The Coming Transformation Of Public Addiction Treatment

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Provisions of the Affordable Care Act and other recent legislative changes will transform public substance abuse treatment in the United States, substantially increasing the funding, expanding access to care, and better integrating it with other health services. That's the conclusion of an article by Jeffrey Buck, senior advisor for behavioral health in the Center for Strategic Planning, Centers for Medicare and Medicaid Services, in the August 2011 issue of *Health Affairs*.

Buck's article is among a cluster of articles in the issue that focus on substance abuse. Also in the issue:

- Nora Volkow, director of the National Institute on Drug Abuse and Julio Montaner, director of the British Columbia Centre for Excellence in HIV/AIDS, focus on the urgent need to better integrate care for substance abusers with HIV.
- Claire Trescott and colleagues from Group Health in Seattle describe how that system responded to an emerging crisis of opioid drug abuse and misuse by overhauling prescribing and use of opioids.
- Robin Clark at the University of Massachusetts Medical School and colleagues argue that state Medicaid programs have no reason to ration substance abuse treatment with the costly drug buprenorphine — because overall it is neither more costly nor less safe than other therapies such as methadone.

Public Substance Abuse Treatment

"Transformation of the public substance abuse treatment system was never one of the explicit goals in health care reform," writes Buck. "But policies expanding health insurance coverage and providing substance abuse treatment benefits at parity with medical and surgical benefits are likely to have that effect." The result, he concludes, "should be a system of care that significantly improves the treatment of substance abuse disorders in the United States."

Under the Affordable Care Act, the broad expansion of Medicaid in 2014 is expected to double the number of non-elderly adults with behavioral health disorders who will be covered by the program. It's likely that many of these newly eligible Medicaid beneficiaries will have some level of mental health and substance abuse treatment coverage for the first time. What's more, these services must be provided on parity with other medical benefits. In addition, the federal government will fully finance coverage for newly eligible beneficiaries through 2016, after which its share will decline only slightly.

Many of those newly eligible are likely to have substance abuse disorders, many of them severe. The current public treatment system, which comprises mainly small, stand-alone, non-profit or government-operated facilities with little to no competition and severe funding and infrastructure restraints, will need to adapt to these new demands.

Because there will be a fundamental shift in public funding for substance abuse treatment from a patchwork of state and local grants and contracts toward federally supported health insurance, health reform will provide incentives to modernize the delivery system for addiction treatment and provide better care based on best practices and evidence.

Buck predicts that, over the next 10 years, the system for delivering substance abuse treatment will become increasingly professionalized, less residential, and more outpatient-focused.

Non-specialty providers, in particular federally qualified health centers, which will receive a large boost in federal funding, will probably assume a greater role in substance abuse treatment, as will physicians, psychologists, nurse practitioners, and other health professionals. Health information technology systems — currently lacking among many substance abuse treatment providers — will become more prominent.

In addition, treatment will become more medically oriented and less reliant on education and psychosocial support provided by peer or lay counselors, services that generally do not qualify for Medicaid reimbursement. Treatment based on medications such as methadone and buprenorphine will likely increase. New incentives under health reform will also encourage the use of evidence-based practices and the integration of substance abuse treatment with general medical treatment, Buck notes.

Substance Abuse and HIV

- Substance abuse contributes significantly to new HIV infection, yet treatment for these conditions is not coordinated or integrated in any meaningful way. Nora Volkow and Julio Montaner argue that, in fact, "drug abuse treatment is also HIV prevention" and that providing substance abusers with universal access to HIV treatment is essential to reversing the epidemic. More than two decades of research have shown that integrating HIV treatment with substance abuse treatment can greatly reduce HIV morbidity and mortality, as well as disease incidence, they say. Volkow and her colleague support a "seek, test, treat, and retain" policy to aggressively seek out high-risk, hard-to-reach substance abusers, offer them HIV testing, and bring them into treatment for both HIV and substance abuse.

Overcoming Opioid Abuse and Misuse

- Increased opioid prescription for chronic pain that is not due to cancer has been linked with alarming increases in prescription opioid abuse and overdose. (Opioids are drugs that mimic the effect of opium and include medications such as morphine and

oxycodone.) Claire Trescott and colleagues describe that system's response to this emerging drug abuse crisis by developing a detailed guideline for standardizing opioid prescribing and enhancing patient safety. Key to this guideline is a tailored care plan created by the clinician with the patient that outlines treatment goals, medication regimens, and standardized refill procedures.

Substance Abuse Treatment in Medicaid

- Although buprenorphine treatment offers several advantages over other opioid addiction therapies, many state Medicaid programs shy away from it under the belief that it will lead to higher costs and higher death rates. But Robin Clark and colleagues find that treatment with buprenorphine is neither more costly nor less safe than other therapies such as methadone. In fact, mean annual spending for buprenorphine therapy was $1,330 lower than for methadone when used for maintenance treatment, and did not increase death rates. Unlike methadone, which must be administered at an approved clinic, patients can get a prescription for buprenorphine from their physicians and take the medication at home. This can help expand access to opioid addiction treatment, although buprenorphine therapy is also associated with higher relapse rates than methadone, possibly because of lower treatment compliance. The researchers note that, if anything, policies that significantly reduce the use of buprenorphine therapy "could have the unintended effect of increasing costs." And, if they reduce overall use of opioid substitution therapy, such policies might also lead to more deaths.