REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Mandated Substance Abuse Treatment Programs

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Report of the
Joint Subcommittee Studying Mandated Substance Abuse Treatment Programs
to
The Governor and General Assembly of Virginia
Richmond, Virginia

To: The Honorable Lawrence Douglas Wilder, Governor of Virginia
and
The General Assembly of Virginia

Part I

AUTHORITY FOR STUDY

The Joint Subcommittee Studying Mandated Substance Abuse Treatment Programs was created in 1987 by Senate Joint Resolution No. 171 (Senate Document 28, 1988) and continued in 1988 (SJR 65, Senate Document 22, 1988) and 1989 (SJR 169). The scope of the study was broad and directed the joint subcommittee to review legislatively mandated substance abuse programs, determine the need for coordination of rehabilitative and preventive services provided by various state agencies, determine the efficiency and effectiveness of the administration of substance abuse programs and services delivered by the community services boards, assess the delivery of substance abuse services in light of federal and state cutbacks, and recommend methods of maximizing the utilization of available funds and enhancing service delivery mechanisms. Since the nature of and solutions to these problems are complex and provide no simplistic answers, the joint subcommittee has been continued for two years to provide the General Assembly continued input on the issue of treatment for substance abuse.

BRIEF HISTORY OF JOINT SUBCOMMITTEE

A number of issues have been raised during the course of this study including funding for treatment and research; organizational placement of substance abuse services and resultant philosophy about priorities; adequacy of staff providing services on the state level; coordination of drug treatment and education endeavors between state agencies; insurance coverage, including Medicaid, for more appropriate levels of care for substance abusers; drug interdiction efforts by the Commonwealth; adequacy of provision of services on the local level through the community services boards structure; and life skills training as a practical prevention and treatment effort. Debate continues among members of the joint subcommittee, as well as the population at large, about the grouping of all mood-altering drugs into one category under the generic term "substance" and the lack of prioritization in terms of treatment and funding. Many individuals feel that certain drugs, such as alcohol, are tolerated and even promoted by our society. Other drugs are perceived to be used without apparent addiction, while some drugs, such as cocaine and heroin, are truly addictive. Suggestions have been offered which would differentiate between drugs and funds for control, education, and regulation. (See Appendix 1.)

In response to these issues, the joint subcommittee recognizes that continual review and evaluation of substance abuse treatment and prevention efforts are essential. The cost of substance abuse, in both human and economic terms, is staggering. Alcohol is the most widely used intoxicant in the United States today, and abuse costs an average of $117 billion per year in lost productivity and medical bills. According to the National Institute of Drug Abuse, 14 to 18 percent of workers abuse alcohol or other drugs or both and that percentage translates to 16.5 to 21.2 million impaired workers. Lost productivity, absenteeism, medical expense, disability claims, and theft due to the abuse of drugs other than alcohol cost businesses about $16 billion annually. Not included in these figures are the family members who are affected by the member who abuses substances. Costs of substance abuse are generally underestimated due to the hidden nature of the disease, the tendency toward denial among users, and inadequate treatment for the primary diagnosis of substance abuse.

As of October 1989, community services boards have implemented 93 percent of all new projects funded during the past biennium. These funds have enabled a significant increase in substance abuse services to occur. By the end of fiscal year 1989, these funds had provided for the following additional services: 57,624 service hours; 23,369 bed days; 3,235 days of service; and 13,876 new clients.

During the course of the past three years of study, the joint subcommittee has offered a number of comments or legislative solutions which have been directed at the improvement of substance abuse treatment in the Commonwealth. The joint subcommittee has:

- Provided in § 37.1-205.1 for the annual report to the General Assembly by the Department of Mental Health, Mental Retardation and Substance Abuse Services on its activities in administering, planning, and regulating substance abuse services. The provision requires a specific statement of the extent to which the Department's duties, as specified, have been performed. Constant oversight allows the continual update of activities and opportunity to provide immediate legislative remedy if practical.

- Directed and encouraged the development of an Interagency Comprehensive Substance Abuse Plan for the Commonwealth by the Department of Mental Health, Mental Retardation and Substance Abuse Services in conjunction with the Department of Criminal Justice Services. The plan was formulated under the power of the DMHMRSAS as the sole agency for planning, coordination, and evaluation of the state comprehensive plan for substance abuse services, the authority to formulate such a comprehensive plan for the development of adequate and coordinated programs for research, prevention, and control of substance abuse, and the authority to effect such a plan in cooperation with other federal, state, local, and private agencies. The plan is reviewed by the Governor's Council on Alcohol and Drug Abuse Problems, and recommendations offered are reviewed by the joint subcommittee. A copy of the executive summary of the Comprehensive Plan is attached, but, as a result of its volume and detail, the entire Plan is not included. For information on the availability of the complete version of the Plan, please contact the Office of Substance Abuse Services in the Department of Mental Health, Mental Retardation and Substance Abuse Services.

- Endorsed various proposals for the development of clinical research through the combined efforts of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Medical College of Virginia. Virginia Commonwealth University received state support for the Commonwealth Center for Drug Abuse in 1988. This research focused effort is based in the Department of Pharmacology. However, the Division of Substance Abuse Medicine is part of the Center, and approximately $50,000 of the $500,000 awarded to the Center went to the Division to support a part-time research assistant and small pilot studies.

  These efforts resulted in a successful application for federal funding ($9 million over five years) by the Division of Substance Abuse Medicine for services to and research for pregnant addicted women and their children. Further, the Department of Pharmacology has been awarded a major grant ($3 million) by the Alcohol, Drug and Mental Health Administration to study drug development in the areas of substance abuse and mental health treatment.

  The Office of Substance Abuse Services, through the Department of Health, has received federal funding from the Center for Disease Control to identify intravenous users of drugs who test positive for AIDS as well as tuberculosis.

- Established a two-year task force of various professionals involved in the treatment delivery system for substance abuse to evaluate the 30-day insurance mandate currently provided in the Code. A copy of their findings and recommendations is included in this document.

- Endorsed the addition of crucial personnel to the staff of the Office of Substance Abuse Services within the Department. The joint subcommittee and various individuals who testified before the committee were not critical of the quality of the current staff but found the original size of the Office of Substance Abuse Services, which was seven individuals, to be inadequate for the massive size of the problem with which they were dealing. As a result, positions to manage the interagency planning process and to coordinate efforts by agencies serving youth have been filled. The previously cited funding from the Center for Disease Control, obtained through interagency collaboration with the Virginia Department of Health, netted approximately $250,000 to fund an AIDS specialist in the Office of Substance Abuse Services as well as funding for AIDS counselors in five communities. Also, the Department recently obtained funding from the National Institute on Drug Abuse (NIDA) for two data analysts.

- Directed the Division of Youth Services to thoroughly evaluate and consider the concept of substance abuse treatment and education for juveniles housed in their facilities in the Commonwealth. The Office of Substance Abuse Services continues to work with the Division, soon to be the independent Department of Youth Services, and its new director. Funding for an assessment of the substance abuse education and treatment needs of the youth served in DYS institutions was provided by a grant from the Governor's Council via the federal Drug Free Schools and Communities Act. The completed report of this activity forms the basis for parts of the Department of Youth Services' biennium budget. In addition, DYS has also requested support from the Governor's Council on Alcohol and Drug Abuse to implement a new substance abuse curriculum and provide training for cottage counselors.

