Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Follow-up to Detoxification Services For Medicaid Beneficiaries

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Inspector General

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E X E C U T I V E S U M M A R Y

PURPOSE

To assess whether Medicaid and other State programs provide linkages for patient services between substance abuse detoxification and follow-up treatment programs.

BACKGROUND

Detoxification and substance abuse treatment are funded federally by the Health Care Financing Administration (HCFA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Annually, the SAMHSA spends over $1.5 billion on substance abuse prevention and treatment services. In addition, HCFA covers substance abuse detoxification and treatment in most State Medicaid programs.

Substance abuse detoxification is the process through which a person who is physically dependent on alcohol, illegal drugs, prescription medications, or a combination of these is withdrawn from the drugs of dependence. Detoxification, the vital first step of the rehabilitative process, has moved in some States from inpatient hospitalization settings to outpatient programs. However, many treatment professionals expressed concerns that individuals enrolled in detoxification programs may not receive follow-up substance abuse treatment.

We obtained information on detoxification and treatment programs through a mail survey to each Medicaid State agency. Analysis was conducted and follow-up contacts were made to clarify responses and to obtain additional information based on survey data.

FINDINGS

Fifteen States Report Having Formal Processes Providing Transition from Substance Abuse Detoxification to Treatment; Thirty-two have Informal Processes

Fifteen States said they had written language addressing continuum of care in their Medicaid State plan, Medicaid managed care contract, or the State's quality assurance plan. Thirty-two of 35 remaining States report having informal processes to provide a transition for Medicaid beneficiaries to move from substance abuse detoxification to substance abuse treatment programs. Also, States without Medicaid-funded detoxification programs coordinate arrangements with other treatment entities outside the Medicaid program to facilitate a continuum of care.

States Tailor Substance Abuse Programs to Complement Their Own Service Delivery Systems

Substance abuse programs have evolved over the years into very State-specific oriented activities, with State directors of alcohol and drug abuse services choosing programs that they believe function optimally in their own particular State. States utilize a variety of treatment settings and types of staff in their Medicaid substance abuse programs to ensure that integrated systems of care exist for Medicaid beneficiaries in their State.

States Have Limited Data on Detoxification and Treatment Activity and Outcomes

We found that States vary in their capturing of quality and performance data. Over three-fourth's of the States could not provide data on the average time elapsed for Medicaid beneficiaries from discharge from a detoxification program to onset of treatment. As a result, States which do not capture information on continuum of care linkages have little basis to assess whether beneficiaries are receiving timely treatment services.

One-Third of States Conduct Performance Monitoring of Substance Abuse Programs

Sixteen States report having performance oversight efforts which include case record reviews and site visits. Also, some managed care programs include performance requirements as part of their quality assurance plans.

States Seldom Use Outpatient Settings for Detoxification Services

Only 30 percent of States employ an outpatient component for detoxification services. Five States utilize a Medicaid outpatient detoxification component on a primary basis while another 10 States use outpatient detoxification services on an alternative or less-extensive basis. In contrast, 40 States cover Medicaid outpatient treatment programs, and 33 States have inpatient treatment programs available. Half of the States cover both Medicaid inpatient and outpatient treatment programs.

RECOMMENDATION

SAMHSA and HCFA Should Work With States to Develop Appropriate Performance Measures

The SAMHSA should work with State agencies to develop performance indicators that measure linkages from substance abuse detoxification to treatment. We believe this will help ensure that linkages and coordination are a priority for improvement, and that Medicaid beneficiaries are not merely engaging in detoxification without treatment.

The SAMHSA and HCFA should collaborate and encourage State Medicaid agencies to include language regarding continuity of substance abuse services in their managed care contracts.

The SAMHSA and HCFA also should work with States to facilitate enhanced data collection on the continuum of care. Such treatment and outcome data are essential to capture information on what is occurring in the treatment field. This will enable reasonable conclusions to be drawn to enhance the quality of existing programs.

AGENCY COMMENTS

Both HCFA and SAMHSA concurred with our recommendation but emphasized they cannot ensure that States meet goals and provide treatment and outcome data. However, they expressed

a willingness to work with States in these efforts and toward greater continuity for treatment care following detoxification services.

The SAMHSA also suggested exploring mechanisms for shifting to greater use of outpatient detoxification services which have been shown to be as safe and effective as, and more cost efficient than, inpatient detoxification. We agree this issue is important and warrants further examination. However, while our report contains a finding on the uneven use of this service among the States, our study was not sufficient to draw conclusions on outpatient detoxification safety and efficiency.

TABLE OF CONTENTS

I N T R O D U C T I O N

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Substance abuse detoxification is the process through which a person who is physically dependent on alcohol, illegal drugs, prescription medications, or a combination of these is withdrawn from the drugs of dependence. Detoxification, the vital first step of the rehabilitative process, is basically a mere stabilization of physiological functions. The treatment process or treatment phase of substance abuse services is perhaps the most critical determinant of a Medicaid beneficiary's success. Substance abuse and mental health professionals believe that a treatment program should be undertaken subsequent to detoxification to assist the beneficiary in making the transition from addiction to recovery, to prevent relapses, and promote healthy alternative living skills for Medicaid beneficiaries to more effectively deal with their addictions.

States utilize a combination of Medicaid fee for service and managed care programs in administering their inpatient and outpatient detoxification and treatment programs. Forty States still utilize a Medicaid fee for service program to reimburse for substance abuse detoxification services. Ten States have a Section 1915b behavioral health waiver to specifically treat the substance abuse population. Such waivers strictly deal with only a small subset of a State's Medicaid population. Also, 28 States currently have a Medicaid managed care program in place for substance abuse detoxification services (see Appendix A).

