criteria" (UPC) and is in the process of modifying and retesting it. The UPC creates a common set of standards relating to substance abuse treatment options.

All programs receiving Substance Abuse Block Grant funds are required to screen applicants for tuberculosis before or upon entry into drug treatment. However, often funds are not available for treatment, and clients are unable to pay for treatment either; in those cases, the clients remain untreated.

FINANCING

State AOD Agency

The State's substance abuse treatment resources primarily come from the Substance Abuse Block Grant and the General Fund.

Medicaid

Medicaid covers inpatient hospital, outpatient, and day treatment services, but does not cover nonhospital residential programs (although health maintenance organizations [HMOs] may choose to provide residential services if medically necessary). All treatment must be medically necessary and based on an assessment by a qualified professional.

MANAGEMENT OF SERVICES

The counties are required to establish human service agencies, known as "5142 boards" after a section in the statutes, to provide substance abuse, mental health, and developmental disabilities services. The State provides the boards with annual funding according to a formula based on population and other factors; the counties must provide a minimum match of 9.89 percent, although the counties often provide more than the minimum. The boards either provide services directly or contract with local providers, depending on the availability of providers. The local providers must be licensed by the State. The boards or the contracted providers bill for services based on a sliding scale, then the boards bill the State on a fee-for-service basis up to the amount of the annual grant.

MANAGED CARE SYSTEMS

The Wisconsin Division of Health has initiated a Medicaid Managed Care Expansion Initiative for Aid to Families with Dependent Children and Healthy Start recipients. Under this Initiative, 64 of the 72 counties in Wisconsin will expand Medicaid coverage through HMOs, and both substance abuse and mental health services will be covered through 19 HMO providers under contract with the Wisconsin Division of Health. Additionally, for the 1997-99 biennial budget, the Wisconsin Department of Health and Family Services will pilot six managed behavioral health programs that combine substance abuse, mental health, and physical health services. State-funded services are not capitated.

WYOMING

SERVICES/MODALITIES

The following publicly funded services and modalities are available in the State:

- Three residential treatment centers with 36 beds;

- Three halfway houses with 48 beds;

- One methadone center in Cheyenne; and

- Twenty drug-free programs.

Publicly funded detoxification or aftercare programs are not provided.

The State's entire population is only 450,000; thus, the substance abuse problem is not very large. The State plans to conduct a needs assessment to document the nature and extent of the need for substance abuse treatment.

SPECIAL POPULATIONS

Women: Pregnant women are the State's only special priority population.

PROVISIONS/LIMITATIONS

There are no caps or limits to services.

FINANCING

State AOD Agency

Funding primarily comes from the Substance Abuse Block Grant and the State General Funds.

Medicaid

With a few exceptions (the rare dual diagnoses of mental health and substance abuse treatment needs), Medicaid does not reimburse for substance abuse treatment.

MANAGEMENT OF SERVICES

The State contracts with and oversees local private nonprofit service providers. The State provides each local program with a \$20,000 base and negotiates with the programs for caps on the total amounts that can be billed to the State. Each program then provides services on a fee-for-service basis and bills for costs up to the total contract amount. The provider must continue delivering

necessary services even after billing up to the contract cap, but does not receive any additional reimbursement.

MANAGED CARE SYSTEMS

The State views its substance abuse treatment needs as being too small to warrant implementing a managed care system.

APPENDIX B

**MANAGED CARE MODELS AND ISSUES
IN THE CURRENT MANAGED CARE ENVIRONMENT**

MANAGED CARE MODELS

Many States are seeking to control their Medicaid costs by establishing managed care structures either within their own systems or through contracts with private managed care organizations (MCOs). Public sector alcohol and other drug (AOD) services funded through Block Grants, other Federal discretionary grants, and State appropriations also have begun to move into managed care models in a number of States. Historically, the State AOD agencies have disbursed funds earmarked for AOD services to providers who offered treatment on a fee-for-service (FFS) basis. As States have initiated healthcare reforms, they have begun to turn to MCOs to manage delivery of services funded through the State as well as through Medicaid.

Public sector contracting for managed care services has created various behavioral healthcare structures that incorporate both carve-ins (i.e., AOD and mental health services are included in the same managed care plan with general medical services) and carve-outs (i.e., AOD and mental health services are not included with general medical services). In some States, AOD services have been carved out of State contracts with MCOs for services for Medicaid recipients. The State has either left its AOD services in the traditional FFS system or directly contracted with a managed behavioral healthcare organization (MBHCO). Other States have contracted with an MCO, which may then either manage behavioral healthcare services within its total MCO or carve out behavioral healthcare services to an MBHCO. The MBHCO may be either a specialty unit of their organization or another provider group with which the MCO contracts under an additional capitation agreement (i.e., subcapitation). Some States have incorporated two behavioral healthcare carve-outs: one for mental health and one for AOD services. Still other States have carved out mental health and AOD services by contracting directly with service providers in local areas (e.g., local public mental health systems).

The specific structures for managing behavioral healthcare costs vary from State to State. It is clear, however, that whatever form it takes, managed care is affecting the delivery and accessibility of AOD services in both the private and public sectors as increasing numbers of payers contract with MCOs. Managed care models employed by State Medicaid and AOD agencies vary from the traditional health maintenance organization (HMO) model to a variety of provider network models. Any of these may include AOD services or may carve out AOD

services to an MBHCO, which may then be structured as a behavioral health HMO or other provider network model.

HMO Models

Various models exist for HMOs. One model includes both general medical and behavioral healthcare practitioners as salaried employees of the HMO. In this model, costs are usually controlled through a general profit-sharing or bonus plan for practitioners who stay within or below the specified norms for referrals for hospitalization or expensive tests. Other models include a group model, in which the HMO contracts with a group of practitioners at a negotiated per capita rate that is then distributed among the individual practitioners; a network model, in which practitioners work out of their own offices under contract with the HMO; and an individual practice association (IPA), in which practitioners continue with their individual or group practice but may be compensated by capitation for all of the enrollees in their geographic area. Alternatively, the IPA may receive a case rate, whereby it accepts a set payment for the care of each treated patient; the payment includes all required services for treatment of a specific diagnosis in a designated time period. Access to AOD services in each of these models traditionally requires referral from a primary care physician (PCP). The requirement for referral from a PCP has been eliminated in HMOs that carve out their behavioral healthcare services, as opposed to providing these services through a carve-in. In the carve-out model, mental health and/or AOD services are subcapitated through contract with an MBHCO that controls access to all mental health and AOD services.

Preferred Provider Organization and Point-of-Service Models

The preferred provider organization (PPO) contracts with healthcare practitioners, hospitals, pharmacies, labs, and other providers at a negotiated, discounted FFS. Enrollees in PPOs are given incentives to use only network providers, although they may choose to go outside the network and pay a higher copayment and/or deductible. The PPO also controls costs through a structured system of utilization management that requires practitioners and hospitals to get authorization from the PPO before providing any nonemergency services. The PPO may use its internal utilization management system for AOD services or may subcontract with an MBHCO to provide utilization management for this area of healthcare.

The point-of-service (POS) model combines features of both the HMO and the PPO. Like the PPO, the POS contracts with a network of healthcare providers. These providers may be paid through a negotiated or discounted FFS, a case rate for patients they treat, or capitation for enrollees in their geographic area. The enrollees are encouraged to stay within the network, although they may receive services from non-network providers and pay a higher copayment, and/or deductible. The POS is similar to an HMO in that each enrollee selects or is assigned to a PCP, who controls access to specialists. When AOD services are not carved out to an MBHCO, enrollees are covered only for these services after referral from their PCP. If the POS has carved out its behavioral healthcare services to an MBHCO, referral is not required from the PCP. Methods of accessing and receiving continued authorization for AOD services are defined by the MBHCO's utilization management structure.

ISSUES IN THE CURRENT MANAGED CARE ENVIRONMENT: BENEFITS AND POTENTIAL PROBLEMS

The advent of managed care has raised a number of policy issues. These include issues related to the following:

- Efficient and effective financing of AOD services and possible conflicts of interest created by cost-saving incentives;
- System designs that may increase managed care providers' incentives for provision of AOD prevention and early intervention services or may actually provide disincentives for those services; and
- Utilization and case management systems that may enhance AOD-treatment efficiency and effectiveness or may simply reduce costs by inappropriately denying needed services.

Although restructuring behavioral healthcare delivery systems may prove to be beneficial in many respects, problems have been reported by key informants in the States as well as through reports by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Additional problems are anticipated as managed care moves more deeply into the realm of public AOD services. Concerns have been raised relating to all aspects of AOD services, including treatment access and quality of care.

Financial

MCOs are designed to reduce costs by eliminating unnecessary or inappropriate services. This is generally accomplished through gatekeeping systems requiring that specialty care be accessed through referrals from a patient's PCP or preauthorization from the MCO's utilization management staff. MCOs report lower use of inpatient care and expensive tests and are specifically designed to remove the incentives for providing inpatient care that existed in traditional indemnity plans. Instead, these plans focus on patients receiving care in the least restrictive setting.