- Directed the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services, pursuant to SJR 196, 1989, to conduct a study to determine the size of the Medicaid-eligible population in need of substance abuse treatment, the services required by that population, and the projected cost of providing the required treatment services. A copy of the report of that study as presented to the joint subcommittee is included.

- Endorsed additional funding, within current budget restraints, for support of pilot public/private employee assistance programs. Funding for pilot employee assistance programs was included in the budget and the Department provided staff assistance in a request for proposals offering. As of December 1989, the process was virtually complete with awards to be made in the immediate future. The Department also provides current literature on drug-free workplace activities but is unable to provide developmental or technical assistance to businesses and industry due to staffing limitations.

EXECUTIVE SUMMARY

The Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs was continued by the 1989 Session of the General Assembly expressly to provide oversight to a number of task forces studying a variety of designated topics. These topics included the interagency plan for substance abuse services, Medicaid coverage for substance abuse treatment, the adequacy of insurance coverage for psychiatric illnesses, and insurance coverage for substance abuse treatment.

The joint subcommittee should:

- **Continue to provide legislative oversight for issues related to substance abuse treatment and rehabilitation.**

  The very existence of the joint subcommittee has served to create considerable momentum in the area of substance abuse treatment and rehabilitation. Since the joint subcommittee was formed in the 1987 Session of the General Assembly, significant new state resources have been allocated to the Department of Mental Health, Mental Retardation and Substance Abuse Services to enhance community treatment capacity. The 1988 Session enacted legislation requiring the presentation of an annual report by the Department on activities pertaining to substance abuse, and the first report was presented to the 1989 Session. The first interagency substance abuse planning document in 10 years, and the first ever of such large scale (involving 17 state agencies), was developed and a continuing planning process established. Issues of third-party pay, both private and public, were considered. Yet, all of these important accomplishments are only a starting point. The joint subcommittee can provide pivotal leadership for continued direction for both current and emerging substance abuse treatment and rehabilitation issues. (See Appendix 2.)

  Two specific areas which would benefit from the joint subcommittee's attention are the increased availability of ancillary services for persons who abuse substances (e.g., vocational rehabilitation, medical care, social services) and the ongoing legislative support for the Interagency Comprehensive Substance Abuse Plan process.

The complex nature of substance abuse requires the attention of many community resources. Persons in the early stages of recovering from substance abuse are often unemployed or underemployed, and vocational satisfaction has been demonstrated to be a significant factor in relapse prevention. Substance abuse also has clear and negative consequences on physical health, and many of the persons treated with state resources are without personal resources to pay for needed medical attention. Income supports, day care for women with children, and additional social services are also frequently needed to help the recovering person address basic needs.

The interagency plan provides, for the first time, a summary of current and planned substance abuse activities for 17 state agencies. Cosponsored by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Criminal Justice Services, the plan captures information about criminal justice and public safety, education and prevention, and treatment and rehabilitation programming related to substance abuse. This resource document also arrays facts about funding amounts and sources and exhibits information pertaining to interagency collaboration involved in implementing these programs. Finally, the document provides clear direction and goals, mutually agreed upon by the participating agencies, for addressing the issue of substance abuse in the Commonwealth.

The participating agencies will continue this interagency planning and collaboration effort. The Interagency Comprehensive Substance Abuse Plan process has established a forum for addressing the relationships between treatment and rehabilitation, the criminal justice system, and education and prevention. The continuance of the joint subcommittee would provide a necessary legislative linkage for the implementation of goals and objectives developed in this interagency planning process. (See Part II for an executive summary of the Comprehensive Plan.)

- **Recommend that the Governor assign a special assistant to be the single point of contact in the Governor's office for issues pertaining to substance abuse.**

The diverse issues associated with substance abuse require a focused and concentrated approach. Assignment of a special assistant would provide the Governor with broad oversight and enhance communication regarding substance abuse in the Commonwealth. Such person would be informed of current projects, as well as those under discussion, and could provide guidance to the Governor, cabinet heads, and relevant state agencies in developing substance abuse policy for the Commonwealth. Furthermore, the position would work closely with the interagency plan process for input, exchange of ideas, and perspective.

- **Recommend state funding for substance abuse treatment, rehabilitation, education, and prevention services as outlined in the 1990-1996 Comprehensive Plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services.**

The Commonwealth's approach to substance abuse and related problems must be balanced between the criminal justice system, education and prevention, and treatment and rehabilitation. Data collected from the Department of Corrections demonstrates that an overwhelming majority of persons incarcerated in state correctional facilities report a history of significant substance abuse. The increase in violent crime has been directly attributed to increased drug trafficking and use. Needle-sharing among persons who abuse drugs intravenously has become the leading transmission method of the virus which causes Acquired Immunodeficiency Syndrome (AIDS). Concurrently, jails and prisons around the state are overcrowded, and many substance abuse rehabilitation programs have waiting lists.

Community services boards have identified, in addition to waiting lists, a significant number of people in need of alcohol and other drug services. Even with the current level of services, a large proportion of Virginians with substance abuse problems are going unserved. There are an estimated 400,000 to 500,000 Virginians with alcohol abuse problems and an estimated one million citizens using mood-altering drugs in an illicit or nonprescribed fashion each year. The current service delivery system is reaching only 8 to 12 percent of those that require services. Over 110,000 people are in need of, but are not receiving, alcohol or other drug services. Current program capacity is not adequate for response to increasing service demands from the criminal justice system. Therefore, the $15 million expansion in alcohol and other drug abuse services proposed in the 1990-96 Plan is critical to meet the increased demand for services.

The substance abuse services proposed for the 1990-92 period will increase current substance abuse service capacity and expand the array of services available in a given community. The emphasis in program development during this period is on residential, outpatient and case management, day support, and early intervention services.

The need for additional resources in support of substance abuse service development was identified to the Department through public testimony delivered by professionals, parents, consumers, and other human service agencies during a series of public hearings on the Comprehensive State Plan, held July 27-29, 1989. In the Department's plan, additional resources will be translated into services to address the needs of local schools, the criminal justice system, social service agencies, and other organizations and individuals. The proposed services represent increased capacity of existing services and expansion in the array of services.

The amount would be budgeted for expenditures in the following manner:

Community Substance Abuse Services

Emergency Services	$ 145,689
Local Inpatient Services	562,277
Outpatient Services	3,313,520
Case Management Services	1,498,426
Day Support Services	3,093,911
Residential Services	5,795,493
Early Intervention Services	590,684
TOTAL REQUESTED:	$15,000,000

- **Recommend funding for treatment research.**

Substance abuse treatment and rehabilitation require further research. The Department has long recognized the importance of additional research in this area and has built two research projects into its 1990-92 biennium budget proposal. Client Treatment Models - Which Treatment Works for Which Clients is a proposal establishing state support for this type of research effort. As a result of state support and resultant new research efforts, the state will be in an improved position to capture federal funding for continued research. The second project is to describe specific motivational factors which attract and retain intravenous drug users in treatment.