A review of the "SAMHSA Managed Care Tracking System: State Profiles on Public Sector Managed Behavioral Healthcare and Other Reforms" (July 1997) and various State Alcohol and Drug Rehabilitative Services manuals suggests that treatment services are a logical, integrated component of a continuum of substance abuse services offered to Medicaid beneficiaries in some States. However, in other States, detoxification services and treatment services are distinctly separate programs. Within these States, Medicaid beneficiaries may not receive substance abuse treatment or may not receive such treatment services in a timely manner following discharge from a detoxification program.

Treatment journals such as Psychiatric Services[1] and the American Journal of Public Health[2] emphasize the critical importance of substance abusers receiving immediate, follow-up treatment services. If Medicaid beneficiaries are not linked into a treatment program right away, the beneficiary may abandon the recovery effort. For example, Medicaid beneficiaries often present

other problems in addition to their dependence on drugs or alcohol. The Medicaid substance abuser may be having difficulties in the areas of employment, and medical and psychiatric health as well. The presence of these factors often complicates the provision of substance abuse treatment, and other problems, if left unattended, can provoke a relapse to substance use or abuse even among well-motivated, abstinent individuals. Therefore, the provision of treatment services is seen as vitally important both for the purpose of retaining beneficiaries in a treatment program and for reducing the risk of a relapse.

Coordinating continuum of care poses a challenge in the delivery of adequate and appropriate substance abuse services to Medicaid beneficiaries. In addition, States are increasingly relying on managed care plans to provide behavioral health services to Medicaid populations which include vulnerable beneficiaries who may have special health problems.[3] Some States are also attempting to "carve-out" certain populations or services from mainstream managed care plans moving them toward other systems of care offering specialized services for individuals with particular conditions.

Provision of Medicaid services by managed care organizations is relatively new in the delivery of health care, especially in the field of substance abuse. To ensure accountability within Medicaid managed care contracts and State plans, some States have adopted specific provisions to describe substance abuse activities and services which are guaranteed to be provided as a condition of the contract or plan. However, there are no requirements mandated by the Medicaid program on continuum of care or linkage from detoxification to treatment.

METHODOLOGY

We mailed surveys to each Medicaid State agency to determine whether State Medicaid programs provide for substance abuse treatment following detoxification programs. The surveys were completed by State agency-designated respondents from various disciplines. Many States coordinated a comprehensive response by assembling appropriate individuals from the State Medicaid health care policy division, State department or bureau of alcohol and drug treatment services, and a managed care division representative. Follow-up contacts were made with both Medicaid State agencies and alcohol and drug treatment professionals for the States to clarify responses and to obtain additional information from the 35 States that initially indicated that they had no formal continuum of care from detoxification to treatment within their State Medicaid coverage policies.

We collected information on the following topics: types of detoxification and treatment programs reimbursed by Medicaid; settings and staff involved in substance abuse programs; managed care and Medicaid fee for service; linkage of services from detoxification to treatment; traditional hospital-based inpatient programs versus outpatient programs; waivers and "carve-out" programs; recidivism; admission and treatment data; program expenditures; and future programmatic concerns.

We asked States whether their substance abuse detoxification programs are provided by a Medicaid managed care contract, and if so, whether the contract specifies that treatment follows detoxification. We did not request nor review specific contracts. We asked States to list and define performance indicators that apply to their States' detoxification and treatment programs. We requested States to identify managed care providers of detoxification and treatment services, recidivism data, and Medicaid expenses for various drug categories. In order to determine types of detoxification services reimbursed by the State Medicaid agencies, we had States select placement settings based upon the American Society of Addiction Medicine (ASAM) criteria. We obtained information based on the five generally accepted categories of patient placement criteria promoted by ASAM.

We analyzed information from a compiled survey database to determine whether State Medicaid programs, especially those that contract with managed care organizations, have specific provisions for detoxification and for follow-up substance abuse treatment. We also determined if they are incorporating substance abuse detoxification and treatment issues into writing their managed care contracts. Since we did not review medical treatment records, we did not draw any conclusions regarding quality of care of Medicaid recipients in the States' substance abuse programs.

We also conducted onsite visits in two States that offer detoxification services on an outpatient basis to obtain in-depth material on their detoxification programs, treatment, and coverage policies and processes. We met with directors of family services, directors of mental health and substance abuse departments, Medicaid policy staff, Medicaid program chiefs, managed care representatives, and directors of State bureaus of alcohol and drug treatment services.

We conducted our review in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

F I N D I N G S

Fifteen States Report Having Formal Processes Providing Transition from Substance Abuse Detoxification to Treatment; Thirty-two have Informal Processes

Fifteen States said they had written language addressing continuum of care in their Medicaid State plan, Medicaid managed care contract, State's quality assurance plan or within other formal agreements among State entities (See Appendix B). Ten of the 15 States employ Medicaid managed care as part of their substance abuse detoxification programs.

Since only 15 States initially reported formal linkage or transition policies to assure continuation of services from detoxification to treatment, we re-contacted the remaining 35 States to determine the level of their coordination efforts. While only 15 States had formal processes to provide a transition for Medicaid beneficiaries in moving from substance abuse detoxification programs to treatment services, 32 of the 35 remaining States report having informal processes at various levels in local communities to facilitate the transition from detoxification programs to treatment programs.

Detoxification programs often refer Medicaid beneficiaries to available treatment services programs in the State. States report that the referral to treatment programs is primarily made before discharge from the detoxification facility. States also reported that such linkages to treatment are immediate if there are treatment center slots available at the time. Moreover, in some States, the treatment is part of a comprehensive plan of care (including both detoxification and treatment), and the Medicaid beneficiary is immediately transferred to the appropriate treatment program.