One concern raised about MCOs is the lowering of the percentage of the healthcare dollar used for direct provision of services as opposed to administrative costs and profits. Utilization management systems increase administrative costs. In MBHCOs, trained clinicians, including nurses, physicians, and clinical social workers and psychologists, develop and administer utilization management protocols and review each case with the treatment provider. The treatment provider must also spend administrative time completing individual treatment plans (on a variety of forms) to be mailed in for review, and/or they must spend significant telephone time talking with a reviewer about the patient's symptoms, treatment plan, and progress. If the MBHCO is unwilling to authorize the recommended treatment, an appeal process may be initiated by the treatment provider, requiring the expenditure of additional administrative time.

Layers of contracts and subcontracts also contribute to increased administrative costs. For example, in the public sector a State may enter into a capitated contract with an HMO for management of its Medicaid services. The HMO may then subcapitate with an MBHCO for mental health and AOD services, and the MBHCO may then subcapitate with a provider group in a local area. Each layer adds additional administrative fees and possible profits and reduces the funds ultimately available for direct service to the enrollees. MCOs have been reported to expend anywhere from 6 to 40 percent of premium dollars for administrative cost and profit (Church, 1997; Boodman, 1997).

Direct healthcare expenses as a percentage of premium revenues are referred to in the healthcare insurance industry as "medical loss ratio." One method used by for-profit healthcare insurance

companies to provide a high return to shareholders is to minimize the medical loss ratio. For-profit MCOs frequently are accused of valuing healthy profits over healthy membership. Minimizing medical loss ratios serves as an incentive for MCOs to reduce their expenditures for healthcare services, particularly those services that have the highest costs. Along with a need to keep premium rates low, a strong incentive exists for erring in the direction of undertreatment or denial of services. This incentive is true for both nonprofit and for-profit MCOs. If the cost of delivering services increases beyond what had been expected at the time capitation rates were negotiated, the MCO faces diminished profits and, possibly, significant losses that must be recouped. This risk is of particular concern when the MCO is a public or nonprofit group that may not be sufficiently capitalized to continue providing services.

HMOs and PPOs use a variety of methods to encourage healthcare providers to be cautious about treatment expenditures. HMOs that operate with a staff model may either reward all staff for total efficiency by providing a bonus plan based on financial success, or they may focus on their salaried staff physicians who function in a gatekeeping role. Salaried PCPs may be awarded bonuses on the basis of cost of referrals for specialty and hospital care. For example, if there is a surplus in the HMO's budget for inpatient care, a designated amount of that surplus may be divided among all PCPs. Similarly, a limited amount of any deficit might be deducted from PCP salaries. HMOs also may provide bonuses to PCPs based on their individual referrals for specialty and hospital care relative to the HMO's established norms. Another method used by HMOs and POS plans is to compensate individual PCP or physician groups and other gatekeepers, such as MBHCOs, through a capitation method. In this system, the gatekeeper receives a set amount of money per month for all enrollees under its care, and the cost of hospitalization or other specialty services is borne by the individual PCP or group.

PPO, HMO, and POS plans also routinely provide "report cards" to contracted healthcare providers; these reports rate the providers' practice patterns regarding referrals for specialty care, inpatient hospitalizations, and length of stay (outpatient visits or inpatient days per patient). Many MCOs will suggest improvements for providers who fall outside the norm. For example, an MCO might suggest that an inpatient hospital with an average length of stay for AOD treatment admissions that is above the regional norm consider discharging inpatients more

quickly to partial hospitalization. This reporting is presented as part of a quality improvement program. If practice patterns do not remain within specified norms, MCOs and MBHCOs may drop the clinician or facility from their panel of contracted providers. Service providers sometime refer to this practice as being "blackballed" by managed care. Opponents of managed care believe this practice discourages providers from requesting authorization for the AOD services they might clinically view as being the most effective intervention for the patient.

All of the above methods of sharing the medical loss ratio risk with gatekeepers and other clinicians are incentives for the undertreatment of both physical and behavioral healthcare problems. Consumer and provider advocates alike have raised serious concerns about the financial incentives for denial of appropriate care that are inherent in bonus and shared-risk structures. Coverage for AOD services may be at even greater risk than other physical or mental disorders because there are fewer public advocates for these services than for other medical disorders.

A number of informants described situations in which treatment options had been scaled back and stricter limits imposed on length of stay after managed care programs were implemented. In some cases, AOD treatment was subsumed under mental health services, and in at least two situations, detoxification centers had been converted into crisis stabilization units that provided only 24 hours of detoxification.

Although managed care critics complain that the system's financial incentives result in undertreatment of substance use disorders, proponents believe that managed care has simply corrected a system that previously provided financial incentives for unnecessary hospitalization or lengthy treatment for substance use disorders.

Prevention and Early Intervention

HMOs were created and marketed initially as a system that would promote health rather than focus only on illness. In light of this focus and the financial deterrents for providing costly treatment services for preventable illnesses (or at least abating those costs through early intervention), advocates for managed care tout its potential for the development of prevention and intervention programs for enrollees. The premise that MCOs have financial incentive for prevention and early intervention presumes that their enrollees will remain with them for a period of years. However, managed care contracts are time limited and cost competitive. Contract awards that are, in fact, initiated in an effort to control healthcare expenditures will certainly be based heavily on cost proposals. Although the expense of providing prevention and early intervention services may have a long-term payoff for an MCO's enrollees, the costs will be high in the short term. The current contracting systems and opportunities for enrollees to voluntarily change plans on a periodic basis is unlikely to provide an incentive for MCOs to invest heavily in prevention and early intervention services.

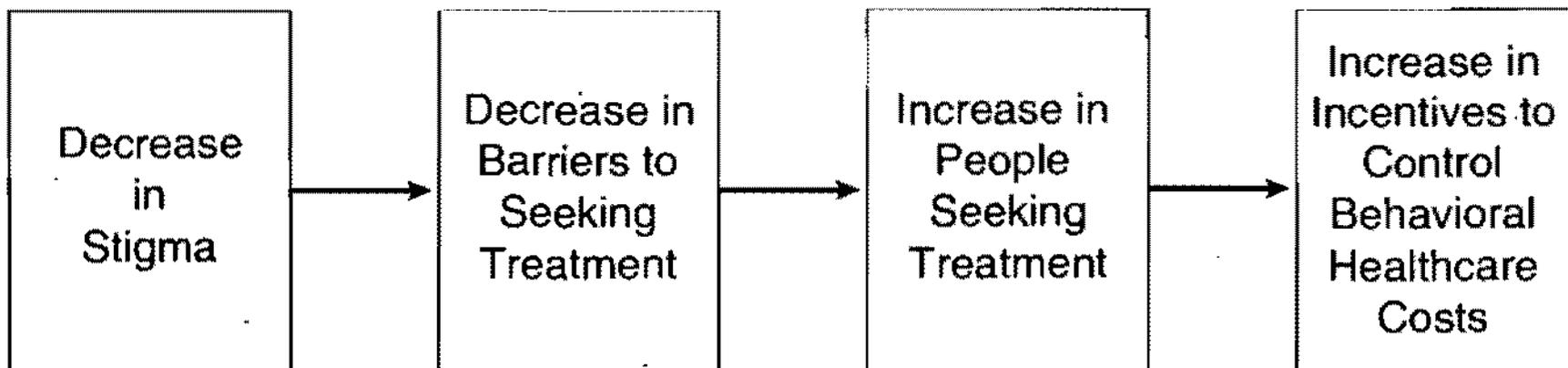
Early intervention is encouraged by public education efforts seeking to convey the fact that substance use disorders are preventable and treatable. Public education campaigns that encourage people to recognize symptoms and to seek treatment earlier in the progression of their illness are laudable efforts to increase early intervention. However, they may actually have an adverse financial impact on MCOs looking for short-term cost savings, as demonstrated in Exhibit B-1, following this page.

Utilization Management

Costs for AOD services are controlled by MCOs and MBHCOs through systems designed to manage enrollees' utilization of benefits. These systems are designed with the stated purpose of increasing the efficiency of the healthcare delivery system; they begin with procedures for accessing treatment services and continue with structures for ongoing review of each patient's need for continued treatment. Proponents of managed care view these utilization management systems as a means to maximize benefit coverage by providing cost-effective care for mental health and substance use disorders in the most clinically appropriate and least restrictive environment. Critics of managed care view utilization management systems as "gatekeeping"

Exhibit B-1

Short-Term Financial Impact of Prevention/Early Intervention Efforts



functions that may be designed to deny appropriate treatment services in order to enhance profits. Concerns surrounding the gatekeeping functions of MCOs were expressed by numerous States and reported by NASADAD.