Recommended amounts:

Which Treatment Works for Which Clients ----	$125,000
Specific Motivational Factors for Attracting and Retaining Intravenous Drug Users Into Treatment ----	50,000

- **Explore in detail the advantages and feasibility of establishing an institute on alcohol and other drug abuse at Virginia Commonwealth University.**

A solid foundation for an institute on alcohol and other drug abuse already exists at Virginia Commonwealth University. Current efforts at VCU include the provision of direct services, clinical and pharmacologic research, and teaching. An institute could be supported with a limited amount of state funds and would serve to heighten an organized focus on alcohol and other drug abuse research, training, and policy development.

The result would be increased collaboration, coordination, and effectiveness among various alcohol and other drug components participating in the institute. As experience has shown, this enhanced focus, utilizing a relatively small amount of state funding, could result in significant federal support for alcohol and other drug abuse research, service, training, and policy activities.

Cost: $200,000 for implementation of institute

- **Endorse the continuation of the Task Force to Study the Continued Availability of Adequate Insurance Coverage for Persons with Mental Disabilities.**

House Joint Resolution No. 319, as authorized by the 1989 Session of the General Assembly, requested that the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Commissioner of Insurance establish a task force to study the continued availability of adequate insurance coverage for persons with mental disabilities. The task force is comprised of service providers, the insurance industry, advocates for individuals with mental disabilities, and university teaching hospital representatives. (A summary of the progress of this task force is found in Part III.)

The task force has divided itself into four subcommittees, namely definitions, benefits, access and monitoring, and the public sector. It has monitored the efforts of the Task Force Studying Insurance Coverage for Substance Abuse Treatment, and it is clear that, since many of the issues were identical, coordination between the two groups would be beneficial. The HJR 319 task force wants to have the opportunity to review the report of the substance abuse insurance task force as well as to review a benefits survey that will be conducted by the Bureau of Insurance beginning in January of 1990. This survey will provide needed data on the health insurance benefits available, the number of Virginians enrolled in various health insurance plans, those enrolled in self-insurance programs, and those who are uninsured. It is anticipated that the data from the survey will be available in the spring of 1990.

In order to review this data and to complete its study, the HJR 319 task force is requesting that its work be continued for another year by the respective commissioners.

- **Support the recommendation by the Secretary of Health and Human Resources, the Department of Planning and Budget, and the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide limited Medicaid coverage for certain substance abuse services.**

The substance abuse services proposed for Medicaid coverage are:

> Case management - the identification of and outreach to clients to ensure continuity of care by assessing, planning with, advocating for, monitoring, and linking clients to appropriate services in response to their changing needs.
>
> Methadone Treatment and Maintenance - detoxification, treatment, or rehabilitation of persons addicted to drugs through the use of prescribed methadone in conjunction with counseling and other services.

Projected direct service cost for substance abuse case management, day treatment, and methadone treatment is $3,020,418. This amount will be paid for through the Medicaid program inclusive of both state and federal funds. Emphasis is placed on limiting services in an effort to control expenditures and/or uncontrolled usage of substance abuse services. Scheduled implementation of substance abuse coverage is July 1, 1991.

Background: SJR 196 directed the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services to research the feasibility of providing Medicaid coverage for substance abuse treatment in Virginia. The purpose of expanding the Medicaid program would be to obtain federal financial participation for some current programs and services as well as meet future demand for treatment services. The Departments reported their findings to the joint subcommittee at its November meeting and included the following executive summary:

> The federal Medicaid plan allows states a great degree of flexibility in determining services to be covered under Medicaid. Coverage for substance abuse services is an option allowable under the federal plan which Virginia has not used. In some states, Medicaid has served as a major funding source for substance abuse services.
>
> In Virginia, substance abuse services for indigent persons are primarily provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services through the community services board system. If the Virginia Medical Assistance Plan is changed to cover substance abuse services, it is estimated that approximately 11,000 to 14,000 citizens currently enrolled in the Medicaid program would be potential users of a substance abuse treatment option. Although other eligible groups could be covered, the largest portion of the population that would be addressed under a substance abuse services option would be families receiving Aid to Dependent Children, pregnant mothers, the disabled, and the aged.
>
> Medicaid allows coverage for detoxification, psychiatric assessments and psychological testing, ambulatory detoxification, associated medical testing, acute/intensive stabilization, counseling, and pre-vocational counseling. Some existing treatment services being provided by DMHMRSAS through the local community services board system could be covered, with restrictions that address appropriate treatment relative to patient needs and the environment of services delivered, i.e., inpatient, day treatment, or outpatient. Other states that have covered substance abuse services under Medicaid have experienced some cost savings by reducing some social services and general health care costs. These potential cost savings would need to be balanced with the potential cost increases tied to increased enrollees and entitlement to services if the state added this option.

In order to manage any inclusion of substance abuse treatment, operate the program efficiently, and minimize fiscal risks, certain management and operational controls would have to be implemented as well as requiring a utilization review component to act as a safeguard against unnecessary and/or inappropriate use of Medicaid coverage. (The complete report of the study committee is found in Part IV.)

- **Endorse the recommendations regarding levels of care, treatment environment, and the concept of conversion ratios for inpatient days of insurance coverage offered by the Task Force Studying Insurance Coverage for Substance Abuse Treatment. In light of variances among program costs and the lack of consistent cost data, the joint subcommittee recommends that a pilot project be conducted in the public sector to determine the feasibility of allowing inpatient days of coverage to be converted to other levels of care and the procedure by which such program can be accomplished so that treatment is maximized and client benefits are not reduced. A select committee shall be appointed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to outline a plan of implementation of such pilot project and shall report to the General Assembly no later than April 18, 1990.**

The task force reported that mandated insurance coverage for inpatient substance abuse treatment has been the law for over 10 years with ambulatory treatment offered as a "mandated option." Many clients are not covered for optional services, due to rising costs among other things, and coverage for treatment addiction is limited to inpatient care, which is the most costly and intensive type of care. Many patients, though, can be treated effectively on an ambulatory basis.

In the past few years, our experience in treating addiction disorders has grown and alternative levels of care have been developed. Treatment environments and modalities have become more varied and sophisticated with greater attention being paid to individual need. In addition to the traditional 28- or 30-day inpatient model, we now have available such programs as day treatment, after work, evening, weekend, and after school, as well as a full range of a la carte outpatient services including individual, group, and family therapy. The options are now available to better match patients to treatments in the most clinically appropriate and cost-effective way.

The key to appropriate management of addictive disorders is to provide a continuum of care which ranges from very restrictive acute hospital services to nonrestrictive outpatient services. Patients should be able to be matched to treatment options based on their medical and psychiatric status as opposed to the limitations of their insurance. At the same time, it is critical to look at issues of cost containment and that any revision of current insurance coverage be as cost-neutral as possible.