Treatment services can be provided at an inpatient treatment center, a community mental health center, a psychiatric center, residential center, or a community based health organization. Depending upon the assessment of the Medicaid beneficiary, it may be determined that the person should be seen by a psychologist or licensed clinical social worker. Therefore, a beneficiary might see a mental health professional (e.g., a psychologist) in addition to treatment at an outpatient clinic.

Most States have Medicaid covered detoxification and treatment programs (See Appendix C). However, in States such as Minnesota and Kansas where Medicaid does not cover substance abuse detoxification services, they use a variety of options. For example, Minnesota counties are required to arrange for the provision of detoxification services for anyone who requires them. Local funds pay for detoxification services with State funds paying for some transportation costs. In Kansas, community-based detoxification services are provided, but are not paid by Medicaid. Other funding mechanisms which States utilize for substance abuse services include SAMHSA treatment grants, community development block grants, and State general assistance and local monies to treat the Medicaid population.

Also, States without Medicaid-funded detoxification programs coordinate arrangements with other entities outside the Medicaid program to facilitate a continuum of care from detoxification programs to treatment programs. This is not an obstacle for Minnesota or Kansas. In both these

States, planning for the treatment begins well before the beneficiary completes detoxification.

Twenty of the 35 States re-contacted mentioned community-based, local, or State-sponsored treatment programs available in locations throughout their State. Two-third's of these States reported "timely" or immediate linkage to treatment, with no interruption of services. They emphasized that the beneficiary must be compliant, noting that there is nothing they can do to change a beneficiary's will or decision to abstain from entering treatment. However, 7 of the 32 States having informal detoxification to treatment linkage processes expressed concerns about fragmented services in their State, or that their State has had difficulty in the past in coordinating a full range of services (from detoxification to treatment).

States Tailor Substance Abuse Programs to Complement Their Own Service Delivery Systems

We found that detoxification programs within the States vary widely. Each have evolved over the years into very State-specific oriented activities. These programs also differ widely in composition, with some programmatic changes occurring over the last few years to the States' current configurations of inpatient and outpatient programs. There has been a general movement towards outpatient settings for substance abuse programs, especially intensive outpatient treatment programs. In addition, some States are moving toward outpatient detoxification services, sometimes as part of a managed care initiative. However, inpatient detoxification services are more common.

State bureaus of alcohol and drug abuse services oversee the coordination of substance abuse detoxification and treatment programs within and outside of State Medicaid programs. Each State has developed functional working relationships among various substance abuse treatment providers and programs, despite application of different funding sources for programs. State directors of alcohol and drug abuse services choose programs that they believe function optimally in their own particular State. Substance abuse treatment and addiction professionals use resources as efficiently as possible, given the constraints of various funding streams and the often scattered programs that exist throughout many States.

Also, State bureaus provide technical assistance to local programs and oversee the delivery of diverse treatment programs at urban and rural locations. Each provide interpretation of level of care distinctions, assist substance abuse detoxification and treatment program providers in determining approved reimbursement rates for the various levels of care, and may publish administrative informational bulletins to clarify State policies and provisions.

State bureaus may assist treatment programs in determining appropriate level of care settings for Medicaid beneficiaries who also have a mental illness. Each help to ensure that integrated systems of care exist for all Medicaid recipients in their State, regardless of a beneficiary's particular substance of abuse or co-occurring health or mental health problems. Bureaus may also become involved in transportation and access to services issues, and certification or approval of certain treatment programs reviewed during their on-site visits.

As noted in Table 1 below, States utilize a variety of treatment settings for their State Medicaid detoxification programs. More than half of the States indicated that both acute care hospitals and inpatient psychiatric hospitals are the most common settings.

Table 1

TYPES OF TREATMENT SETTINGS

No. Of Medicaid Programs using each setting	Type of Setting of Medicaid Detox Programs
28	Acute care general hospital
27	Psychiatric hospital inpatient unit
15	Hospital outpatient department
15	Hospital emergency room
10	Addiction treatment facility
9	Freestanding detoxification center
8	Day hospital program
6	Freestanding urgent care
6	Social detoxification program
3	Clinic
1	Home health care agency
1	Regional treatment center

States vary in their usage of different types of placement criteria in determining which categories of Medicaid beneficiaries should receive particular kinds of detoxification services. The American Society of Addiction Medicine (ASAM) has established levels of settings for adult patients in need of detoxification. Thirty-six States said that their substance abuse detoxification setting most closely resembles the ASAM category of "medically managed intensive inpatient detoxification" (See Appendix D). Many of these States utilize other categories of placement settings or a mixture of inpatient and outpatient detoxification settings. Ten States use clinically managed residential detoxification. (See Appendix D, pages D-4 and D-5, for an explanation of the five generally accepted categories of patient placement criteria published by ASAM.)

States identified many types of staff who participate in their State's Medicaid detoxification programs. While a physician is utilized in 84 percent of the States, Table 2 below identifies various medical professionals and social workers who function as participants in the detoxification process.

Table 2

PARTICIPANTS IN THE DETOXIFICATION PROCESS

Treatment Professionals	**# of States**
Physician, not including psychiatry	42 States
Registered nurse	37 States
Psychiatrist	36 States
Licensed practical nurse (LPN)	30 States
Psychologist	27 States
Certified alcohol/drug counselor	23 States
Licensed clinical social worker	22 States
Degreed social worker (e.g., MSW)	20 States
Physician assistant	18 States
Non-licensed counselor	11 States
All hospital staff	5 States
Acupuncturist	3 States

Another critical distinction among States is the numerous care settings that may exist within their Medicaid detoxification programs. States reported that they commonly use the following categories: inpatient hospitalization - 42 States; outpatient hospitalization - 13 States; clinical services - 11 States; and rehabilitation - 9 States.