Increased Efficiency of Delivery System

Before the advent of MCOs, patients often received healthcare services through a fragmented delivery system, with duplication and limited communication between the various healthcare providers. For example, an adolescent patient with a substance use disorder might have been seen by a school counselor, tested by an outpatient psychologist, received outpatient therapy from a clinical social worker, hospitalized following an emergency room visit after an overdose and assigned to that hospital's on-call psychiatrist, and then discharged to an intensive outpatient program in the hospital psychiatrist's practice group. Frequently, the family would serve as the client's historian, with varying degrees of effectiveness based on their understanding of the treatment attempts that had been made. Psychological testing might be repeated, and treatment interventions for both the adolescent and family that had been ineffective in past outpatient counseling might be implemented again in the intensive outpatient program. An MCO's utilization management system would have information available from all the treatment providers involved with the family and might be able to streamline service delivery, avoiding unnecessary duplication. Proponents of managed care support utilization management systems in their ability to provide this service. Critics of managed care raise concern that these systems too often fail to integrate services effectively and more often serve simply as systems for creating obstacles to treatment access.

Access to Treatment Services

MCOs and MBHCOs may be structured in ways that can either facilitate or hamper AOD treatment access. Obstacles to treatment presented by MCOs most often gain public attention, but the potential also exists for carefully structured managed care systems to enhance access for patients seeking treatment.

Patient and provider advocates frequently criticize both general medical MCOs and specialty MBHCOs for denying access or establishing significant barriers to patients seeking treatment for

a substance use disorder. Critics complain that enrollees in many MCOs and MBHCOs are required to provide detailed information about their current symptoms and personal history to a succession of strangers before they can receive treatment. For many MCOs, the first step an enrollee must take is to call a behavioral healthcare referral line, where a triage worker will ask about (1) the current symptoms or events that prompted the call, (2) the caller's past treatment history, and (3) the potential for self-harm or harm to others. The triage worker may then either direct the enrollee to contact "self-help" resources in the community or refer the enrollee for an individual face-to-face assessment. If approved for the assessment, the referral to a specific therapist may be made simply on the basis of the enrollees' zip code. (The assessing therapist may or may not have any specific substance abuse skills or training.) A number of MCOs and MBHCOs require that the initial face-to-face assessment session be conducted by a therapist or psychiatrist who will not become the treating therapist or psychiatrist. (This requirement for an "independent assessment" is most often the case in an FFS arrangement, such as a PPO structure.) The information gleaned from this assessment must then be reviewed with the MCO/MBHCO staff, who will refer the patient to a specific treatment provider if they concur with the assessing therapist's recommendation. Thus, patients must discuss the details of their drug history and current symptoms to at least two people (the initial telephone triage worker and the initial therapist or psychiatrist) before they can be referred to treatment. If the patient receives a treatment referral, this patient will need to describe his/her history and current symptoms again, this time to the treating clinician, before treatment can actually begin. In light of the stigma attached to substance use disorders, many people hesitate to acknowledge their symptoms even to themselves, close friends, or family members. Systems that require people to describe their personal symptoms and histories to a succession of strangers can be a significant barrier for MCO enrollees to access treatment services. Providers and patient advocates raise the concern that this process is daunting for most people and impossible for someone whose functional level is limited by a serious substance use disorder.

Access to AOD services is one of the most important considerations that must be monitored when implementing managed care programs. MCOs are most frequently criticized for denying access or establishing significant barriers to enrollees seeking treatment. The way in which MCOs and MBHCOs are structured to respond to issues of treatment access thus can facilitate or

obstruct enrollees seeking behavioral healthcare services. A variety of factors promoting and obstructing access to treatment, in addition to those described above, are listed in Exhibit B-2, following this page.

Medical Necessity Criteria

To establish a mechanism for authorizing enrollees' use of behavioral healthcare benefits, MCOs and MBHCOs have developed criteria for placing patients in appropriate levels of care based on assessed treatment needs. Although proponents of managed care believe it provides a means for matching patients with cost-effective treatment interventions that will result in positive patient outcomes, State informants raised concerns regarding placement criteria (frequently referred to as "medical necessity" criteria). They fear that the criteria will lead to denial of services for clients who are not experiencing acute medical symptoms as a result of their substance use.

Critics of managed behavioral healthcare argue that because treatment decisions are complicated by so many variables, standardized criteria and treatment practices are not appropriate. Most behavioral healthcare researchers and providers agree that no single form of AOD treatment is effective for all people with a given diagnosis. However, current knowledge is limited regarding which treatments are most effective for which people at which time.

In recent years, organizations such as the American Society for Addiction Medicine (ASAM) have made a significant investment in developing a consensus for patient placement criteria. Through ASAM's efforts, a multifactorial system was developed that assesses patients on various biopsychosocial dimensions and results in defining the level, focus, and type of care needed as shown in B-3. It is clear from reviewing this set of patient placement criteria that determining the level of care appropriate for individual patients is a complex process. However, the ASAM patient placement criteria is one of the few well-developed systems that takes into consideration both the many dimensions that must be assessed and the severity level in each dimension. These criteria are then used to determine the appropriate level, focus, and type of care that should be provided.

Exhibit B-2

Factors Influencing Access to Treatment

Obstacles to Access

Factors Promoting Access

Not identifying individuals in need of treatment	↔	Effective screening, assessment, AOD training
Not reaching clients in the locations in which they enter the "system" (i.e., courts, criminal justice system)	↔	Satellite sites, systematic linkage, training
Long waiting periods for appropriate service	↔	Services within 72 hours, depending on severity of clinical need
Multiple steps, places, and people needed to access services	↔	Widely available and simplified intake processes
Arbitrary service limits	↔	Individualized treatment plans
Automatic "fail first" policies (e.g., the client must fail a less intense level of treatment before a more intense level is made available)	↔	Individualized comprehensive assessment used to guide appropriate placement
Geographic inaccessibility	↔	Geographically well-distributed sites located on transportation lines
Resource-intensive review and appeal procedures	↔	Highly efficient, publicly known utilization review processes
Excessive and clinically inappropriate exclusionary criteria	↔	Restricted ability to exclude specified types of hours/days of operation
Cultural, gender, and/or ethnic insensitivities	↔	Priority placed on cultural competence development
Restrictive copayments	↔	Elimination of copayments
Unknown, untimely, or nonobjective appeals processes	↔	Widely known, timely, objective appeals
Lack of transportation	↔	Transportation available as needed
Patient placement criteria that are nonstandardized, financially driven, and/or subjectively applied	↔	Patient placement criteria that are collaboratively developed, clinically driven, objective, and standardized

Source: Moss, 1995.

Exhibit B-3

Summary of the ASAM Adult Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders

This overview of the Adult Admission Criteria is an approximate summary to illustrate the principal concepts and structure of the criteria.

Levels of Care/ Criteria Dimensions	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment	Level IV Medically Managed Intensive Inpatient Treatment
1 ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL	No withdrawal risk	Minimal withdrawal risk	Severe withdrawal risk, but manageable in Level III	Severe withdrawal risk
2 BIOMEDICAL CONDITIONS AND COMPLICATIONS	None or very stable	None or nondistracting from addiction treatment and manageable in Level II	Require medical monitoring but not intensive treatment	Require 24-hour medical and nursing care
3 EMOTIONAL/BENAVIORAL CONDITIONS AND COMPLICATIONS	None or very stable	Mild severity, with potential to distract from recovery	Moderate severity, needing a 24-hour structured setting	Severe problems requiring 24-hour psychiatric care, with concomitant addiction treatment
4 TREATMENT ACCEPTANCE/ RESISTANCE	Willing to cooperate, but needs motivating and monitoring strategies	Resistance high enough to require structured program, but not so high as to render outpatient treatment ineffective	Resistance high despite negative consequences; needs intensive motivating strategies in 24-hour structure	Problems in this dimension do not qualify patient for Level IV treatment
5 RELAPSE POTENTIAL	Able to maintain abstinence and recovery goals with minimal support	Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support	Unable to control use despite active participation in less intensive care; needs 24-hour structure	Problems in this dimension do not qualify patients for Level IV treatment
6 RECOVERY ENVIRONMENT	Supportive recovery environment and/or patient has skills to cope	Environment unsupportive, but with structure or support, patient can cope	Environment dangerous for recovery, necessitating removal from environment; logistical impediments to outpatient treatment	Problems in this dimension do not qualify patients for Level IV treatment

Source: American Society of Addiction Medicine, 1995.

In contrast, the patient placement protocols used by many managed care systems tend to focus simply on broad criteria (often limited to issues related to potential for "harm to self or others") that must be met for approval of a particular level of treatment. Such criteria are criticized by many AOD treatment providers who believe that managed care systems do not take into account individual differences and clinical needs.

Another commonly expressed concern relates to differing interpretations of criteria between and among MCO reviewers, MCOs, and practitioners. In addition, treatment focus differs from MCO to MCO. For example, some MCOs emphasize medical detoxification and little or no counseling, whereas others emphasize counseling by nonphysician clinicians and authorize the use of inpatient or residential detoxification only when other options have failed. Managed care critics argue that this lack of reliability results in utilization management (as described earlier in this report) being used too easily as a vehicle for denying clinically needed care in order to enhance profits.

