



Do benefits restrictions limit Medicaid acceptance in addiction treatment? Results from a national study☆



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ABSTRACT

Objective: To assess the relationship of restrictions on Medicaid benefits for addiction treatment to Medicaid acceptance among addiction treatment programs.

Data sources: We collected primary data from the 2013–2014 wave of the National Drug Abuse Treatment System Survey.

Study design: We created two measures of benefits restrictiveness. In the first, we calculated the number of addiction treatment services covered by each state Medicaid program. In the second, we calculated the total number of utilization controls imposed on each service. Using a mixed-effects logistic regression model, we estimated the relationship between state Medicaid benefit restrictiveness for addiction treatment and adjusted odds of Medicaid acceptance among addiction treatment programs.

Data collection: Study data come from a nationally-representative sample of 695 addiction treatment programs (85.5% response rate), representatives from Medicaid programs in forty-seven states and the District of Columbia (response rate 92%), and data collected by the American Society for Addiction Medicine.

Principal findings: Addiction treatment programs in states with more restrictive Medicaid benefits for addiction treatment had lower odds of accepting Medicaid enrollees (AOR = 0.65; CI = 0.43, 0.97). The predicted probability of Medicaid acceptance was 35.4% in highly restrictive states, 48.3% in moderately restrictive states, and 61.2% in the least restrictive states.

Conclusions: Addiction treatment programs are more likely to accept Medicaid in states with less restrictive benefits for addiction treatment. Program ownership and technological infrastructure also play an important role in increasing Medicaid acceptance.

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1. Introduction

Few Medicaid enrollees in need of addiction treatment ever receive it. Although they are approximately 50% more likely to have an addiction than the general population (Busch, Meara, Huskamp, & Barry, 2013; SAMHSA, 2010), fewer than one in three Medicaid enrollees with a substance use disorder reported any lifetime treatment for

their condition (Busch et al., 2013). Medicaid enrollees face the same barriers that limit treatment access for all persons with addictive disorders: difficulty locating addiction treatment programs (McAuliffe & Dunn, 2004; Perron, Gillespie, Alexander-Eitzman, & Delva, 2010), long wait times to enter treatment (Andrews, Shin, Marsh, & Cao, 2012; Carr et al., 2008; Hoffman, Ford, Tillotson, Choi, & McCarty, 2011), and challenges in getting to and from treatment (D'Aunno, 2006; Friedmann, D'Aunno, Jin, & Alexander, 2000; Friedmann, Lemon, Durkin, & D'Aunno, 2003). But Medicaid enrollees also face another major challenge: At present, only about half of all addiction treatment programs in the United States report they accept Medicaid enrollees, and approximately 40% of U.S. counties lack a single outpatient addiction treatment program that accepts any Medicaid enrollees (Cummings, Wen, Ko, & Druss, 2014).

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Moreover, Medicaid acceptance varies significantly across the states. For example, in California, home to the nation's largest Medicaid program and 14% of all Medicaid enrollees, fewer than 30% of addiction treatment programs accept Medicaid (SAMHSA, 2014). In contrast, approximately 85% of addiction treatment providers in Connecticut accept Medicaid (SAMHSA, 2014). Programs located in the South are among the least likely in the nation to accept Medicaid enrollees (Cummings et al., 2014). This variability derives from several factors. For-profit providers, which are over-represented in the Southern region of the country, are less likely to accept Medicaid enrollees than public and non-profit providers of addiction treatment (Andrews, 2014; Terry-McElrath, Chriqui, & McBride, 2011). Local socio-demographic characteristics are also important. For example, on average, Medicaid acceptance increases with the percentage of low-income individuals in a county or state, and decreases with the percentage of African-American residents (Andrews, 2014; Terry-McElrath et al., 2011).

Some addiction treatment programs may face additional barriers to accepting Medicaid enrollees. Historically, addiction treatment programs have operated outside of the mainstream health care system, functioning with institutional values, practices, and funding streams separate from those of general health care (Andrews et al., 2015). Some addiction treatment programs may have the desire to accept Medicaid enrollees, but are unable to do so because they lack the technological infrastructure required to bill services and report on quality and performance measures as required by Medicaid (Andrews et al., 2015; Buck, 2011; McLellan & Meyers, 2004). Moreover, many addiction treatment programs do not employ staff who possess credentials and/or licensure required to serve as Medicaid-billable providers (Andrews et al., 2015). High front-end costs required for investment in new technology and professional staff may present formidable barriers for providers looking to gain entry into the Medicaid "market."