Also, some States use multiple categories, and one State indicated it uses all these types of categories for Medicaid reimbursement. This variety among States may hinder the capturing of consistently reliable data on detoxification programs.

States Have Limited Data on Detoxification and Treatment Activity and Outcomes

We found that States vary in their capturing of quality and performance data, whether reimbursed by Medicaid fee for service or part of a managed care program. Over three-fourth's of States could not provide data on the average time elapsed for Medicaid beneficiaries from detoxification discharge to onset of treatment. Among 11 States that responded to a question on waiting times for Medicaid covered treatment, elapsed waiting time from detoxification to enrollment into a treatment program averaged 4.9 days, ranging from 1 to 30 days.

Of the 28 States with managed care programs, 23 States responded they did not know whether managed care substance abuse detoxification services are less costly than providing these services through Medicaid fee for service. Only 5 of the 28 States said that Medicaid managed care for substance abuse detoxification is less costly than Medicaid fee for service.

Some respondents said that detoxification programs are expected to refer Medicaid beneficiaries to treatment, but no one oversees or collects data on this function. We also heard that detoxification programs are indeed referring Medicaid beneficiaries to available treatment programs, but it is up to the beneficiary to oversee their individual recovery. Only 16 States reported that they have case management to monitor a beneficiary's progress. Twelve of those 16 States had managed care programs (See Appendix A).

Only 15 States were able to provide information on Medicaid expenditures for detoxification for fiscal year 1996. Some States did not have management information systems to break out admission data by drug, and only two States had information on numbers of Medicaid beneficiaries who were admitted for detoxification and subsequently enrolled into a treatment program.

States which do not capture information on continuum of care linkages have little basis to assess whether beneficiaries are receiving timely treatment services, or even if the initial referral was adhered to or heeded. As a result, State departments or bureaus of substance abuse services may be unaware of the overall effectiveness of their substance abuse program services.

Only seven States reported recidivism data. The average recidivism rate was 47 percent covering a range of 23 percent to 93 percent (23%, 27%, 28%, 40%, 50%, 70%, and 93% were the responses from the 7 States) of Medicaid beneficiaries readmitted for detoxification services within one year. This figure from the seven States is consistent with information from the 1997 Drug Abuse Treatment Outcomes Study commissioned by the National Institute of Drug Abuse which found that between 40 to 50 percent of beneficiaries entering drug treatment have prior treatment experience. Five of the seven States reported the following breakout of known recidivism rates by episodic categories:

- 45 percent of beneficiaries were readmitted 1 - 2 times
- 17 percent of beneficiaries were readmitted 3 - 5 times
- 15 percent of beneficiaries were readmitted more than 5 times

One-Third of States Conduct Performance Monitoring of Substance Abuse Programs

Survey responses indicate that 16 States conduct quality assurance performance oversight efforts. These include case record reviews and site visits by the States' departments or bureaus of alcohol and drug abuse programs. Also, some of the managed care programs have their own performance requirements listed in their quality assurance plans. These performance requirements may include engaging beneficiaries in the treatment process after being discharged from inpatient detoxification, reducing recidivism rates of beneficiaries, and increasing the number of Medicaid beneficiaries served.

States which have performance indicators are able to demonstrate results in several areas. Some of these areas include: beneficiaries are abstinent/drug-free at termination of the program; reduction of use of the primary abuse substance; referral to alcohol and drug treatment or continued treatment; employability improvement or academic improvement of beneficiaries; beneficiaries are not being arrested during treatment or not driving under the influence; pregnant women abstinent 30 days before delivery; and beneficiaries are experiencing continued abstinence at regularly-checked intervals (e.g., one month, three months, six months, one year).

States with performance requirements have sobriety maintenance goals to monitor beneficiaries' continued periods of abstinence or reduction of drug use. In addition, two States have specific programs and another two States are implementing programs to follow pregnant and post-partum women through their rehabilitation.

States Seldom Use Outpatient Settings for Detoxification Services

Some States appear to be limited by what they can provide under Medicaid reimbursement provisions. For example, a State Medicaid agency may historically reimburse only for inpatient detoxification. Geographical considerations also influence the delivery of detoxification and treatment services. Two States report having large outlying rural areas where managed care is neither practical nor cost-feasible. In these States, Medicaid fee for service may be used for substance abuse services or in distinct geographic areas only. In addition, a State may only offer Medicaid detoxification to adults under emergency circumstances. Other States use the inpatient detoxification component primarily for acute cases, and some offer inpatient detoxification in exceptional circumstances, such as the Medicaid beneficiary who has an accompanying illness or is pregnant. Nearly all (44 States) offer some form of Medicaid inpatient care for detoxification.

According to analysis of State responses, only five States (Georgia, Maryland, Massachusetts, South Carolina and Vermont) have moved from a primarily hospital-based (i.e., inpatient) detoxification program to State detoxification programs where outpatient detoxification is a standard choice. Another 10 States utilize outpatient detoxification on an alternative or less extensive basis. However, each State continues to offer Medicaid inpatient detoxification services when medical conditions require a medically-managed or medically-monitored inpatient detoxification.

Maryland and Vermont have covered outpatient detoxification services for Medicaid recipients for 15-20 years. Massachusetts moved to managed care programs about six years ago, opening up many different types of detoxification alternatives, including various outpatient programs. Georgia has offered outpatient detoxification services provided by Community Mental Health Centers for the past four years, with their State mental hospitals discontinuing inpatient detoxification treatment in 1994. However, inpatient detoxification is still available in acute care hospitals when conditions warrant. South Carolina began offering outpatient detoxification services in 1997.