Individualized Treatment Planning

Supporters of managed behavioral healthcare believe that individualized care is most likely to occur in a managed care environment. They see managed care as having prompted the development of ASAM's patient placement criteria and as having provided the impetus for the current development of clinical pathways taking place within hospitals, outpatient clinics, and behavioral healthcare professional associations. Without the requirement that clinicians review cases with utilization management staff in MCOs and justify their planned treatment interventions, managed care supporters believe that providers would simply treat clients based on individual provider preference or convenience. When treatment plans are not individualized, patients may be placed in programs designed to address the general needs of someone with a particular diagnosis, but not the specific needs of an individual client. The analogy used by some practitioners and researchers in reference to this type of programming is "making the foot fit the shoe."

To defend the legitimacy of their patient placement criteria and treatment protocols, MCOs have been charged with validating them. In this regard, managed care is credited with encouraging the

development of outcome studies in behavioral healthcare. Few studies to date document the comparative efficacy of the many treatment techniques used in behavioral healthcare (Wickizer, Lessler, and Travis, 1996). Purchasers of managed behavioral healthcare services are requesting that MCOs provide outcome evaluations to document the clinical efficacy of their managed care strategies. In turn, both MCOs and regulatory agencies are beginning to require that behavioral healthcare provider groups and hospitals conduct outcome studies to maintain their credentials. The results of these outcome studies should be valuable in planning for continued reform of behavioral healthcare delivery systems.

Intensive Case Management

Another process that has developed out of the utilization management practices of some MBHCOs is intensive case management. When an enrollee has multiple admissions to treatment programs or has a documented need for lengths of stay outside the norm for his or her particular diagnosis, a specific case manager may be assigned to follow the case. For example, when a patient is referred for treatment, the case manager may be required by the MBHCO to check with the treatment provider in order to ascertain whether the patient has attended scheduled appointments. If the patient has not kept an appointment, the case manager may call the patient directly to encourage him or her to follow through with treatment recommendations. The MBHCO staff assigned for this type of case management is generally a licensed clinician who will collaborate with treatment providers, advising them of previous treatments and making recommendations for continued care. Some AOD treatment providers find this process to be intrusive and view it as simply another method for MBHCOs to scrutinize the care of high-risk patients in order to find a way to deny them continued professional care. However, other providers welcome the input.

Whether the intensive case management systems currently employed by MBHCOs are effective, managed care proponents cite the opportunity to enhance AOD treatment outcomes through the provision of specialty case management services. Integration of services from the diverse and multiple providers in the system requires management and coordination. Intensive case management to coordinate services and to support patients' transitions as they move across treatment settings is a potential benefit to be gained from managed care.

Confidentiality Issues

Privacy and security of personal information is a significant public concern. Many AOD treatment providers and consumer advocacy groups have expressed serious concern about the detailed information that must be made available to managed care companies during the utilization review process in order to get approval for coverage. AOD-use histories, psychiatric diagnoses, treatment plans, and clients' responses to treatment all are provided to the MCO. Although confidentiality is an issue for everyone involved in the healthcare field, this issue is an even greater concern for those who use AOD treatment services because of the stigma attached to AOD-use disorders and the possible negative effects of disclosure of this information to employers or others not directly involved in a client's care. Critics of managed care view MCOs as unnecessarily expanding the network of information systems whereby personal client information is now available. The MCOs respond that they have safeguards that limit those who have access to the information within their organizations, and that they do not release nonaggregate information to employers or others who might inappropriately disclose individual client information.

Carved-Out/Carved-In AOD Services

AOD services are carved out to specialty MBHCOs in increasing numbers. These companies manage behavioral healthcare as part of general health coverage for more than 1 million people in the United States (Geraty, 1996). Ongoing debate exists among stakeholders (i.e., consumer advocates, public and private sector AOD providers, and MCOs) regarding the positive and negative outcomes of carving out AOD and other behavioral healthcare services.

Critics of carve-outs point to the effort that has been expended in recent years to increase recognition of substance use disorders as similar to other illnesses. They believe that carve-outs accentuate differences and reinforce public misperception that substance use disorders are not truly "illnesses." In fact, substance use disorders are very similar to other medical disorders: They can be chronic, recurring, and disabling conditions and have been described as analogous to diabetes or heart disease. The difference between substance use disorders and other illnesses is more often in the treatment systems for chronic conditions, particularly the community supports needed to avoid or diminish relapse.

Proponents of carve-outs argue that substance use disorders are underidentified by PCPs. This issue is significant in MCOs that require enrollees to obtain referrals from PCPs for AOD services. HMOs appear to underidentify and undertreat substance use and other behavioral health disorders, as evidenced by reports indicating that they spend only 3 to 5 percent of benefit dollars on behavioral health, whereas other types of plans spend about 10 percent (Warren, 1995). PCPs and nurses employed by HMOs generally would be expected to have limited training or expertise in substance use disorders and limited understanding of treatment needs, even when the illnesses are identified. Carve-outs to MBHCOs arise partially from AOD and other behavioral healthcare clinicians' distrust of PCPs' ability or willingness to adequately identify patients with substance use and mental health disorders as well as from their distrust of PCPs' ability to appreciate the need for referral to specialty care systems.

Structure of the AOD Service System

Unlike traditional healthcare systems, AOD services use a variety of practitioners, including addictionologists, clinical psychologists, certified substance abuse counselors, nurses, social workers, marriage and family therapists, and rehabilitation counselors. Many substance abuse programs also employ experience-based counselors who are not covered in traditional healthcare plans. AOD treatment systems use an array of social support and self-help groups, including Alcoholics Anonymous, Narcotics Anonymous, and Children of Alcoholics. AOD service providers generally recognize the need to integrate services and provide continuing-care supports to prevent or ameliorate relapse. MBHCO carve-outs tend to have better linkages than general medical MCOs with all the direct AOD service providers within the community as well as with the support systems. These networks are vital, because services must be coordinated from multiple providers and linked to support wraparound services, such as child care and transportation, the lack of which may serve as major treatment barriers if left unaddressed.

People with substance use disorders also have co-occurring physical problems that may be secondary to or exacerbated by their substance use. Coordination of primary healthcare and specialty AOD services is important both to help patients manage their physical medical problem and to ensure that prescribed medications and treatments do not unnecessarily exacerbate either their physical condition or their substance use disorder. Although advocates for carve-outs point

to that system's integration with community services, others believe that carve-outs fragment services between primary and specialty healthcare providers.

When AOD treatment is carved in with the general medical system, a financial incentive exists for early identification and treatment of substance use disorders in order to avoid or diminish costs for treatment of co-occurring physical problems. The carve-out of behavioral healthcare to an MBHCO removes what might have been a financial incentive for the MBHCO to identify and treat the substance abuse or addiction. When AOD services are carved out, the MBHCO is at risk only for the cost of providing behavioral healthcare services. The undertreatment of substance use disorders results in a shift of costs to the MCO providing physical medical services. If substance use issues are aggressively identified and treated, the costs for treating physical medical problems secondary to substance use disorders may be avoided or reduced. For example, expensive physical medical treatment costs may be incurred for patients who have cirrhosis or bleeding esophageal varices secondary to their alcoholism; who experience accidental overdoses, infections, and other medical problems associated with drug dependency; or who suffer acute episodes of chronic illnesses, such as diabetes, when they are unable to appropriately care for themselves as a result of their substance use disorder.

Public-Private Partnerships

The public sector is forming an increasing number of public-private partnerships to either manage or provide services that previously were only within the purview of public agencies. These partnerships create opportunities to reengineer service delivery systems and improve the efficiency and effectiveness of services. The privatization of public behavioral healthcare services through contracts with Medicaid and other State programs may potentially enhance services. This enhancement may be accomplished through the development and improvement of provider networks, implementation of appropriate utilization management systems, and cost savings that may allow access to treatment services for a greater number of people. Similarly, many of the tools of the private sector, such as integrated management information systems, may enhance the provision of other public sector services, including primary healthcare, the welfare and child welfare systems, and correctional facility programs.

At the same time, the privatization of public sector programs may present problems for the treatment of persons at risk for or experiencing substance use disorders as well as for the public and nonprofit programs serving these individuals. Persons with substance use disorders often depend on the network of publicly financed providers who have a history of serving populations with multiple needs. Prevention and treatment programs and the social services to which they are linked form a nexus of support critical to helping those who need or are receiving AOD services. As welfare reform and other public sector privatization efforts are initiated from State to State, the system of wraparound services critical to this population may become fragmented. The inexperience of private sector organizations in coordinating care for this population has the potential to result in reduced levels of care and, consequently, reduced levels of functioning by many people who have serious substance use disorders.

Government agencies overseeing AOD services must recognize the potential impact that privatization of publicly funded behavioral healthcare can have on the populations they serve. The impact of such privatization must be identified and monitored so that effective technical assistance and contract oversight for agencies serving this population can be provided.

