
Iowa Legislative Fiscal Bureau

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State Capitol
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October 13, 1995

Substance Abuse Managed Care Contract Status Update

ISSUE

The 1995 General Assembly passed HF 530 (Health and Human Rights Appropriations Act), requiring the Department of Public Health and the Department of Human Services (DHS) to collaborate with other State agencies, consider the recommendations of the Substance Abuse Interim Task Force, and implement an integrated Substance Abuse Managed Care System effective July 1, 1995. A contract to provide managed care for substance abuse treatment was implemented September 1, 1995. The Departments' goal is to provide quality services with continuity of care at an affordable cost without limiting access to care or increasing treatment delays. Managed care experiences in other health care areas suggest a need for contractual safeguards to achieve required treatment quality and quantity.

AFFECTED AGENCIES

Department of Public Health
Department of Human Services (DHS)
Department of Public Safety
Governor's Alliance on Substance Abuse

CODE AUTHORITY

House File 2376, 1994 Health and Human Rights Appropriations Act
House File 530, 1995 Health and Human Rights Appropriations Act
Senate File 462, 1995 Department of Human Services Appropriations Act
Chapter 125, Code of Iowa

BACKGROUND

History - The Governor's budget for FY 1996 recommended and the Legislature enacted a joint statewide managed care plan to provide substance abuse treatment to be a collaborative effort of the Department of Public Health and the DHS. The Governor's stated purpose for the recommendation was to more effectively use substance abuse funds appropriated to several State agencies. The Departments have jointly contracted for statewide managed substance abuse treatment services under the Iowa Managed Substance Abuse Care Plan, effective September 1, 1995.

What is Managed Care? - There is no established legal definition of managed care. The definition and responsibilities of involved entities must be contractually negotiated. The objective of a managed care system is to control costs and maintain quality. A managed care contract generally specifies a fee per covered client or a fee per specified population rather than a fee for service, placing the burden of cost control and profit return on the provider. The money remaining after provision of services becomes the provider's profit unless otherwise specified in the contract. The profit incentive may provide a managed care system with a reason to deny treatment. However, unattended medical problems tend to become worse and more costly to correct, placing a balancing economic incentive on early problem resolution.

For purposes of clarification, a general definition of managed care is provided by "What Legislators Need to Know About Managed Care", National Conference of State Legislatures, April 1994:

A system which integrates financing and delivery of services to covered individuals by arrangements with selected providers to furnish a comprehensive set of services, explicit standards for selection of providers, ongoing quality assurance programs and utilization review, and significant financial penalties for going outside the plan. Managed care systems generally combine the roles of insurance companies (paying for care) and health care providers (overseeing and delivering care). Existing systems of managed care include:

- Health Maintenance Organizations (HMOs).
- Preferred Provider Organizations (PPOs).
- Exclusive Provider Organizations (EPOs).
- Point-of-Service (POS) Plans.

Report of the Substance Abuse Interim Committee and Task Force Recommendations-1994

Interim - The Iowa Department of Public Health created a Task Force consisting of representatives from funded and nonfunded prevention and treatment programs to study service areas and the fiscal implications. The Commission on Substance Abuse was required by HF 2376 (1994 Health and Human Rights Appropriations Act), to coordinate delivery of substance abuse services for treatment to uninsured and court ordered clients by July 1, 1997.

- **Costs of Substance Abuse:** The Department's *Report to the Interim Legislative Committee* estimated the annual cost of substance abuse prorated to Iowa as \$2.6 billion or an average of \$931 annually per Iowan. The recommendations of the Task Force included statistics from the Center on Addiction and Substance Abuse at Columbia University Study showing that "at least one of every five dollars Medicaid spends on hospital care, and one in every five Medicaid hospital days are attributable to substance abuse." Iowa spent \$259.3 million (all sources) on Medicaid hospital costs in FY 1995. Based on the Columbia Study, using a Medicaid federal match rate of 62.80%, the estimated FY 1995 cost to the State General Fund for Substance Abuse related Medicaid hospital care was \$19.3 million. The hospital costs are only a portion of societal costs including drug-related crimes, lost earnings and associated loss of tax revenue, and dependent care costs of unemployed substance abusers and their children.
- **Managed Care Requirements:** The Task Force defined the continuum of care required for a successful system to include:
 1. Prevention
 2. Detoxification
 3. Intake/Screening
 4. Inpatient
 5. Residential
 6. Halfway House
 7. Outpatient
 8. Continued Care
 9. Relapse Prevention

Experiences of Managed Care Initiatives - Examples of problems experienced in implementation of managed care include:

- United Health Care Corporation in Rhode Island - fined a top executive \$100,000 for denial of necessary mental health care to subscribers.
- United Health Care Corporation in Pennsylvania - 66.7% of emergency room claims by members in Pennsylvania were denied payment according to a Pennsylvania Health Department report due to a stringent definition of emergency care.
- Medicaid Managed Care in Ohio - between 39.0-45.0% of women in Medicaid HMOs who gave birth in 1993 had no prenatal care and Medicaid recipients are using emergency rooms for health care needs 300.0% more frequently than before the Program.
- Medco Mental Health Access Plan in Iowa - claims of delayed payment to mental health care providers, possible denials of admission to individuals in need of care, complaints of inconsistency of reviewers, and lengthy resolutions to repealed denials are currently under discussion concerning the Plan that was implemented March 1, 1995.