Forty States cover Medicaid outpatient substance abuse treatment compared to 33 States that cover Medicaid inpatient treatment. Half of the States cover both inpatient and outpatient treatment programs. In three States, Medicaid does not pay for substance abuse treatment services except through the Early Periodic and Screening Diagnosis and Treatment program for children under the age of 21. Also, a few States provide inpatient treatment only when the Medicaid beneficiary presents a co-occurring psychiatric illness or diagnosis; otherwise, an outpatient setting is appropriate for the remaining Medicaid beneficiaries.

R E C O M M E N D A T I O N

Whether in established programs covered by Medicaid, Federal grants, or State and local funding, States find it very difficult to capture extensive information in the areas of treatment completion, linkage from detoxification to treatment, sobriety maintenance, and recidivism. This is particularly apparent with substance abuse beneficiaries who move to and from programs and are not required to report progress in their recovery or lack of recovery. Therefore, to bridge the gaps in performance information and to enhance cost effective detoxification and treatment, we recommend that:

SAMHSA and HCFA Should Work With States to Develop Appropriate Performance Measures

The SAMHSA should work with State agencies to develop performance indicators that measure linkages from substance abuse detoxification to treatment. We believe this will help ensure that linkages and coordination are a priority for improvement, and that Medicaid beneficiaries are not merely engaging in detoxification without treatment.

The SAMHSA and HCFA should collaborate and encourage State Medicaid agencies to include language regarding continuity of substance abuse services in their managed care contracts.

The SAMHSA and HCFA also should work with States to facilitate enhanced data collection on the continuum of care. Such treatment and outcome data are essential to capture information on what is occurring in the treatment field. This will enable reasonable conclusions to be drawn to enhance the quality of existing programs.

AGENCY COMMENTS

We received comments on the draft report from HCFA and SAMHSA. The full text of their comments is included in Appendix E.

Both HCFA and SAMHSA concurred with our recommendation but emphasized they cannot ensure that States meet goals and provide treatment and outcome data. However, they expressed a willingness to work with States in these efforts and toward greater continuity for treatment care following detoxification services.

The SAMHSA also suggested exploring mechanisms for shifting to greater use of outpatient detoxification services which have been shown to be as safe and effective as, and more cost efficient than, inpatient detoxification. We agree this issue is important and warrants further examination. However, while our report contains a finding on the uneven use of this service among the States, our study was not sufficient to draw conclusions on outpatient detoxification safety and efficiency.

E N D N O T E S

[1]"Outcome of Patients in A Veterans Affairs Ambulatory Detoxification Program," Psychiatric Services, February 1997 (Vol. 48, No. 2), pp. 200 - 203.

[2]"Alcohol and Drug Use, Abuse, and Dependence among Welfare Recipients," American Journal of Public Health, October 1996 (Vol. 86, No. 10), pp. 1450 - 1454.

[3]"Negotiating the New Health Care System: An Analysis of Contracts between State Medicaid Agencies and Managed Care Organizations," Center for Health Policy Research and the Center for Health Care Strategies. © Center for Health Policy Research, George Washington University, February 1997.

APPENDIX A

STATES WITH SUBSTANCE ABUSE MANAGED CARE DETOXIFICATION PROGRAMS HAVE LIMITED DATA ON FEATURES AND SERVICES

STATES WITH SUBSTANCE ABUSE MANAGED CARE DETOXIFICATION PROGRAMS HAVE LIMITED DATA ON FEATURES AND SERVICES

Managed Care States	Use Performance Indicators	Patient Placement Criteria	Case Mgt. Svcs.	Have Follow-up/ Aftercare	Capture Recidivism Data
Arizona	X	X	X	X	
Colorado					
Connecticut					
Delaware			X		
Georgia	X				
Hawaii		X	X		
Illinois	X				
Iowa		X	X	X	X
Maryland	X		X	X	X
Massachusetts	X	X	X		X
Missouri	X				
Nebraska			X		
Nevada		X			
N. Hampshire	X				
New Mexico		X	X		
New York		X	X	X	
No. Dakota			X		
Ohio					
Oklahoma					
Pennsylvania					
R. Island	X				
So. Carolina	X				
So. Dakota					
Tennessee		X	X	X	
Texas		X	X	X	X
Utah					
Vermont	X	X			
Wisconsin	X	X			
TOTALS	**11**	**11**	**12**	**6**	**4**

A P P E N D I X B

LINKAGES AND CONTINUUM OF CARE ARRANGEMENTS OF STATES

LINKAGES AND CONTINUUM OF CARE ARRANGEMENTS OF STATES

Basis for Linkage	**States**
Within the State's Medicaid Plan for services	Missouri*
Expressly written in the Medicaid managed care contract	Maryland* Ohio* Oregon Rhode Island* South Carolina*
Within a quality assurance plan mandated by the managed care contract	Arizona* Illinois* Massachusetts*
Within the State's general quality integrity or quality assurance plan	Alaska Illinois (also within contract's quality plan) Maine South Carolina (also in managed care plan) Wyoming
Utilization management contractor ensures link between hospitals and State substance abuse/mental health authorities	Florida
Linkage of services is assured by the Division of Mental Health, Mental Retardation, and Substance Abuse Standards	Georgia*
The Behavioral Health Organizations are required to provide medically necessary services	Tennessee*

* States with Medicaid Managed Care detoxification programs.