The task force has identified three levels of appropriate care for substance abuse treatment, defined these levels in such a way as to provide consistency in terminology across providers, programs, and third-party payors, and developed guidelines to be utilized in appropriately matching patients to treatment options. The three levels identified are inpatient, day support/intensive outpatient, and traditional outpatient. It is recognized that, while most, if not all, chemical dependency programs have psychotherapeutic and psychoeducational components, few have substantial medical psychiatric components. The task force has proposed that both inpatient and day support/intensive outpatient programs be further delineated as either "acute" or "non-acute" based on their capacity to diagnose and treat complicated medical and psychiatric conditions.

The task force also recommends that:

Current inpatient days of coverage for substance abuse treatment be available for conversion to other identified levels of care. After considering a variety of models to accomplish such a conversion, a ratio-based conversion model was favored. Originally, the recommended conversion rate was 1:3 inpatient to day support-intensive outpatient and 1:6 inpatient to outpatient units of treatment. Cost data has been unavailable to substantiate such a conversion, and, for this reason, a pilot project is likely to provide the necessary information to implement such a change in the way insurance coverage is provided for substance abuse treatment.

Deductibles and copayments for insurance coverage of substance abuse be no less favorable than that of any other illness across all levels of care. In this way, it will no longer be financially advantageous for patients to be treated at one level of care over another because of personal financial liability.

Fourteen days of inpatient time should be reserved for acute management of care so that short-term hospitalization will remain an option for those who fail to make adequate progress at less intensive levels of care.

The $80 indemnity clause be stricken from the statute covering mandated insurance coverage since this figure has never been adjusted for inflationary changes.

The $1,000 minimum which currently applies to mandatory outpatient coverage be increased to a minimum of $2,000.

The mandated "option" as provided for outpatient care be maintained as a means of upgrading coverage. (The complete report of the task force is found in Part V.)

Respectfully submitted,

Senator Benjamin J. Lambert, III, Chairman
Delegate Phillip A. Hamilton
Senator Dudley J. Emick, Jr.*
Senator Kevin G. Miller*
Delegate Jerrauld C. Jones
Delegate Franklin P. Hall
Delegate A. Victor Thomas

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Executive Summary

1989 Interagency Comprehensive Substance Abuse Plan

I. Purpose and Scope of the Plan.

The problem of substance abuse has impact on the economic, social, health, and legal quality of life of Virginia citizens. At least seventeen (17) entities of state government are affected enough to have some specific programmatic focus on the issues presented by substance abuse. In 1976, the Department of Mental Health, Mental Retardation and Substance Abuse was designated by the General Assembly as the "sole state agency" for "administration, planning and regulation of substance abuse services in the Commonwealth."

The 1987 Session of the General Assembly established The Joint Subcommittee Studying Mandated Substance Abuse Programs in the Commonwealth, and the work of that group has been continued for two additional sessions. The Subcommittee also perceived the need for increased coordination, cooperation, and collaboration among state agencies affected by substance abuse.

As the agency designated to plan and coordinate substance abuse services for the citizens of Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services initiated an interagency planning process for substance abuse services. Concurrently, the Department of Criminal Justice Services is mandated by its federal funding authority to develop and promote a statewide drug abuse strategy focusing on law enforcement. A marriage of planning efforts, therefore, seemed appropriate and logical, and these two agencies decided to co-sponsor a collaborative interagency substance abuse planning process and document, spanning three cabinet members and initially including fifteen (15) additional state entities.

In Summer 1988, fifteen (15) agencies were invited to send representatives to several meetings to discuss the potential of an interagency substance abuse plan and make decisions regarding its initial focus and process. The agencies agreed on a format and data gathering process for cataloging both current and planned activities related to substance abuse for each agency. A preliminary systems description was presented to The Joint Subcommittee Studying Mandated Substance Abuse Programs in the Commonwealth prior to the 1989 Session of the General Assembly. The documentation clearly revealed gaps in activities relating to substance abuse which required that involved state entities establish mutual goals and identify implementation strategies.

The 1989 Interagency Comprehensive Substance Abuse Plan is the result of these efforts.

The Plan provides a basis for coordinated long range planning among entities of state government which are involved in or affected by the abuse of alcohol and other drugs. The Plan provides

- A description of the nature, scope and degree of substance abuse in the Commonwealth;
- A comprehensive overview of the recent, current and projected programs and activities of seventeen (17) entities of Virginia state government which relate to substance abuse, including
  - resources required and
  - a description of the interagency activity involved in implementing these programs and activities;
- Goals for future interagency planning activities.

II. The Social and Health Indicators Used to Measure Substance Abuse.

Approximately one-tenth of the population will at some time experience a personal problem with substance abuse severe enough to warrant professional intervention. The extent and type of substance abuse in the Commonwealth is difficult to define; measuring the impact of substance abuse is more feasible. In 1987, 2,094 deaths were directly attributed to substance abuse. These include motor vehicle fatalities, suicides, homicides, accidents, and deaths from other causes in which alcohol or another drug was found in the blood of the victim by the Medical Examiner. During the same year, 15,014 persons in Virginia were injured in alcohol-related crashes, amounting to 19 percent of all traffic injuries. Substance abuse has also been demonstrated to have a deleterious effect on health. Alcohol, one of the most toxic of abused substances has been shown to have a negative impact on major organ systems. In addition, more than 15 percent of AIDS cases in Virginia are attributed to intravenous drug use.

About one-third of all 1988 arrests in the Commonwealth are related to substance abuse. The majority of those incarcerated in the correctional system report a history of abuse of alcohol and/or other drugs. It has been estimated that substance abuse costs the Commonwealth $4.4 billion in treatment and support, mortality, reduced productivity and lost employment, and other

related costs. There is a need for a systematic data collection effort in Virginia which can assist in planning and monitoring.

III. Agency-Specific Information.

The 1989 Interagency Comprehensive Substance Abuse Plan contains a chapter for each participating agency. These chapters are based on information provided by the agency in response to a survey, supplemental materials, and interviews with key staff. Inasmuch as possible, the same format was used to present each agency uniformly. Each agency chapter concludes with Recommendations for Action, developed by staff at the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with agency representatives. These recommendations are preliminary and will be refined and made more comprehensive in future editions of the Plan. They are listed as follows:

Commission on Virginia Alcohol Safety Action Programs

1. The Commission should continue to work closely with the Department of Mental Health, Mental Retardation and Substance Abuse Services and all state and private agencies to insure the highest quality prevention, education and treatment services for the least cost that will serve the Driving Under the Influence offender and all the citizens of the Commonwealth of Virginia.

Commonwealth Alliance for Drug Rehabilitation and Education (CADRE)

1. CADRE should continue to work with its member agencies to coordinate resources to confront youth substance abuse at the state and local level.

Department for the Aging

1. The Department for the Aging should work to implement the plan resulting from HJR 365, which will address those issues raised in the report for HJR 156: A Study of the Problems of Suicide and Substance Abuse by the Elderly and the Impact of Family Care Giving on Employee Work Performance.

Department of Alcoholic Beverage Control

1. The Department of Alcoholic Beverage Control should continue to conduct its substance abuse prevention and education activities, including media campaigns promoting strict adherence

to the legal drinking age and conferences such as the fall college leadership conference.