The private sector historically has limited experience providing services for clients with chronic substance use disorders. Private MCOs have tended to focus on acute episodes of illness and may not be prepared to provide or facilitate the use of essential wraparound services over the long term for a large percentage of their AOD clients. Such wraparound services include access to transitional housing programs and group homes, which is essential for many people; transportation and child care, the lack of which are major barriers to treatment access for Medicaid-eligible mothers; public health services necessary to respond to the high-risk pregnancies among substance-abusing mothers as well as to those at risk for HIV and other infections; and community support and rehabilitation programs necessary for people to achieve and maintain the highest possible level of functioning. The advent of Medicaid and other public sector behavioral healthcare service contracts with private MCOs and MBHCOs has the potential to facilitate linkages with these essential services through intensive case management services.

Because most MCOs are primarily experienced in providing managed behavioral healthcare services through employer-sponsored benefit plans, they are inexperienced in providing such services for enrollees who may be homeless or live in isolated rural areas. Lack of experience in the latter can create treatment access barriers for those seeking services in traditional private managed care networks. For example

In New York City, where every borough has a different managed care company, a homeless person may wander into another borough and lose coverage. In some rural areas, the shortest distance to providers is in another State, and using out-of-network providers is not allowed under the closed managed care networks (Warren, 1995).

Private MCOs and MBHCOs must be prepared to respond to these issues.

High Financial Risk for Capitated Contracts and Limited Actuarial Data

Actuarial information for Medicaid and other public sector service recipients' use of AOD services is limited. Many States do not have information systems for accurately estimating costs when establishing capitation rates for MCO contracts (Warren, 1995). However, MCOs have targeted Medicaid and other Government contracts as a growth area and are anxious to compete in this market to increase their premium revenues. Medicaid recipients are overrepresented among those with substance use and mental health disorders. In addition, capitated contracts for Medicaid services may cause a higher medical loss ratio than a private MCO would have anticipated. If an MCO has underbid a contract and needs to minimize the medical loss ratio, reviewers may be particularly stringent with their utilization management criteria and limit the use of AOD treatment services.

Underbidding for managed care contracts also may have a deleterious effect on nonprofit and public sector providers who have entered the managed care arena. Such providers may accept capitation rates that are too low, because of a lack of expertise in analyzing available actuarial data and a need to compete with the private sector MCOs in order to continue operation. The result may be even more serious for nonprofit and public sector programs than for private programs, because the former are not as likely to have capital sufficient to sustain losses. The

question then arises, How would their enrollees continue to receive services, unless Government agencies were prepared to bail out the programs?

Vulnerability of Population

Public sector service recipients with substance use disorders, particularly those who live below the poverty level, do not have the voice of other groups, such as senior citizens, who also may be affected by managed care or privatization of previously publicly operated service systems.

Though advocacy groups for the mentally ill have gained strength in recent years, as a rule they have not included advocacy for those with substance use disorders, leaving this population particularly vulnerable to the negative impact of cost-control efforts by privately operated service providers.

Providers of AOD treatment services report that it is difficult to get approval from private MCOs to provide anything but the most minimal service for those with substance use disorders. MCOs spend very little for care of primary substance use disorders, although 21 million people suffer from them (Rouse, 1995). Many observers indicate that MCOs believe they can cut services in this area with little backlash because of the general public's belief that substance use disorders are not illnesses, that this population is not worthy of healthcare dollar expenditures, and that drug users in particular belong in prisons and not in treatment facilities.

Fate of "Safety Net Providers"

Publicly funded and nonprofit behavioral healthcare providers are often referred to as "safety-net providers" because they are available when all other private treatment benefits a person might use have been exhausted. Safety-net providers may find it difficult to compete in a privatized managed care environment. Typically, nonprofit and public AOD service providers do not have the capital or the administrative sophistication to successfully compete with private providers for preferred-provider contracts. If safety-net providers are unable to obtain managed care contracts and lose their insured and Medicaid patients to private providers, they will lose their economies of scale. When this happens, they will need to cut back on available services or obtain additional publicly funded subsidies to continue providing services. These subsidy requirements will be higher than were necessary before the implementation of managed Medicaid contracts, because

of the safety-net providers' loss of FFS revenue from treatment of Medicaid clients. Additionally, the treatment limits set by MCOs could prevent Medicaid-covered patients from accessing AOD services through their managed care plan. Therefore, these patients are likely to return to community agencies (i.e., safety-net providers) for treatment services, so these agencies end up providing treatment that was denied by the Medicaid MCO. Before the advent of Medicaid managed care contracts, the safety-net providers would have been reimbursed by Medicaid for services for these same clients.

A number of States have considered or passed "willing provider" laws to ensure that any willing provider is able to become a contracted network provider with an MCO, as long as they are willing to meet the standards of that MCO and accept payment at a given rate. However, the safety-net and nonprofit providers may end up with a disproportionate number of people with chronic substance use disorders if they are one of a number of contracted providers in their region. The clients with chronic substance use disorders, having traditionally used the public sector services, would already be on their caseload. It is likely that these patients would select the provider they knew when they were enrolled in an MCO. If payments are subcapitated by the MCO to behavioral healthcare providers, the safety-net provider could find that as a result of this adverse selection process, they are underfunded to meet their clients' needs. Willing provider laws also have the potential to reduce the MCO's ability to negotiate rates. AOD service providers have been willing to accept lower than usual rates from MCOs that offer exclusive contracts or at least restrict the number of contracted providers in their area. If contracts must be offered to any willing provider, the economies of scale that were available under exclusive contracts disappear.

As a result of concerns about the effects of willing provider laws, a number of States have repealed those laws or are amending them to "essential provider" laws. These laws require that MCOs include certain essential public sector providers in their networks but do not require them to make contracts available to all willing providers in the community.

If public providers of AOD treatment services are able to effectively contract with private MCOs in ways that do not seriously threaten public providers' financial solvency, the move toward

privatization of traditionally public services could result in a continuum of care that positively integrates public and private sector services in local communities. The effect of privatization on safety-net providers will need to be closely monitored, because these providers continue to be the only treatment resource for people with substance use disorders who either do not have health coverage or have exhausted their health insurance benefits.

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Coercing Coerced Treatment: How Far Should Public Policy Go?

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Introduction

Coercion of drug-related offenders into treatment programs is occurring more frequently as an alternative to incarceration. Coerced drug and alcohol treatment is an option for those who have been charged with or convicted of an offense to which alcohol or drug dependence has contributed.¹ Failure to comply with treatment requirements may result in sanctions or incarceration. Treatment for drug addiction may be coerced by a variety of sources including the courts, employers, family, friends, medical practitioners, and public welfare agencies. Court-mandated cases comprise forty percent of clients referred to substance abuse treatment.²

Two types of mandatory treatment are described in the literature: civil commitment and diversion from the criminal justice system.³ Civil commitment allows the state to confine a person for treatment without bringing a criminal charge. Diversion from the criminal justice system entails removing a person already charged with or convicted of an offense from indictment, trial, or sentencing.⁴ Informal types of civil commitment have been used in the U.S. as early as the 1930s. More recently, legally sanctioned compulsory treatment began when court-ordered treatment began to be offered as an alternative to incarceration. The California Civil Addict Program, New York Civil Commitment, and the Federal Narcotic Addict Rehabilitation Act each aimed to rehabilitate addicts with legal control, providing treatment to change socially undesirable behavior.⁵ As the impact of drug abuse on the criminal justice system has grown,

various alternatives to incarceration have been developed and employed.

The purpose of this paper is to describe the issues surrounding coerced treatment in the criminal justice system, and examine the public policy response to these issues. This paper is organized broadly around three themes. First, there is a persistent link between drug abuse and crime. Drug-related offenders exhibit a high rate of recidivism, and incarceration alone does little to break this link. Second, substance abuse treatment is equally valuable and effective for voluntary and non-voluntary (i.e., coerced) clients. Moreover, coerced treatment can be effective in breaking the link between drugs and crime. Third, public policy is exploiting the concept of coerced treatment. Recent initiatives have demonstrated success in channeling offenders into treatment and reducing recidivism, and those efforts that have proven fruitful are currently being expanded. Indeed, the concept of coerced treatment is being pushed to the extreme through the Break The Cycle (BTC) program, which tests arrestees — that is, those in the first stage of criminal justice system involvement — to channel them into drug abuse treatment if necessary.

I. There is a persistent link between drug abuse and crime

It has long been recognized that there is a strong link between drugs and crime. While there is no way to estimate the exact number of drug-related crimes, it is evident that much of the social cost associated with illicit drug abuse is related to crime and the criminal justice system. We know that those getting arrested are presumably among the more deviant members of society and thus are more likely to be heavier drug users than the population at large. We also know that many people in prisons and jails have substance abuse problems.