A P P E N D I X C

MEDICAID LEVELS OF CARE COVERING DETOXIFICATION AND TREATMENT PROGRAMS BY STATE

MEDICAID LEVELS OF CARE COVERING DETOXIFICATION AND TREATMENT PROGRAMS BY STATE

STATES	Medicaid I/P Detox	Medicaid O/P Detox	Medicaid I/P Treatment	Medicaid O/P Treatment	Medicaid Managed Care Detox	Linkage of Detox to Treatment within Medicaid	Managed Care Detox Services Less Costly than FFS
ALABAMA	X			X			
ALASKA	X	X	X	X		X	
ARIZONA	X		X		X	X	
ARKANSAS	X		X				
CALIFORNIA		X		X			
COLORADO	X		X	X	X		X
CONNECTICUT	X	X	X	X	X		
DELAWARE	X		X		X		
FLORIDA	X			X		X	
GEORGIA	X	X	X	X	X	X	
HAWAII	X	X	X	X	X		
IDAHO	X		X	X			
ILLINOIS	X		X	X	X	X	
INDIANA	X	X		X			
IOWA	X		X	X	X		X
KANSAS				X			
KENTUCKY							
LOUISIANA	X			X			

STATES	Medicaid I/P Detox	Medicaid O/P Detox	Medicaid I/P Treatment	Medicaid O/P Treatment	Medicaid Managed Care Detox	Linkage of Detox to Treatment within Medicaid	Managed Care Detox Services Less Costly than FFS
MAINE	X	X	X	X		X	
MARYLAND	X	X		X	X	X	
MASSACHUSETTS	X	X	X	X	X	X	X
MICHIGAN	X			X			
MINNESOTA				X			
MISSISSIPPI	X		X				
MISSOURI	X		X	X	X	X	
MONTANA	X			X			
NEBRASKA	X		X	X	X		
NEVADA	X		X		X		
NEW HAMPSHIRE	X		X	X	X		
NEW JERSEY	X	X	X	X			X
NEW MEXICO	X		X		X		
NEW YORK	X		X	X	X		
N. CAROLINA	X			X			
N. DAKOTA	X		X		X		
OHIO	X			X	X	X	X
OKLAHOMA	X		X	X	X		
OREGON				X		X	
PENNSYLVANIA	X		X	X	X		
RHODE ISLAND	X	X	X	X	X	X	
S. CAROLINA	X	X	X	X	X	X	

S. DAKOTA	X		X		X		
STATES	**Medicaid I/P Detox**	**Medicaid O/P Detox**	**Medicaid I/P Treatment**	**Medicaid O/P Treatment**	**Medicaid Managed Care Detox**	**Linkage of Detox to Treatment within Medicaid**	**Managed Care Detox Services Less Costly than FFS**
TENNESSEE	X	X	X	X	X	X	
TEXAS	X	X	X	X	X		
UTAH	X			X	X		
VERMONT	X	X	X	X	X		
VIRGINIA							
WASHINGTON	X		X	X			
W. VIRGINIA	X		X	X			
WISCONSIN	X		X	X	X		
WYOMING	X			X		X	
TOTALS	**44**	**15**	**33**	**40**	**28**	**15**	**5**

A P P E N D I X D

TYPES OF DETOXIFICATION SERVICES REIMBURSED BY STATE MEDICAID PROGRAMS

(using American Society of Addiction Medicine categories)

TYPES OF DETOXIFICATION SERVICES[1] REIMBURSED BY STATE MEDICAID PROGRAMS

STATES	O/P Detox w/o extended onsite monitoring	O/P Detox w/ extended onsite monitoring	Clinically managed Residential Detox	Medically monitored I/P Detox	Medically managed intensive I/P Detox	Other kinds of Medicaid-reimbursed Detox programs
ALABAMA					X	
ALASKA			X	X		
ARIZONA					X	X[2]
ARKANSAS	X				X	X[3]
CALIFORNIA	X					
COLORADO					X	
CONNECTICUT		X	X	X	X	X[4]
DELAWARE	X	X	X	X	X	X[5]
FLORIDA					X	
GEORGIA		X		X	X	
HAWAII	X				X	
IDAHO				X		
ILLINOIS					X	
INDIANA	X			X	X	
IOWA				X	X	
KANSAS						
KENTUCKY						
LOUISIANA					X	
MAINE			X		X	
MARYLAND	X	X			X	
MASSACHUSETTS		X	X	X	X	
MICHIGAN					X	
MINNESOTA						
MISSISSIPPI				X		
MISSOURI				X	X	
MONTANA						X[6]
NEBRASKA					X	
NEVADA					X	
NEW HAMPSHIRE					X	
NEW JERSEY		X			X	
NEW MEXICO			X		X	

STATES	O/P Detox w/o extended onsite monitoring	O/P Detox w/ extended onsite monitoring	Clinically managed Residential Detox	Medically monitored I/P Detox	Medically managed intensive I/P Detox	Other kinds of Medicaid-reimbursed Detox programs
NEW YORK				X	X	
N. CAROLINA					X	X[7]
N. DAKOTA		X			X	
OHIO				X	X	
OKLAHOMA				X		
OREGON					X	
PENNSYLVANIA			X	X	X	
RHODE ISLAND	X		X	X	X	
S. CAROLINA	X	X	X	X	X	
S. DAKOTA				X		
TENNESSEE						X[8]
TEXAS	X			X		
UTAH					X	
VERMONT	X	X	X	X	X	
VIRGINIA						
WASHINGTON					X	
W. VIRGINIA		X			X	
WISCONSIN					X	
WYOMING						
TOTALS	**10**	**10**	**10**	**19**	**36**	**7 others**

[1] American Society of Addiction Medicine categories of services, as identified in pages D-4 and D-5.

[2] Medically necessary inpatient detoxification in an acute care general hospital.

[3] Rehabilitative services for persons with mental illness.

[4] Community clinics.

[5] Delaware has outpatient detox w/o monitoring; outpatient detox w/ monitoring; clinically-managed detox; and medically-monitored detox through managed care only. Medically-managed intensive inpatient detoxification is through both Medicaid fee for service and Medicaid managed care.