Department of Corrections

1. The Department of Corrections should continue its expansion of substance abuse treatment and rehabilitation programs for inmates, and should continue is collaborative relationship with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Criminal Justice Services in planning in implementing this effort.

2. The Department of Corrections should continue development and implementation of uniform standards for substance abuse treatment for inmates.

3. Field Units of the Department of Corrections should establish strong consultative and referral relationships with the Community Services Boards providing substance abuse treatment and rehabilitation to the area in which they are located.

4. Probation and Parole Officers should be trained in identification of clients who are at risk for abuse of alcohol and other drugs; strong consultative and referral relationships should be forged between District Probation and Parole Offices and Community Services Boards providing substance abuse services in those geographic areas.

5. Other community Department of Corrections professionals, such as those in Community Facilities and Community Alternatives, should also be trained in identification of clients at risk for abuse of alcohol and other drugs; these programs should also establish strong consultative and referral relationships with Community Services Boards providing substance abuse services in those geographic areas.

6. Urinalysis surveillance should be continued as a strategy for identification of persons under community supervision who abuse drugs.

7. Local Juvenile and Domestic Court professionals should be trained in identification of youth at-risk for alcohol and other drug abuse; strong consultative and referral relationships should be developed with the Community Services Boards providing substance abuse treatment and rehabilitation services in the geographic location.

8. The Department of Corrections should continue to work with the Department of Mental Health, Mental Retardation and Substance

Abuse Services in assessing need for substance abuse services for children committed to institutional care. In addition to establishing need for educational and clinical services, the assessment should include estimation of need for services which might be purchased, such as residential and intensive day treatment programs.

9. Department of Corrections should request assistance with training of professionals in institutional settings in identification of children at risk for abuse of alcohol and other drugs, as well as intervention with these children.

10. Capacity for routine data collections regarding substance abuse risk assessment for all juveniles under court jurisdiction should be established as a priority in the new Department of Youth Corrections.

Department of Criminal Justice Services

1. The Department of Criminal Justice Services should continue to improve its capability to collect and analyze data regarding the relationship of substance abuse to criminal activity, and the characteristics related to persons in the criminal justice system.

2. The Department of Criminal Justice Services should continue to coordinate its data collection activities and processes with other agencies focusing on similar issues (i.e., Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Corrections, Department of State Police).

3. The Department of Criminal Justice Services should continue to strengthen its linkages with other agencies in the criminal justice arena pertaining to substance abuse detection, enforcement, treatment, and planning.

4. The Department of Criminal Justice Services should continue to co-sponsor the development of the Interagency Comprehensive Substance Abuse Plan process, in collaboration with the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Department of Education

1. The Department of Education should continue to conduct its current substance abuse prevention and education programs.

2. The Department of Education should use the results of the student survey to target specific activities.

Department of Health

1. The Department of Health should continue to work closely with the Department of Mental Health, Mental Retardation and Substance Abuse Services to reduce the spread of Acquired Immunodeficiency Syndrome (AIDS) in persons abusing drugs intravenously.

2. The Department of Health should continue to collect compile and analyze data regarding health status, mortality ascribed to substance use and abuse, and the spread of AIDS related to intravenous drug use.

3. The Department of Health should work closely with the Department of Mental Health, Mental Retardation and Substance Abuse Services to revise the current methodology for determining need for substance abuse services.

Department of Health Professions

1. The Department of Health Professions should continue to provide certification for Substance Abuse Counselors.

2. The Department of Health Professions should continue to coordinate activities regarding Impaired Physicians with the Medical Society of Virginia, and should work to develop similar programs with other boards of health professions, particularly nurses.

3. The Department of Health Professions should continue to investigate the diversion of prescription drugs in conjunction with the Department of State Police and the U.S. Food and Drug Administration.

4. The Department of Health Professions, with assistance from the Department of Mental Health, Mental Retardation and Substance Abuse Services, should initiate, develop and implement public awareness campaigns to prevent the abuse of prescription drugs.

Department of Medical Assistance Services

1. The Department of Medical Assistance Services should continue to participate in the interagency comprehensive planning process for substance abuse services.

Department of Mental Health, Mental Retardation and Substance Abuse Services

1. The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to improve its capability to collect and analyze data internally regarding client characteristics and treatment outcome, and should coordinate data collection processes with other agencies focusing on similar issues (i.e, Department of Health, Department of State Police, Department of Corrections, Department of Criminal Justice Services, Department of Motor Vehicles.)

2. The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to develop and strengthen linkages with the Medical College of Virginia for the training of professionals and for the research capabilities of that institution.

3. The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to develop and strengthen linkages with other state agencies, through the interagency planning process, to identify gaps relating to the provision of substance abuse services and develop strategies to address these needs.

Department of Motor Vehicles

1. The Department of Motor Vehicles should continue its work in reducing substance abuse related deaths, injury and property damage through the Alcohol and Drug Countermeasures Program, the Comprehensive Community Based Program, the Virginia Crash Investigation Team, and its mini-grant program.

2. The Department of Motor Vehicles should continue to place special emphasis on educating the judiciary with respect to the role of sentencing young drivers for alcohol related driving offenses.

Department of Rehabilitative Services

1. The Department of Rehabilitative Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services should use the information collected as a result of the evaluation of the vocational rehabilitation pilot project at Portsmouth Community Services Board to make necessary modifications. If expansion is warranted, the project should be introduced to other Community Services Boards.

2. The Department of Rehabilitative Services should request training from the Department of Mental Health, Mental Retardation and Substance Abuse Services for all rehabilitation workers in the identification and intervention of substance abuse.

3. Once rehabilitation workers are trained, the Department of Rehabilitative Services should collect information pertaining to identification and referral of its clients who are abusing substances.

Department of Social Services

1. The Department of Social Services should request assistance in training its workers in the identification and intervention of substance abuse from the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. Once social service workers are trained, the Department of Social Services should evaluate and consider mandatory routine collection of information pertaining to identification and referral of its clients who are abusing substances so that the impact of substance abuse upon its service system can be more objectively measured.

Department of State Police

1. The Department of State Police should continue to enforce criminal laws related to substance abuse, and should continue its collaborative work with other agencies in pursuit of this mission.

Governor's Council on Alcohol and Drug Abuse Problems

1. The Governor's Council on Alcohol and Drug Abuse Problems should continue to implement its stated mission of advising and making recommendations to the Governor on broad policies and goals, as well as to coordinate the Commonwealth's public and private efforts to control alcohol and other drug abuse.

State Council on Higher Education

1. The State Council of Higher Education should continue to work closely with the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide support to the campus substance abuse coordinators.

2. The State Council of Higher Education should continue to work closely with the Department of Alcoholic Beverage Control in implementing policy regarding the increased legal drinking age.

3. The State Council of Higher Education should work closely with the Department of Mental Health, Mental Retardation and Substance Abuse Services to assess the need for professional training in substance abuse services, and should coordinate the development and implementation of appropriate curricula.