In addition, research has shown that hardcore drug users, while accounting for perhaps a quarter of all drug users, are responsible for a majority of the crime costs associated with drug use. In general, hardcore drug users maintain the illegal market through a disproportionate amount of consumption. A 1994 RAND study found that hardcore cocaine users, who comprise only a third of all cocaine users, demand about two-thirds of all cocaine consumed.⁶ In addition, this group is responsible for a large amount of criminal activity, which increases with use.⁷

There were 1.5 million arrests in 1996 for drug-law violations,⁸ and this number indicates only a fraction of actual crime since a large number of law-breakers avoid apprehension. In addition, the number of all criminal justice offenders determined to be using illicit drugs at the time of their offense remains high. The Drug Use Forecasting system, now the Arrestee Drug Abuse Monitoring (ADAM) program, conducted by the National Institute of Justice reports that over 60 percent of male arrestees tested positive for drug use at 20 of their 23 test sites in 1996, and in some cities, 70 to 80 percent of arrestees tested positive for recent drug use.⁹ In Chicago, 82 percent of male arrestees tested positive for illicit drug use. Among female arrestees, more than 50 percent reported using drugs at the time of arrest in 16 of 18 study sites. Manhattan reported the highest drug involvement among female arrestees with 83 percent testing positive for drug use.¹⁰ Similarly, the Bureau of Justice Statistics reports that in 1996, 62 percent of all offenders under State correctional supervision and 42 percent of all persons admitted to Federal prison had poly-substance abuse problems prior to their incarceration.¹¹

It is clear that the criminal justice system presents an opportunity to access specific populations

that would otherwise be difficult to identify with outreach efforts. We know that substance abusers have a fairly high probability of arrest. There is some disagreement as to what the exact probability is, but whatever the case, it is clear that many come through the criminal justice system.¹² When offered treatment, many choose it not because they want treatment, but because they do not want to enter jail or prison. Having substance abusers within the criminal justice system provides an opportunity to structure incentives to encourage treatment compliance.

However, treatment capacity in prisons and jails remains low. Although the opportunity exists for an extended, therapeutic environment and lengthy periods of abstinence, availability and use of these programs is limited. The 1993 National Drug and Alcoholism Treatment Unit Survey (NDATUS) reports that only 3,335 (out of an estimated 94,827) adult prison inmates receive substance abuse treatment.¹³ However, preliminary results from a recent study sponsored by ONDCP are more encouraging: 38 percent of prisons responding to the survey had substance abuse treatment available on site, and 136,332 individuals were receiving treatment (out of 1,182,169 estimated Federal and State prisoners at year-end 1996).^{14, 15}

A recently released study of probationers reveals the extent of treatment utilization for adult probationers.¹⁶ This population is important because they represent 58 percent of the national population of adults under correctional supervision. The study found that 47 percent of all adult probationers said they were under the influence of alcohol or drugs at the time of their offense. Nearly half of all probationers (49%) reported participation in a drug treatment program during their probation sentence.

II. Substance abuse treatment is effective for both voluntary and non-voluntary clients

Numerous treatment evaluation studies show that substance abuse treatment works.¹⁷ Along with recent scientific evidence showing that drug abuse has profound effects on how the brain functions, it is becoming widely recognized that addiction is a chronic, relapsing disorder. However, research shows that it can be treated effectively. Several studies show that substance abuse treatment can be effective in reducing illicit drug use and improving a number of related social indicators, such as health, employment status, and violent behavior.

Recently published results from the Drug Abuse Treatment Outcome Study (DATOS) show the success of four different types of treatment modalities.¹⁸ Using a sample of 10,010 clients, DATOS reported favorable treatment outcomes on a number of indicators including: drug injection behavior; use of cocaine, crack, heroin, and alcohol; as well as arrests, legal status and employment. Notably, the study reported that clients were most likely to be referred into treatment by the legal system. Similarly, the National Treatment Improvement Evaluation Study (NTIES) — a multi-site study conducted in conjunction with three demonstration grant programs funded by the Center for Substance Abuse Treatment (CSAT) — found that substance abuse treatment cut drug use by half; increased employment; decreased homelessness; improved physical and mental health; reduced medical expenses; and reduced risky sexual practices. The NTIES also found that respondents reported significant decreases in multiple indicators of criminal involvement. The comparison of criminal activity 12 months before treatment and 12 months after treatment exit showed that drug selling declined (from 64% to 13.9%); arrests for any crime declined (from 48.2% to 17.2%); and the percentage of clients who supported

themselves primarily through illegal activity declined (from 17% to 9%). The NTIES found that drug and alcohol use, criminal activity, and employment outcomes were measurably better among individuals who completed their treatment plans, received more intensive treatment, and were treated for longer periods of time.

Evaluations of treatment programs in Federal and State prisons and local jails have also shown promising results. For example, preliminary results from the evaluation of the Federal Bureau of Prisons (BOP) residential drug abuse treatment program suggest favorable outcomes. Inmates who participated in the program were 73 percent less likely to be re-arrested in the 6 months following their release (3.3% versus 12.1%), and 44 percent less likely to have evidence of post-relapse AOD use (20.5% versus 36.7%) than those who did not.¹⁹ An evaluation of drug treatment in local corrections facilities also points to the value of drug treatment within the criminal justice system.²⁰ The research design analyzed program completion rates for participants as well as 12-month post-release outcomes (i.e., the probability of being rearrested and convicted within 12 months after release) for participants and matched comparison groups. The program participants were found to have lower rates of serious behavioral problems (i.e., physical violence) as well as improved performance on other indicators.

Further, treatment programs in correctional facilities have been evaluated to be cost-effective. In general, the marginal cost of treatment per inmate ranges from \$10 to \$18 per day. However, treatment provides long-term benefits in the form of reduced recidivism rates, reduced social costs, reduced crime incidence, and reduced health consequences, which add up to several billion

dollars in social costs over the long term.²¹

Underlying these statistics, however, is a debate regarding internal motivation. That is, can treatment be effective if a person is not internally motivated? Traditional philosophies value the user's motivation as a predictor of treatment outcome. Others suggest that any treatment, regardless of motivation, is more effective than not providing treatment at all.

Many studies show that treatment efficacy for those who are coerced into treatment is as high or higher than it is for those who go through treatment voluntarily. For example, Anglin, et al. reviewed eleven empirical studies that analyzed the relationship between various levels of legal pressure and substance abuse treatment. Out of the eleven, "five found a positive relationship between criminal justice referral and treatment outcomes, four reported no difference, and two reported a negative relationship."²² Similarly, studies by Anglin and colleagues in 1991 and 1992 find that "abusers who are coerced into treatment programs by the criminal justice system emerge from the programs with the same success rates as those who enter treatment voluntarily"²³; and "legal pressure increases admission rates into treatment programs and may promote better retention in treatment, consequently improving the overall results of the program."²⁴

In sum, three positive outcomes are identified repeatedly in the research: a) patients who are legally pressured to participate in treatment are more likely than those without pressure to participate in treatment; b) patients who are legally coerced into treatment tend to remain in

treatment longer than those who are not mandated; and c) patients coerced into treatment and voluntary participants both show positive treatment outcomes.²⁵ These findings suggest that what is important is not the manner in which a client obtains treatment, but the success of treatment in meeting that client's needs.

III. Public policy is responding to the problem appropriately

The *National Drug Control Strategy* (NDCS) is exploiting the concept of coerced treatment. Programs are now being tested and implemented to reach the drug user at the time of arrest, rather than in the later stages of criminal justice system processing. The idea is simple: every individual who is arrested presents an opportunity for drug abuse testing. This concept is relatively new to drug policy, even though treatment in the criminal justice context has been proven effective for several years. As the following will show, past drug strategies have emphasized drug testing and treatment for those involved in the criminal justice system, but primarily for those who are formally charged and sentenced to either parole, probation, or incarceration. The policy focus is now expanding to include all arrestees, regardless of their final outcome within the criminal justice system.

Over time, the public view of drug addiction has changed. Whereas in the past, addiction was viewed primarily as a moral shortcoming, with users bearing complete responsibility for their self-destructive behavior, it is now being recognized that addiction is a more complex phenomena. Indeed, the first drug strategy released in 1973, stated that "[t]here is still much that is unknown about why individuals respond differently to the same drugs under identical

conditions. Most observers have tended to emphasize the personality of the user as determined by the individual's life experience, but recent work has pointed to what may be genetic determinants of the reaction to drugs and the tendency to develop excessive drug-use patterns. Included among the various factors that are conducive to continued or repetitive drug use are the alternatives available to the individual and this in turn depends on the individual, his family and his environment.²⁶ While experts still point to these environmental factors as contributing to excessive drug use,²⁷ there is now a greater understanding of the specific neurological and physiological effects that drugs have on the body.

During the 1980s, there was a shift away from a public health approach to the drug problem to a more punitive approach. Along with the view that addicts could control their drug-using behavior was the idea that they should be subject to punishment when they did not. A law enforcement perspective — designed to both deter and punish drug use — dominated drug policy in the early 1980s. Accordingly, the number of drug-related offenders within the criminal justice system rose dramatically.