[6] Inpatient hospital four-day detoxification.

[7] Outpatient services such as intensive outpatient and day hospital are reimbursed when provided through a community mental health center.

[8] The Medicaid (Tenncare) program does not directly reimburse for any detox service. The behavioral health organizations have the latitude to reimburse for any service they choose.

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ASAM Patient Placement Criteria:
Criteria for Placement of Adult Patients in Need of Detoxification Services

Note: The following information reflects the recommendations of a two-year-long consensus process and field review, convened by the American Society of Addiction Medicine and published as the ASAM *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2).*

This table summarizes the indicators and criteria for placement of adult patients in need of detoxification services at one of five levels of care: **Level I-D** (ambulatory detoxification without extended on-site monitoring), **Level II-D** (ambulatory detoxification with extended on-site monitoring), **Level III.2-D** (clinically managed residential detoxification), **Level III.7-D** (medically monitored inpatient detoxification), and **Level IV-D** (medically managed intensive inpatient detoxification). For more information on this and other patient placement criteria, consult the *ASAM PPC-2* (1996).

CHARACTERISTIC	LEVEL I-D Ambulatory Detoxification without Extended On-Site Monitoring	LEVEL II-D Ambulatory Detoxification with Extended On-Site Monitoring	LEVEL III.2-D Clinically-Managed Residential Detoxification	LEVEL III.7-D Medically-Monitored Inpatient Detoxification	LEVEL IV-D Medically-Managed Intensive Inpatient Detoxification
EXAMPLES	Physician's Office, Home Health Care Agency	Day Hospital Service	Social Setting Detoxification Program	Freestanding Detoxification Center	Psychiatric Hospital Inpatient Unit
SETTING	A general health care facility, such as a physician's office, a free-standing urgent care or hospital emergency service, an addiction or mental health treatment facility, a hospital outpatient department, or the patient's home, as supervised by a licensed home health care agency.	A general health care facility, such as a physician's office, a free-standing urgent care or hospital emergency service; an addiction or mental health treatment facility; or a hospital outpatient department.	An appropriately licensed health care or addiction treatment facility.	A freestanding or other appropriately licensed health care or addiction treatment facility.	An appropriately licensed acute care setting able to provide medically directed acute detoxification and related treatment aimed at alleviating acute emotional/behavioral and/or biomedical distress resulting from the patient's use of alcohol/other drugs.

Criteria for Placement of Adult Patients in Need of Detoxification Services (continued)

CHARACTERISTIC	LEVEL I-D Ambulatory Detoxification without Extended On-Site Monitoring	LEVEL II-D Ambulatory Detoxification with Extended On-Site Monitoring	LEVEL III.2-D Clinically-Managed Residential Detoxification	LEVEL III.7-D Medically-Monitored Inpatient Detoxification	LEVEL IV-D Medically-Managed Intensive Inpatient Detoxification
EXAMPLES	Physician's Office, Home Health Care Agency	Day Hospital Service	Social Setting Detoxification Program	Freestanding Detoxification Center	Psychiatric Hospital Inpatient Unit
SETTING (continued)		When the focus of II-D service initially is on evaluation to determine the need for more or less intensive detoxification services, II-D may be provided in a "23-hour bed." More often, however, this level of detoxification service is offered in addiction specialty service facilities and is fully integrated with Level II addiction services that address Dimensions 2 through 6 of the patient's condition. Thus, intensive outpatient and partial hospitalization service facilities, or settings where such services are offered, are appropriate for Level II-D services.			At least three types of settings provide this level of care: (a) An acute care general hospital; or (b) An acute care psychiatric hospital with ready access to the full resources of an acute care general hospital, or a psychiatric unit in an acute care general hospital; or (c) An appropriately licensed chemical dependency specialty hospital with acute care medical and nursing staff and life support equipment, or an acute care addiction treatment unit in an acute care general hospital.

A P P E N D I X E

AGENCY COMMENTS

HEALTH CARE FINANCING ADMINISTRATION

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE: SEP 17 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Follow-up to Detoxification Services for Medicaid Beneficiaries," (OEI-07-97-00270)

We reviewed the above-referenced report that examines whether Medicaid and other state programs provide linkages for patient services between substance abuse detoxification and follow-up treatment programs. Annually, the Substance Abuse and Mental Health Services Administration (SAMHSA) spends over $1.5 billion on substance abuse prevention and treatment services. In addition, the Health Care Financing Administration (HCFA) covers substance abuse detoxification and treatment in most state Medicaid programs.

The report finds that 15 states have formal processes that provide transition from substance abuse detoxification to treatment, and 32 of the 35 remaining states have informal processes.

We concur with the report recommendations. Specific comments follow:

OIG Recommendation

SAMHSA should develop performance indicators that measure linkage from substance abuse detoxification to treatment.

HCFA Response

We concur. Performance indicators that measure linkage from substance abuse detoxification to treatment are already being incorporated in the quality measurement surveys currently under development by various organizations.

OIG Recommendation
SAMHSA should assist HCFA in ensuring that Medicaid managed care contracts specify the transition from Medicaid detoxification to Medicaid treatment.

HCFA Response
Although we concur, we take exception to some of the language regarding HCFA's role in state managed care contracting. SAMHSA and HCFA can certainly collaborate and encourage state Medicaid agencies to include language regarding continuity of substance abuse services in their managed care contracts. However, HCFA cannot "ensure" that Medicaid managed care contracts meet these goals. HCFA can encourage and guide states to provide the services and monitor their utilization. There are a variety of factors in the provision of substance abuse services that are state-specific and contingent on the type of behavioral health services offered in a managed care context . Therefore, we suggest that the recommendation be revised to reflect that "HCFA will work with states so that the managed care contracts specify the transition from Medicaid substance abuse detoxification to treatment," rather than "ensure" that the contracts so specify.