IV. Mutual Goals are Established.

As the activity of collecting information from agencies participating in this first iteration of the 1989 Interagency Comprehensive Substance Abuse Plan drew to a close, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Criminal Justice Services sponsored a planning workshop in June 1989 for the participating agencies. Representatives from the Department of Planning and Budget and the State Crime Commission also attended. Structured to capitalize on the perspectives and experiences of the agency representatives, the meeting resulted in the identification of three major themes, each with two goals:

A. Support for the Interagency Planning Process

Goal 1:
To have the Governor's Office, the General Assembly, and Cabinet members commit to a workable substance abuse plan which will define a state mission for the implementation of substance abuse services.

Goal 2:
To coordinate legislation, policy review and planning among state agencies involved in activities related to substance abuse.

B. Emphasis on Essential Support for Substance Abuse Service Development

Goal 3:
To establish a central clearinghouse of solid statistical data concerning the nature, scope and degree of substance abuse, including efforts at intervention, to which all agencies would contribute and have access.

Goal 4:
To have increased budget support for substance abuse programming through interagency planning efforts.

C. Support for Substance Abuse Program Implementation

Goal 5:
To provide all populations with access to enhanced substance abuse services.

Goal 6:
To promote community ownership and solutions to the problem of substance abuse in the Commonwealth.

V. Conclusion: A Strong Foundation for Interagency Planning and Implementation is Established.

The Interagency Comprehensive Substance Abuse Plan process was initiated to provide a mechanism for coordinated and collaborative service delivery and program development throughout the Commonwealth. Major areas of plan implementation include support for the interagency planning process, support for essential substance abuse services, and support for program implementation. The seventeen (17) state entities involved are committed to an ongoing interagency planning process, including policy development, advocating for resources, collecting and analyzing descriptive data, and identifying and remedying gaps in services, collaborating whenever possible. The Interagency Comprehensive Substance Abuse Plan Work Group, consisting of representatives from each participating agency, will continue to work toward this end.

REPORT TO THE JOINT SUBCOMMITTEE ON MANDATED SUBSTANCE ABUSE TREATMENT AND PREVENTION PROGRAMS

FROM THE INSURANCE TASK FORCE ESTABLISHED PURSUANT TO HOUSE JOINT RESOLUTION 319, 1989

November 28, 1989

HJR 319 requested that the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Commissioner of Insurance establish a task force to study the continued availability of adequate insurance coverage for persons with mental disabilities.

The Task Force was appointed in the Spring and comprises service providers, the insurance industry, advocates for individuals with mental disabilities and university teaching hospital representatives. The group is chaired by Isabel Brenner, a member of the State Mental Health, Mental Retardation and Substance Abuse Services Board.

The group convened on June 21 and has met monthly since. In reviewing the issues, the Task Force divided into four subcommittees:

1. The Subcommittee on Definitions is chaired by Joel Silverman, M.D., Chairman of the Department of Psychiatry at the Medical College of Virginia. This subcommittee is reviewing the definitions of mental disabilities, as defined by the medical and legal professions and those used in insurance policies. These definitions are being reviewed to determine the kinds of illnesses covered and the extent of the coverage available. The subcommittee has reviewed over 60 insurance policies, including policies of all the major carriers and HMOs in Virginia. The subcommittee is reviewing the techniques utilized by insurers to restrict or limit benefits, such as, utilization review, limitations or non-availability of long-term care and/or outpatient benefits.

2. The Subcommittee on Benefits is chaired by Frank Singleton, Ph.D., Administrator of the Eastern Virginia Medical School of the Medical College of Hampton Roads. The subcommittee has reviewed the current benefits available and what is needed for persons with mental disabilities. They are looking at methods of conversion of inpatient

benefits to partial hospitalization and other alternative kinds of treatment. This subcommittee is reviewing recommendations regarding the coverage of psychiatric care for children and coverage of substance abuse treatment by the State Medical Assistance Plan.

3. The Subcommittee on Access and Monitoring is chaired by Charles N. Davis, M.D., Medical Director, Charter Westbrook Hospital. This group has been reviewing the accessibility and availability of services. Its members have been looking at quality assurance, cost control monitoring and management of costs. It is currently developing recommendations on how and by whom treatment should be monitored to provide the most cost-effective and appropriate care.

4. The Subcommittee on the Public Sector is reviewing the impact of any changes in the current reimbursement system on the public sector. This group has been looking at the appropriate role of government in financing mental health services. Preliminary recommendations are being considered on ways to provide some form of conversion from inpatient care to intensive outpatient or partial hospitalization.

The Task Force received a report of the Substance Abuse Insurance Task Force, chaired by Dr. Haller. It was clear that the two task forces are studying many of the same issues and that it will be important to coordinate any recommendations of the two studies. The HJR 319 Task Force wants to have the opportunity to review the report of the Substance Abuse Task Force, as well as to review a benefits survey that will be conducted by the Bureau of Insurance, beginning in January. This survey will provide much needed data on the health insurance benefits available, the numbers of Virginians enrolled in various health insurance plans, those enrolled in self-insurance programs, and those who are uninsured. It is anticipated that the data from the survey will be available in the Spring.

In order to review this data, and to complete its study, the Task Force is requesting of the two Commissioners that its work be continued for another year.

Senate Joint Resolution 196

Medicaid Coverage for Substance Abuse Treatment in Virginia

Executive Summary

Background:

Senate Joint Resolution (SJR) 196 directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Medical Assistance Services (DMAS) to research the feasibility of providing Medicaid coverage for substance abuse treatment in Virginia. The purpose of expanding the Medicaid program would be to obtain federal financial participation for some current programs and services as well as meet future demand for treatment services.

Federal Options:

The Federal Medicaid plan allows states a great degree of flexibility in determining services to be covered under Medicaid. Coverage for substance abuse services is an option allowable under the federal plan that Virginia has not used. In some states, Medicaid has served as a major funding source for substance abuse services.

Current Service Providers/Eligible Population:

In Virginia, substance abuse services for indigent persons are primarily provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services through the Community Services Board system. If the Virginia Medical Assistance Plan was changed to cover substance abuse services, it is estimated that there would be approximately 11,000 to 14,000 potential users of a substance abuse treatment option. Although other eligible groups could be covered, the largest portion of the population to be addressed under a substance abuse services option would be families receiving Aid to Dependent Children, pregnant mothers, the disabled, and the aged.

Potential Coverage:

Medicaid allows coverage for detoxification, psychiatric assessments and psychological testing, ambulatory detoxification, associated medical testing, acute/ intensive stabilization, counseling and pre-vocational counseling. Some existing treatment services being provided by DMHMRSAS through the local community services board system could be covered, with restrictions that address appropriate treatment relative to patient needs and the environment of service delivery, i.e., inpatient, day treatment or outpatient. Other states that have covered substance abuse services under Medicaid have experienced some cost savings by reducing some social services and general health care costs. These potential cost savings would need to be balanced with the potential cost increases tied to increased enrollees and entitlement to services if the state added this option.

