United States General Accounting Office

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Report to Congressional Requesters

June 1991

SUBSTANCE ABUSE TREATMENT

Medicaid Allows Some Services but Generally Limits Coverage

GAO/HRD-91-92

GAO

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

Human Resources Division

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June 13, 1991

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

The Honorable Bob Dole
United States Senate

The Honorable Daniel P. Moynihan
United States Senate

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

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

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

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

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

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

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

Background

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

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

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

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

Results in Brief

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

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

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

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

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

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

HCFA's Guidance to States Was Consistent

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

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

HCFA's Responses Consistent

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

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

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

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

HCFA's Guidance Issued in 1990

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

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

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

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

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

Variation in States' Substance Abuse Services

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

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

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

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

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

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

Barriers to Expanding Medicaid Coverage

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

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

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

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

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

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

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

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

Spending Data Not Available

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

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

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

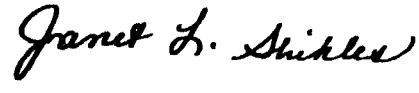
[9]See Drug-Exposed Infants (GAO/HRD-90-138).

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

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

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

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



Janet L. Shikles
Director, Health Financing
and Policy Issues

Contents

Abbreviations

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

Description of the Medicaid Program

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

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

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

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

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

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

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

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

Objectives, Scope, and Methodology

The objectives of our review were to determine:

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

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

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

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

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

HCFA's August 1990 Guidance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

AUG 2 1990

All State Medicaid Directors

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

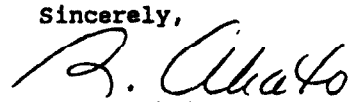
A number of primary care services may be used, including physicians' services, clinic services, and pharmaceuticals (e.g., methadone). Additionally, services appropriate for treating addiction may be provided (1) by home health agencies, (2) under home and community-based services waivers, and (3) as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

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

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

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

Sincerely,



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