Experiences of managed care initiatives in traditional health care and mental health care applications have resulted in the administrators of the Iowa Substance Abuse Managed Care Plan having several concerns:

- The financial incentive to underserve clients may be stronger than the incentive to render effective treatment of a minimally sufficient quality, therefore quality measures must be defined and monitored.
- Successful managed care depends on management of care and not primarily management of payment.
- Individualized assessment, treatment and follow-up care must be contractually defined to insure inclusion in the process.

Iowa is the first state to define and implement managed care for both Medicaid and non Medicaid populations in the complex area of substance abuse. The Report of the Substance Abuse Interim Committee and Task Force Recommendations-1994 Interim notes that lessons of managed care in the mental health and traditional health care fields may not be completely applicable to substance abuse health services. Private sector treatment may also be incomparable to public sector treatment given the economic, motivational, and social differences in the populations served by the two systems. A total of 65.0% of the client population currently supported by Public Health substance abuse funding has been referred from the criminal justice system. The correctional client is typically unmotivated, reluctant to participate, and often drops out of the system. The unmotivated client must be served differently than the typical self-motivated private sector client. Training of service providers to accomplish individualized treatment is suggested.

CURRENT SITUATION

Need for Managed Care Approach - The Substance Abuse Interim Task Force identified a need for continuity of care and change in the organizational structure of current substance abuse treatment options. Steps vital to successful treatment, such as detoxification and follow-up continued care, were not provided to both Medicaid and non-Medicaid populations.

Status of Substance Abuse Managed Care Contract - The Plan was effective September 1, 1995. The Plan is administered by the National Council on Alcoholism which contracts with the DHS and the Department of Public Health. The National Council on Alcoholism has subcontracted with Medco Behavioral Care of Iowa to provide key managed care functions. Medco has contracted with the DHS to provide services under the Mental Health Access Plan since March 1,

1995. The continuity between the two plans will directly affect many clients dual-diagnosed with mental health and substance abuse problems. Specific safeguards written into the contract include:

- **Provider Network** - The provision of substance abuse services by a comprehensive network of providers, including all programs previously licensed under Chapter 125, Code of Iowa, and all programs exempted from licensure. The National Council on Alcoholism assures the Departments that special attention will be paid to:
 - ⇒ Substance abusers within the criminal justice system (adult and juveniles).
 - ⇒ Outreach and appropriate treatment to racial and ethnic minorities.
 - ⇒ Particular needs of pregnant women and women with children.
 - ⇒ Intravenous drug users.
 - ⇒ Clients infected with the human immunodeficiency virus (HIV/AIDS).
 - ⇒ Special population groups.
- **Covered Population** - An estimated 220,000 Iowa Medicaid and non-Medicaid clients will be included in the Plan. Non-Medicaid eligibility includes a sliding-scale fee basis for individuals with incomes at or below 400.0% of the Federal poverty level. An estimated 2,500 Medicaid clients seeking treatment will be referred to the Plan, including:
 - ⇒ Those eligible for the Family Investment Program and related categories.
 - ⇒ Those eligible through Supplemental Security Income and related categories under the age of 65.
 - ⇒ Medically needy clients with no spend down.
 - ⇒ Individuals enrolled in Medicaid HMOs.
- **Reporting and Review Process** - The Department of Public Health's Division of Substance Abuse and Health Promotion has developed a Substance Abuse Reporting System (SARS) form to record admission, services, discharge planning services, and follow-up provided to all clients by the Plan. The forms will be reviewed to track services provided and client demographics. A System Manual has been distributed to providers to standardize the process. Current licensure requirements provide additional audit opportunity.
- **Additional Specifications** - The contract specifies the level of care and placement criteria, defines the continuum of care and requires the provision of the continuum to a specified population.

BUDGET IMPACT

First year funding budgeted for provision of substance abuse treatment through managed care for FY 1996 is \$6.7 million from all sources from the DHS and \$12.8 million from all sources from the Department of Public Health. Since federal funds contribute over 50.0% of the total, future funding of the Plan may become an issue dependent upon the national budget climate. The loss of federal funds would leave a potential minimum deficit of \$9.8 million.

The Health Care Finance Authority (HCFA) has granted a waiver for Medicaid funding to allow the Plan to use a nontraditional payment form. The federal Medicaid match available through the Plan,

combined with anticipated savings under a managed care contractor, is estimated to leverage an additional \$1.0 million annually. The estimated savings was included in the FY 1995 budget for the DHS.

ALTERNATIVES

The managed care approach is new to substance abuse treatment services. As with any new system, careful monitoring and review of services provided may shape future alternatives. Ongoing program evaluation may include:

- Data from the Department of Public Health and the DHS concerning relapse rates may help determine the effectiveness of treatment provided.
- Data from the Department of Public Health and the DHS concerning the average hours/days in treatment phases over time may help to evaluate changes in the quantity of services provided by the System.
- The Plan currently incorporates the use of client population surveys for satisfaction indicators. Compilation of the data may result in policy suggestions.

Assured funding for System success may become an issue if anticipated federal funding is not forthcoming. Alternatives would include additional State General Funds to compensate for lost federal funds, investigation into the diversion of other federal funds (such as corrections federal grants to serve the corrections client or education federal grants to serve juveniles), increased client contributions, or funds from the private sector or decreased services.

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