Management/Operational Controls:

In order to manage any inclusion of substance abuse treatment, operate the program efficiently and minimize fiscal risks, eligible providers should:

- be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services,
- provide services regardless of ability to pay,
- provide access to 24 hour emergency services, and
- meet all other administrative requirements of the Department of Medical Assistance Services.

A strong utilization review component would be required as a safeguard against unnecessary and/or inappropriate use of Medicaid coverage.

Fiscal Impact:

Using FY 90 community substance abuse services as a base, preliminary estimates are that $7.3 million of the $52 million cost for existing community services could be covered if the Medicaid plan is amended. This includes utilization review costs. Other costs associated with implementation of the proposal are:

- Fiscal/reimbursement costs for the Department of Mental Retardation and Substance Abuse Services and the Community Services Boards and
- systems costs for the Department of Medical Assistance Services.

Medicaid system costs are extimated to be $400,000 for the first year of implementation and would not be a recurring cost. All other administrative costs for all areas involved are expected to be $675,072 annually.

If services costing $7.3 million can receive federal financial participation, the potential state savings would be approximately $3.65 million. However, there is also the very real potential for greatly expanded enrollee use resulting from the entitlement nature of the Medicaid program. It is anticipated that increased Medicaid expenditures during 1990-92 would more than offset the potential savings.

Potential Risks:

Virginia's experience with the federal Medicaid program is that implementation of a substance abuse services Medicaid option would not be risk-free in terms of expenditure growth. The number of Medicaid enrollees potentially in need of substance abuse treatment and care is difficult to project as staff have no experience projecting this particular service need among the current enrollee population. There are also continuing changes in federal legislation and regulations that could significantly impact the future eligible population, service requirements and costs. Finally, the high recidivism rate for persons with severe substance abuse problems may affect future program use and costs.

Conclusion:

The use of Medicaid for community mental health, mental retardation and substance abuse programs is now under review by the Secretary of Health and Human Resources and the Department of Planning and Budget as part of the Governor's 1990-1992 budget process. Medicaid coverage of existing community substance abuse services is an option available to Virginia. Potential short-term savings tied to current community services appear to be more than offset by potential growth in expenditures tied to enrollee use under this entitlement program

Feasibility of Medicaid Coverage for Substance Abuse Services

I. Introduction

Senate Joint Resolution 196, enacted by the 1989 Session of the General Assembly, directed the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services to study the provision of substance abuse treatment services to persons who are eligible for Medicaid in Virginia. The study was to define the population at risk of needing substance abuse services, the services required by this population, and the projected costs of providing the services. (Appendix V)

In Virginia, public substance abuse treatment programs are largely provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the local Community Services Boards and are, likewise, funded by the state and localities.

In some states, Medicaid is major source of funding for substance abuse services. The coverage of substance abuse services under Medicaid is optional for each state according to federal regulations. Should a state decide to include the coverage as a part of its Medical Assistance Plan, all individuals, who meet Medicaid eligibility requirements are entitled to receive all necessary care for treatment of substance abuse. This differs from services offered by state and local agencies because entitlement is not an issue. In states that do not cover substance abuse services under Medicaid, the extent of service is largely determined by the amount of money budgeted for the service.

II. Services Currently Funded by the Department of Mental Health, Mental Retardation and Substance Abuse Services

The Code of Virginia defines "substance" as "both alcoholic beverages and drugs", and "substance abuse" as "the use, without compelling reason, of any substance which results in psychological or physiological dependence as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior." (Sec. 37.1-203.1 & 2). The Core Services Taxonomy III of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services defines three levels of substance abuse:

A. Severe Substance Abuse: Tolerance and withdrawal; or a pattern of pathological substance use in conjunction with significant impairment in social or occupational functioning due to substance use.

B. Moderate Substance Abuse: A pattern of pathological use as indicated by one or more of the following: multiple episodes of a complication of substance intoxication, e.g.,

blackouts, overdose, driving or performing other responsibilities while intoxicated, use of illegal substances; intoxication throughout the day; inability to reduce use; need for daily use for adequate functioning; impairment in meeting social/familial obligations; deterioration in occupational functioning; erratic and impulsive behavior; and legal difficulties. Duration; at least one month; however, signs need not be present continuously throughout the month but frequent enough to illustrate a pattern, e.g., binges.

C. Mild Substance Abuse: Substance use involving intoxification associated with isolated episodes of less severe complications, e.g., driving or performing other responsibilities while intoxicated, or use of illegal substances.

Services currently funded by the Department of Mental Health, Mental Retardation and Substance Abuse Services are outlined in a taxonomy of services used for performance contracting with and reporting by the local Community Services Boards. In substance abuse, these include the core services of outpatient, case management, day support, residential, emergency, inpatient, and prevention/early intervention along with appropriate subcategories. Of these major substance abuse services, only inpatient services are covered to a very limited extent by the current State Medicaid plan.

III. Potential Medicaid Services and Criteria

The Virginia State Plan for Medical Assistance Services could be amended to include services in the Inpatient, Residential and Day Treatment environments for clients who meet treatment admission criteria.

A. DEFINITIONS OF TREATMENT ENVIRONMENTS

(1) **Inpatient** programs are hospital-based, and are generally not utilized for more than fourteen (14) days per incident (to be extended to twenty-one (21) days with proper documentation) for the delivery of services pertinent to substance abuse. Medicaid coverage is available for 14 and up to 21 days of inpatient care only if 60 days has lapsed since a prior admission of 14 to 21 utilized Medicaid days.

Need for medical and/or psychiatric stabilization is the principle criterion for treatment in an inpatient setting. An inpatient setting would include the hospital-based medical detoxification program, which provides services in a hospital under the direction of a physician and hospital staff and is designed to monitor and control medical complications and other disorders which may be associated with withdrawal.

Also included in this category of treatment setting is the "inpatient substance abuse facility", which is an organizational unit established to provide effective intervention in a hospital or state institutional setting for substance abuse treatment by providing detoxification and by treating medical and psychiatric complications of substance abuse through an

organized medical and professional staff, with continuous nursing service at the hospital level of care. Admission to this environment should be limited to those persons diagnosed as exhibiting severe substance abusing behavior.

It is therapeutically appropriate for most services to be provided in non-hospital settings. Therefore, inpatient Medicaid coverage eligibility, as described earlier, could be limited to complex medical and/or psychiatric and/or substance abuse clients. Examples would include medical detoxification treatment along with psychiatric complications or acute exacerbation of medical and/or psychiatric problems related to chemical dependence such as cardiomyopathy, hepatitis or depression.

Potential Criteria for admission to an inpatient unit include:

a. Failure to make progress in less intense levels of care

b. High risk chemical withdrawal which, without medical attention, might lead to complications such as seizures or delirium tremens.

c. High tolerance to one or multiple substances.

d. Acute exacerbation of medical and/or psychiatric problems related to chemical dependence, such as cardiomyopathy, hepatitis, or depression.

e. Concomitant medical and/or psychiatric problem(s) which could complicate treatment, such as diabetes, bipolar disorder or hypertension.

f. Severely impaired social, familial or occupational functioning.