1.1. Medicaid benefits for addiction treatment

As the major public health insurance program for low-income citizens in the U.S., Medicaid has become an increasingly important payer of addiction treatment over the past several decades. The number of states providing benefits for addiction treatment expanded dramatically from just a handful of states in the 1980s to nearly every state in the country on the eve of the enactment of the Affordable Care Act (ACA) in 2010 (Andrews, 2014; Buck, 2011; SAMHSA, 2005). From 1986 to 2005, Medicaid funding for addiction treatment more than doubled, and increased its share of total addiction treatment expenditures from 9% to 21% (Mark et al., 2007). In 2014, 19 states expanded Medicaid eligibility, allowed under the ACA. By the end of 2016, 32 states had adopted the Medicaid expansion. As a result, Medicaid spending on addiction treatment is expected to more than double in the years ahead, from \$5.2 billion in 2009 to \$11.9 billion by 2020, and the share of addiction treatment expenditures paid for by Medicaid is also expected to increase over the same period, reaching 28% by 2020 (Mark, Levit, Yee, & Chow, 2014).

While the Affordable Care Act requires that all state Medicaid programs provide at least some basic benefits for addiction treatment for newly-eligible enrollees through the Essential Health Benefits requirement, it does not define which specific services must be included, permitting wide variation in the benefits covered across states. In the absence of an established federal standard for addiction treatment benefits, the American Society of Addiction Medicine's (ASAM) clinical guidelines for addiction treatment services represent the scientific and clinical consensus regarding the appropriate course of care, and are the most widely-used and evaluated set of guidelines for addiction treatment (ASAM, 2016). However, only 13 states provided benefits that meet ASAM recommendations, and 24 states lacked benefits in one or more of the four levels of care considered essential to the effective treatment of addiction (Grogan et al., 2016). States most commonly

excluded treatment requiring higher levels of care, such as intensive outpatient, residential, and medically managed inpatient services.

1.2. Medicaid benefit design and treatment program acceptance of Medicaid

Despite Medicaid's varied role in financing addiction treatment across states, we know relatively little about the influence of its benefit design on acceptance of Medicaid by treatment programs. Prior research suggests a positive relationship between state Medicaid benefits and willingness of addiction treatment programs to treat Medicaid enrollees (Andrews, 2014; Terry-McElrath et al., 2011). Terry-McElrath et al. (2011) found that programs receiving public funding were more likely to accept Medicaid in states in which Medicaid provided any kind of basic benefit for addiction treatment. Andrews (2014) found that the extent of benefits matters, as well. Medicaid acceptance among addiction treatment programs was positively associated with the number of treatment services covered.

Use of utilization controls—including preauthorization, concurrent review, and limits on the frequency and intensity of service use—have been inversely related to Medicaid acceptance (Backus et al., 2001; Berman, Dolins, & Tang, 2002; Cunningham & May, 2006; Mitchell, 1991). For example, medical care providers are less likely to accept Medicaid enrollees in managed care plans, which commonly employ utilization controls, than they are to accept enrollees in fee-for-service plans (Backus et al., 2001; Barbee, 2016). In addition to the potential of these controls to reduce the overall volume of services received by Medicaid enrollees, providers also cite administrative burden related to some utilization controls as a disincentive to participate (Terry-McElrath et al., 2011). Smaller medical care providers with smaller budgets and fewer patients may be especially ill-equipped to handle the financial and administrative burdens associated with more restrictive state Medicaid programs (Andrews et al., 2015).

The present study assesses whether the restrictiveness of Medicaid benefits—as measured by the comprehensiveness of services covered and use of utilization controls—is linked to addiction treatment providers' choices regarding Medicaid acceptance. Understanding how Medicaid benefits design for addiction treatment may be linked to Medicaid acceptance is critical, as states continue to possess broad discretion in structuring Medicaid benefits for addiction treatment. Moreover, although the future of the ACA is uncertain under the Trump Administration, it is important to consider the potential effect that dismantling the ACA could have on SUD benefits within state Medicaid programs. For example, repeal could result in the removal of the Essential Health Benefits requirement that states provide benefits for addiction treatment to enrollees newly-eligible under the Medicaid expansion. Repeal could also remove behavioral health parity requirements imposed on Medicaid managed care programs through extension of the MHPAEA. If these requirements related to addiction treatment coverage and parity are repealed, it is possible that some states could elect to increase coverage restrictions and utilization controls. Deepening knowledge of the relationship between benefits design and providers' willingness to serve Medicaid enrollees is a first step in understanding the potential impact of such policy changes on access to addiction treatment for Medicaid enrollees in the United States.

2. Methods

This study draws on data and methods from the sixth wave of the National Drug Abuse Treatment System Survey (NDATSS). The study includes data from two surveys administered during this wave of data collection: first, a nationally-representative, longitudinal study of addiction treatment programs in the United States; and second, a survey of all 50 state Medicaid programs including the District of Columbia. To ensure that the sample of addiction treatment programs is nationally representative at each wave of data collection, we used a split panel design with

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