The important linkage between detoxification and treatment, as pointed out in the report, could be a topic for technical assistance and/or training with the states.

OIG Recommendation
SAMHSA and HCFA should work with States to facilitate enhanced data collection covering such areas as continuum of care.

HCFA Response
We concur, and believe this data will be useful in order to determine possible fraud, waste, or abuse with this benefit as well as improve and monitor quality of care. Data collection and analysis of the amount, utilization, and quality of services the systems provide is a high priority for states. In this area, as in other aspects of health care delivery, SAMHSA and HCFA, through discussions with states on block grant plans and waiver proposals, could expect states to establish up-to-date management information system programs that would enable the states to collect essential information.

General and Technical Comments
The charts were particularly useful in helping to interpret the data presented throughout the report. We believe the report will lend a great deal of support to the claim that more needs to be done to improve data collection and performance monitoring in order to ensure that all substance abusers receive appropriate care.

Executive Summary, Background, Pg. I - "Detoxification and substance abuse treatment are *jointly* funded federally. . . ." Each funding stream is separate and the word *jointly* is misleading.

Executive Summary, Recommendations, Pg. ii - Why are states missing the linkage between detoxification and treatment? Did the study uncover a payment reason or a provider or payment problem which could be explored further?

Introduction, Background, Pg. - Same comment as above regarding *jointly.*

Throughout the document persons receiving Medicaid are referred to as *clients*. We suggest using the word *beneficiary* as a substitute.

Introduction, Background, Pg. 1, Paragraph 4 - "Literature suggests. . . ." Is there a citation that could be given for reference; a SAMHSA document or research study? Paragraph 5 talks about "Treatment literature" - are there any references?

Introduction, Background, Pg. 1, Paragraph 5, last sentence, last line on page - and these problems" insert the word *other* before "problems."

Methodology, Pg. 3, next to last paragraph - ". . . .directors of *behavioral health.* . . ." Does this refer to directors of mental health and/or directors of a combined mental health and substance abuse department?

Findings, Pg. 4, Paragraph 4 - ". . . .Depending upon the assessment of the Medicaid client" - Substitute *beneficiary* for client, "it may be determined that the patient" - Substitute *person* for patient, should be seen by a. . . .Therefore, a beneficiary might see both" - Delete the word *both*, "a mental health professional. . . .in addition to," Insert the word *receiving* before "treatment at an outpatient clinic."

Findings, Pg. 8, Paragraph 5 - "Only seven States reported recidivism data with a range of 23 percent to 93 percent. . . ." - What is the value of this average?

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

AUG 4 1998

TO: June Gibbs Brown
Inspector General

FROM: Administrator, SAMHSA

SUBJECT: Comments on OIG Draft Report: "Follow-up to Detoxification Services for Medicaid Beneficiaries (OEI-07-97-00270)

Thank you for the opportunity to review this well-written and valuable report. After having been invited several months ago to meet with your staff to discuss an earlier draft of this report, we were particularly pleased to see that this version incorporates a number of our suggestions and supports the policy issues of concern to us in the areas of managed care and substance abuse treatment. In general, we agree with the findings and conclusions of the report and expect that they will be very useful to us as we move forward to create managed care performance measures and work with States on contracting for managed care.

With regard to your specific recommendations for action, we agree with your recommendations that SAMHSA should work with State agencies to develop performance indicators that measure linkage from substance abuse detoxification to treatment and that SAMHSA should assist the Health Care Financing Administration in ensuring that Medicaid managed care contracts address the need for treatment following detoxification. With regard to your third recommendation, SAMHSA strongly supports enhanced data collection and the development and implementation of performance measures in the States, and is working with the States and their representatives to move toward the voluntary adoption of such measures. Nevertheless it should be noted that SAMHSA cannot "ensure that States provide encounter, waiting time, treatment and outcome data" without a change in the legislation governing the Substance Abuse Prevention and Treatment block grant. In addition to the existing recommendations, SAMHSA also would like to suggest the need to work with States and providers to explore mechanisms for shifting to greater use of outpatient detoxification services, which have been shown to be as safe and effective as, and more cost-efficient than, inpatient detoxification.

We also would like to offer the following specific comments:

- Page i, last paragraph, first sentence. If this statement is meant to suggest that there has been little change in the States' emphasis on inpatient vs. outpatient care in the past few years, it is inconsistent with our understanding that there has been a general trend toward outpatient settings. If it is meant to suggest that inpatient and outpatient programs themselves have not changed much, it is also inconsistent with our understanding that within outpatient settings there has been a greater emphasis on intensive outpatient treatment in the past few years.

- Page ii, third paragraph, first sentence. The statement that "Only 5 States use outpatient detoxification on an extensive basis. . . " seems to contradict Appendix C, which lists 15 States that use outpatient detoxification. Some of these States overlap with those listed as using inpatient detoxification.

- Page 1, second paragraph. Consider the following edits:

  Third sentence: ". perhaps the most *critical* ~~crucial or fateful~~

  Fourth sentence: ". . . that a ~~subsequent~~ treatment program should be undertaken *subsequent to detoxification to assist the client in making the transition from addiction to recovery, to prevent relapse, and to* ~~to provide and~~ promote healthy . . . "

- Page 1, fourth paragraph. Consider the following edits:

  First sentence: ". component *of a continuum* ~~all~~ of substance abuse services

- Page 2, first full paragraph. Consider the following edit;

  Third sentence. "*Some* States are also attempting to

Again, thank you for the opportunity to comment on this worthwhile and timely report. We look forward to receiving a copy of the Final Report.

Nelba Chavez, Ph.D.