By the late 1980s, it became evident that the criminal justice system could not shoulder the burden of increasing numbers of drug abusing offenders. Despite the increase in convictions for drug law violations, and the concomitant growth in prison facilities, the number of drug-related cases continued to grow. It became clear that incarceration alone does little to address an individual's substance abuse. Subsequently, an effort to develop more comprehensive strategies to deal with drug abusing offenders arose.

The *National Drug Control Strategy*, published annually by ONDCP since 1989, has highlighted the importance of drug testing and alternatives to incarceration. Strategies of the late 1980s and early 1990s generally had a law enforcement orientation, but started to recognize the value of alternatives to incarceration. The 1989 Strategy included the following among its criminal justice priorities: Federal funding to States for planning, developing, and implementing alternative sentencing programs for nonviolent drug offenders, including house arrest and boot camps; and adoption by the States of drug-testing programs across the entire criminal justice system (i.e., for arrestees, prisoners, parolees, and those out on bail). Implementation of State drug testing became a condition for receipt of Federal criminal justice funds.²⁸

The 1990 Strategy continued to promote drug testing by calling for the creation of a drug testing information clearinghouse to advance the concept within the criminal justice system. It also went one step further, calling for expanded drug treatment availability within the criminal justice system for both prisoners and probationers (who represented two-thirds of all adults in the care or custody of a correctional facility at the time). The 1990 Strategy also highlighted the need to maintain proper supervision of convicted drug offenders as they returned to their communities, noting that intensive supervision programs were effective at this stage of the criminal justice system.²⁹

The 1991 Strategy described intermediate punishments as expanding the range of options between incarceration and unsupervised release and an effective way to “complement and enhance a State’s ability to punish drug offenders in a less costly and more efficient fashion...”³⁰

(emphasis added). Examples of such intermediate punishments mentioned are: shock incarceration ("bootcamps"); house arrest; electronic monitoring; home confinement (for non-dangerous offenders); and intensive probation supervision. However, this Strategy also recognized the necessity of drug treatment in prisons, stating that "the population under the jurisdiction of the criminal justice system — arrestees, probationers, convicts, and parolees — tend to be much more heavily involved with drugs than the general population."³¹

The acceptance of coerced treatment and other alternatives to incarceration is manifested in later Strategies, touted as innovations in the criminal justice system. The 1992 Strategy describes the emergence of Drug Courts as helping to manage "the flood of drug cases in urban courts" and including pretrial diversion programs, special courts or judges, and/or distinctive case management systems.³² It also reiterates support for alternative sentencing measures, stating that "some States and localities have had success" in dealing with increased prison populations using these techniques.³³

The 1993 Interim Drug Strategy, the first published by the Clinton Administration, sought to integrate various drug control efforts by viewing the drug problem as a core domestic policy issue that has implications for other aspects of social policy. For the first time, the Strategy characterized drug addiction as a chronic, relapsing disorder requiring treatment and aftercare. The 1993 Strategy recognized the value of both treatment programs for chronic abusers, and local efforts, such as community policing, to minimize the negative social costs of the drug problem. In addition, the 1993 Strategy recognized that different law enforcement approaches

are warranted for heavy users as opposed to casual users. Specifically, it stated that while there must be sufficient prison space to house convicted criminals, some first-time, non-violent offenders would be better served by alternative sanctions, including diversion into treatment.¹⁴

Subsequent Strategies (1994-1998) advocated successful alternatives to incarceration. The 1995 Strategy strongly embraced the notion of accessing the hardcore user population through the criminal justice system. Indeed, it stated that "[d]espite increases in prosecutions and convictions, drug-using offenders all too often pass through the criminal justice system without having been encouraged to stop using drugs. It is imperative that this Nation take advantage of the criminal justice system's ability at all levels of government to break the cycle of drug dependency and criminal activity... Fundamental to maximizing the drug treatment benefits through the criminal justice system is the concept of coerced abstinence."¹⁵ During this time, Drug Court successes in Fort Lauderdale, Miami, Oakland, Portland, and New York generated continued support for expansion of the program nationwide. Drug control budgets during this time included funding for Drug Courts as well as for substance abuse treatment in Federal and State prisons.¹⁶

The 1996 Strategy continued to stress that the criminal justice system must be linked to drug treatment, stipulating that "[e]ffective correctional treatment includes accurate initial assessment of rehabilitative needs, appropriate programming within the correctional walls, and, most importantly, extensive transitional supervision and support as the offender is gradually reintegrated into the community."¹⁷ The 1997 and 1998 Strategies reiterate this theme, pointing

to the success of break-the-cycle efforts in identifying chronic drug users in the criminal justice system.³⁸ In addition, these more recent Strategies provided reliable estimates of the scope of substance abuse within correctional facilities and emphasized the need to implement drug treatment and education for prisoners. The 1998 Strategy points to the success of the Breaking the Cycle (BTC) demonstration program, and reiterates that "the coercive power of the criminal justice system can be used to test and treat drug addicts arrested for committing crimes."³⁹

However, there is some skepticism on the part of the public as to the value of providing treatment for incarcerated populations. A recent study published in the *Journal of the American Medical Association* highlights the fact that there is a wide divergence between the scientific community and the public on the issue of addiction.⁴⁰ Specifically, the public feels that more law enforcement is needed to address the drug problem, while groups such as Physician Leadership on National Drug Policy are voicing the need for more treatment. Thus, there is a need to convince the public that addiction can be treated effectively, and that treating addicts in the criminal justice system is a cost-effective way to break the link between drugs and crime.

Policy initiatives

Pursuant to the Violent Crime Control and Law Enforcement Act of 1994 (42 U.S.C. 3796 ff, as amended), Federal funds are authorized to support both treatment and sanctions of drug-using and violent offenders. The Residential Substance Abuse Treatment (RSAT) of the State Prisoners Formula Grant Program, created pursuant to Subtitle U of this Act, provides funding for the development of programs in State and local correctional facilities. States are encouraged to adopt comprehensive approaches to substance abuse treatment for offenders within correctional facilities. Authorized funding for FY 1999 is \$72 million.

Approximately three-quarters of the States and the District of Columbia have some statutory provision governing the involuntary civil commitment of drug-dependent persons. Among States that have no specific provision, most have the authority to involuntarily commit drug-dependent persons under general mental illness commitment laws.⁴¹ Guidelines were published by the World Health Organization (WHO) in 1987 to assist members in establishing legislation regarding treatment of alcohol- and drug-dependent persons. WHO distinguishes five types of treatment diversion related to the criminal justice system: a) prior to, or instead of arrest; b) after arrest and while in police custody; c) during trial and in lieu of criminal conviction; d) during trial, but pending completion of proceedings; and e) after conviction. Treatment in prison is distinguished separately from diversion cases.

As of January 1, 1997, all 52 State correctional agencies conducted drug testing of inmates. Fifty agencies conducted random tests, and 49 conducted tests when there was a suspicion that the inmate was using drugs. In 1996, 776,779 inmates were tested for drug use. The average cost of testing an inmate for drugs (average of costs reported by 40 agencies) was \$6.65. In 1996, the average percentage of positive drug tests for incarcerated individuals across agencies was 9.3 percent.⁴²

Recently ONDCP initiated a study of drug treatment in correctional facilities to determine availability of treatment services for incarcerated individuals. Coordinated by ONDCP with the support of SAMHSA, various agencies within DOJ, and some State correctional agencies, the study has thus far yielded promising results. The study had a large sample size (8,242 correctional facilities were identified as the universe of correctional facilities; and the study

contacted 7,741 of these) as well as a high response rate (of 7,741 facilities contacted, 95 percent (7,211) responded to the survey). It found that 38 percent (2,705) of those that responded reported having drug treatment facilities on site, and most (2,357) could provide outcome data. The study found that 33.6 percent of juvenile facilities provided treatment; 32.4 percent of jails provided treatment; 55.9 percent of State prisons provided treatment; and 94.7 percent of Federal prisons provided treatment. With these results, we can develop a baseline and track progress on treatment availability in correctional facilities.

As described above, the Federal government has pursued several programmatic initiatives related to substance abuse treatment through the correctional system in recent years. Major programs are described below:

Breaking the Cycle (BTC) demonstration program

Breaking the Cycle (BTC) is a comprehensive effort to sever the connections between illegal drug use and crime. Initiated in Birmingham, Alabama in June of 1997 by ONDCP and the Department of Justice, this program explores the viability of community-supervised rehabilitation instead of incarceration for drug-dependent offenders. Offenders are screened and tested for drugs when they are first arrested. Treatment and sanctions regimes are fashioned by local officials for those offenders with drug abuse problems. Interventions are coordinated from the first day of detention throughout the individual's contact with the criminal justice system. During the first six months, 4,602 offenders were screened and 784 became active participants.

The National Institute of Justice (NIJ) is evaluating the BTC program to determine how this continuum of intervention and monitoring affects long-term drug use and crime. While the BTC

program is currently still officially a demonstration project, based upon the promising results achieved thus far, the Department of Justice is seeking to expand the program to other local jurisdictions. These communities will be offered assistance in planning and implementing new BTC programs. The BTC program represents an aggressive public policy effort to reach the addict. By accessing the individual at the point of arrest, it reaches out to those that are on the perimeter of the criminal justice system.

Drug Courts

In the late 1980s, some State and local jurisdictions began to create Drug Courts with the goal of providing treatment as an alternative to incarceration. While courts had traditionally referred some offenders "out" for treatment as a condition of probation, Drug Courts placed treatment oversight responsibility with the judge, who could then hold the client accountable for his or her own progress.⁴³ The goal of Drug Courts is to leverage the court system to change defendants' drug use behavior, and in so doing, reduce crime. In addition, Drug Courts are creating linkages between the community, government agencies, and law enforcement organizations, and these linkages serve to maximize the effectiveness of the criminal justice system.

In Drug Courts, the judge serves as a central figure, rewarding progress and penalizing non-compliance. Clear choices are presented and offenders are encouraged to take control of their own recovery. A work plan is developed describing roles, responsibilities, and graduated requirements. Clear and certain rules are defined with measurable performance standards. Communication between the court and treatment providers is on-going, and progress reviews are conducted frequently.⁴⁴ Upon successful completion of treatment programs, the court may dismiss the original charges, reduce or set aside the sentence, offer a lesser penalty, or offer a

combination of the above.⁴⁵ Dismissal from the program results in reinstatement of the original criminal charges and prosecution.

As of March 1998, more than 300 jurisdictions have implemented a Drug Court, and another 161 jurisdictions are now in the planning stages. These jurisdictions cover the 48 contiguous states as well as the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Since 1989, over \$125 million has been made available for the planning, implementation, enhancement, and evaluation of Drug Courts. Federal funds totaling \$80 million have been offered to communities (primarily through grants administered by the Departments of Justice and Health and Human Services), and State and local governments have provided \$45 million.⁴⁶ Pursuant to the Violent Crime Control and Law Enforcement Act of 1994, the Drug Courts Grants Program is authorized to run through the year 2000.

Data on existing Drug Courts are currently being collected and reported. Currently, individual courts are being assessed and preliminary results suggest that Drug Courts have been successful in raising treatment retention rates and reducing recidivism.⁴⁷ Evaluations of Drug Courts in Portland, Washington, DC, Phoenix, and several other areas suggest very positive results. For example, in the Los Angeles Municipal Courts, 413 nonviolent drug offenders convicted of felonies were admitted between May 1994 and June 1996. One year later, statistics showed that almost half of the original group had graduated or was still in the program. On average, over 70 percent of Drug Court participants graduate successfully or continue to participate in the program. Among Drug Court graduates, criminal recidivism ranges from 2 to 20 percent, and more than 95 percent of this recidivism is made up of misdemeanors. In addition, Drug Courts have been cost-effective: one comprehensive evaluation states that "[s]avings in jail bed days

alone have been estimated to be at least \$5000 per defendant — which does not factor in the value of the added capability ... to incarcerate the more serious offenders which many jurisdictions are also deriving from these programs.”⁴⁸

Presidential Directive on Coerced Abstinence in the Criminal Justice System

On January 12, 1998, the President issued a directive to the Attorney General on coerced abstinence in the criminal justice system. The President requested the Attorney General to draft and submit to Congress legislation that would grant states flexibility in their prison construction and residential substance abuse treatment funds to provide the full range of drug testing, treatment, and sanctions for offenders under criminal justice supervision. One goal of the program is to allow Federal judges to determine appropriate release conditions for defendants. On March 24, 1998, the Attorney General submitted to Congress legislation addressing this issue. A pilot drug-testing program is now underway in twenty-five of the ninety-four Federal judicial districts.

We believe that we are promoting a policy of outreach to at-risk populations (i.e., those that become involved with the criminal justice system). Indeed, by targeting not only those who have been sentenced to serve time in prisons, jails, or on parole, but also arrestees who may or may not later be incarcerated, we believe we are “pushing public policy” as far as it can go in this area.

Holding criminal justice treatment efforts accountable

The 1998 *National Drug Control Strategy* presents 5 Goals and 32 Objectives, forming a comprehensive and balanced plan of action to address the problems of drug abuse and its

consequences. There are three Objectives under Goal 2 that relate specifically to treatment in criminal justice settings. Goal 2 reads as follows: "Increase the safety of America's citizens by substantially reducing drug-related crime and violence." Related Objectives are listed below.

- *Objective 4:* Develop, refine, and implement effective rehabilitative programs — including graduated sanctions, supervised release, and treatment for drug-abusing offenders and accused persons — at all stages within the criminal justice system.
- *Objective 5:* Break the cycle of drug abuse and crime
- *Objective 6:* Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

This year, ONDCP also released *Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy*, which lays out performance targets and measures that are linked to Strategy Goals and Objectives. The nucleus of the PME system consists of 12 Impact Targets — key performance targets that define desired end states for the Strategy's 5 Goals — and 82 performance targets that reflect progress toward the Strategy's 32 supporting Objectives. The primary impact targets of the PME are to: (1) reduce the availability of illicit drugs in the United States (25% by 2002; 50% by 2007); (2) reduce the demand for illegal drugs in the United States (25% by 2002; 50% by 2007); and (3) reduce the health and social consequences associated with drug use (10% by 2002; 25% by 2007).

The performance targets that are most relevant for the expansion of criminal justice treatment are related to Goal 2, Objectives 4, 5, and 6 as listed above. Achieving these performance targets will not only have an impact within the criminal justice system, it will contribute to reducing the overall social costs of illicit drug use (the majority of which are crime-related). Moreover, progress toward these performance targets will have collateral effects on other elements of the Strategy related to Goals 1 and 3, which have to do with drug use prevention and the reduction of

health and social costs of drug use. The PME system will allow us to track progress of national drug control efforts, and more importantly, allow us to identify and correct impediments to reaching our priorities.

The National Drug Control Budget

The President's National Drug Control Budget for FY 1999 includes funding for several initiatives related to treatment and the criminal justice system. Specifically, the Break the Cycle program will receive \$6 million to expand the demonstration beyond Birmingham, Alabama. The funds will be used to fund the operation of three adult BTCs for one year (i.e., Birmingham and two other sites TBD, for \$2 million); fund the startup and evaluation of two juvenile BTC programs (\$3 million); and evaluate BTC-related research (\$1 million). In addition, the Drug Intervention program will be funded at \$85 million to implement the BTC in additional sites and assist interested communities in developing comprehensive programs to address the links between drugs, crime, and communities. The budget also includes \$30 million to provide grants to localities to develop Drug Courts, as well as \$4.7 million to implement the President's drug testing program.

Others initiatives include \$72 million for the State Prison Residential Substance Abuse Treatment (RSAT) program. These funds will provide grants to States to implement treatment programs within correctional facilities. Also, in FY 1999, an additional \$26 million will be allocated to support treatment for incarcerated individuals in Federal prisons. Two new demonstration programs will be initiated in FY 1999: the first is a \$5 million demonstration program to combat juvenile drug use, and the second is a \$6 million drug-free prison zone demonstration program. Finally, ONDCP will conduct a field test of operating standards for

prison-based Therapeutic Communities, developed by Therapeutic Communities of America (TCA) and the Ohio Department of Alcohol and Drug Addiction.

Conclusions

Public policy efforts to support and expand substance abuse treatment within the criminal justice system have grown in recent years. The confluence of various factors — the link between drugs and crime, the knowledge that substance abuse treatment works, and the burden that substance abusers place on the criminal justice system — have produced this shift in policy. However, there are still important issues for the drug control community to resolve.

At a recent ONDCP conference on treatment in the criminal justice system, a group of experts was convened to share research findings and develop ideas to advance the state of knowledge in this area. It was agreed that the research community must develop principles that are widely accepted and understood regarding treatment protocols. Researchers stated that quality control (“fidelity of treatment”) and staff training guidelines were critical elements of success in prison-based treatment programs. Researchers noted that continuity of offender treatment is important and should include: outreach (institution staff reach out to the community treatment providers), reach-in (community providers begin treatment before release); third-party (e.g., TASC-type programs, when a third party assumes responsibilities for coordinating between community treatment and institutional treatment providers) or a combination of these options.⁴⁹ The group also pointed to the need for public acceptance of the efficacy and value of coerced treatment in order to expand its value as a public policy tool.

Other emerging issues are: managed care in the criminal justice system, which threatens to

shorten the length of time a person is in treatment; the development of a "seamless" system of case management that includes treatment, testing and sanctions, and aftercare; the value and efficacy of faith-based treatment; treatment for special populations; and agreement on the other goals of substance abuse treatment in the criminal justice system, such as improving health, job skills, and psychological well-being. In November, ONDCP will sponsor its second conference on this topic to explore these and other issues.

A final caveat: while we support treatment in the criminal justice system, it is important that treatment is available to all those who seek it on a voluntary basis. It should not be the case that treatment is only available through the criminal justice system. Therefore we must continue to expand resources for publicly-funded treatment both in and out of correctional facilities.

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