(2) **Day Support** programs provide a planned program of treatment interventions generally for more than three consecutive hours, several times per week, to groups of substance abusing persons. Such a program may include the detoxification, treatment or rehabilitation of persons addicted to drugs through the use of the controlled drug methadone. The interventions are provided in a nonresidential setting and focus on treatment of pathological conditions or training and strengthening client abilities to deal with everyday life.

This environment includes, but is not limited to, day treatment/partial hospitalization and psychosocial rehabilitation programs. For Medicaid purposes only, sheltered employment or work activity programs, supported or transitional employment programs, alternative day support arrangements, education programs and recreational programs are typically excluded from this category.

Admission to this environment should be limited to those persons diagnosed as exhibiting moderate to mild substance abusing behavior and meeting the following criteria:

a. Does not require twenty-four (24) hour medically supervised chemical withdrawal.

b. Psychiatrically and/or medically stable.

c. Interpersonal and daily living skills are sufficiently developed to permit a satisfactory level of functioning in a nonresidential setting.

d. Not in need of intensive psychiatric care.

e. Free of drugs which alter the state of consciousness other than prescribed medication approved by the program.

f. Requires daily support rather than weekly or biweekly sessions.

g. Has a social system; i.e., family friends and/or employment, which is capable of providing support.

(3) **Outpatient** programs provide a variety of clinical interventions generally for less than three hours duration per day, including ambulatory detoxification or maintenance through the use of methadone. Services are provided in a nonresidential setting for individuals or groups.

Services housed in an outpatient setting, (e.g. psychological testing, pre-vocational rehabilitation counseling) may be utilized by clients receiving services in other environments. Clients may utilize these services in some combination for several years. The nature of substance abuse indicates that extended involvement with an outpatient program following inpatient or residential treatment is critical to successful recovery.

Admission to this environment should be limited to those persons diagnosed as exhibiting moderate to mild substance abusing behavior and meeting the following criteria:

a. Capable of functioning autonomously in present social environment.

b. Psychiatrically and/or medical problems are stable.

c. Has sufficient capacity to function in individual, group and/or family therapy sessions.

d. Does not require twenty-four (24) hour medically supervised chemical withdrawal.

e. Willing to work towards goal of abstinence from harmful drug use.

B. Generic Definitions for a Medicaid Reimbursable Services

The same specific services are often provided in all four settings, varying in intensity appropriate to the needs of the

client. These definitions are purposefully broad, recognizing that many combinations of useful services are necessary in a successful substance abuse treatment program.

(1) **Evaluation and assessment** is the initial procedure of intake into a treatment system, and must include an assessment of the client's physical and mental health, degree of physical and psychological dependence, and social support system. Included in this process is an evaluation by a physician to establish a diagnosis of substance abuse.

(2) **Psychological evaluation** is the administration of various test instruments to determine the level of psychological or intellectual functioning.

(3) **Psychiatric evaluation** is the evaluation of a client by a professional licensed in this area.

(4) **Detoxification** is the safe management of withdrawal from alcohol and other drugs under the supervision of trained health professionals. Services include medical screening and evaluation, basic laboratory analysis, physical exams and chemotherapy, as ordered by a physician. Emergency medical referrals are made as necessary. Case management including referral to further residential or outpatient treatment is available.

(5) **Acute intensive stabilization** is the management of medical or psychiatric difficulties associated with alcohol or other drug abuse, such as delirium tremens or drug induced psychosis provided in an inpatient setting.

(6) **Rehabilitation** means assistance provided for an individual with a disability to return to his fullest potential in occupational, social and psychological life by reducing the residual effects of his disability. It includes counselling, otherwise informing the client of the results of substance abuse and of methods which reduce the likelihood that the client will abuse substances again. Rehabilitation services include:

Individual counselling

Group counselling, not to exceed 7 clients per facilitator

Concerned Person (family) unit counselling, to provide group collateral counselling to those persons who are legally related to the client or who reside with the client. In the case of inpatient or residential treatment, the concerned person is the source of primary social support immediately prior to admission.

Concerned Person individual counselling, to provide individual collateral counseling to those persons who are legally related to the client or who reside with the client. In the case of inpatient or residential treatment, the concerned person is the source of primary social support immediately prior to admission.

(7) **Case management** is identification of and outreach to clients to assure continuity of care by assessing, planning with, advocating for, monitoring and linking clients to appropriate services in response to their changing needs.

(8) **Crisis management** is unscheduled intervention, including evaluation and assessment, and case management.

(9) **Pre-Vocational Counselling** is the assessment of vocational skills and aptitudes, combined with counseling to assist attainment of vocational/educational capability.

Placement of a client in one treatment environment does not restrict the client from receiving services available in other environments. For instance, a client in residential treatment might receive services, such as psychological testing or specialized individual counselling, which might be located in another environment (e.g., outpatient).

A plan of care would be established for each recipient, addressing the diagnosis(es) identified by the physician, the necessary substance abuse services, the treatment goals and the timetable for treatment. The development and updating of the Plan would be the case manager's responsibility.

IV. Medicaid Population

The following listing represents some of the major categories of persons eligible for Medicaid:

--Recipients of Aid to Families with Dependent Children (ADC)
--Pregnant women who meet ADC income and resource guidelines
--Pregnant women with incomes up to 100% of the poverty level
--Children under 21 in foster care
--Children under 14 with one parent who is absent or disabled
--Recipients of SSI subject to income and resource limits
--Persons who are 65 or older, are blind or disabled, subject to income and resource limits.

Eligibility for Medicaid includes large numbers of pregnant women and children. Therefore, indigent women who abuse substances and their children are the population who would benefit the most from inclusion of substance abuse treatment for Medicaid coverage. Coverage for pregnant addicts, the newborn children of these women, and other children living with these mothers would increase resources available to treat these persons.

V. DURATION OF COVERED SERVICES

Federal Medicaid regulations indicate that covered services services should be sufficient in duration and scope to reasonably approximate the need for successful treatment of a given illness. Table I (Apendix I) is a matrix that identifies specific services within each major environment, and limits of covered services that could be part of an amended Virginia plan.

VI. QUALIFIED PROVIDERS

Providers that meet the following criteria would be enrolled by the Department of Medical Assistance Services.

A. licensed and certified under regulations promulgated by DMHMRSAS;

B. guaranteed client access to emergency services on a 24-hour basis;

C. demonstrated service to all in need, regardless of ability to pay or eligibility for Medicaid or reimbursement;

D. an administrative capacity to ensure quality of services in accordance with state and federal requirements;

E. a financial management capacity and system that provides documentation of services and costs;

F. capacity to document and maintain individual case records in accordance with state and federal requirements;

G. capacity to provide services, directly or under contracts for mental health, substance abuse or mental retardation services as may be required for individuals needing these services.

H. completion of a provider participation agreement with the Department of Medical Assistance Services.

The Commonwealth of Virginia does not now require licensing or certification of health care professionals who would provide the proposed covered services. The State Board of DMHMRSAS and the Virginia Association of Community Services Boards are, however, engaged in a process to develop and implement statewide policies for credentialing of health care professionals who provide services through DMHMRSAS.

Under the new policy, all services provided through these agencies would be delivered by health care professionals who are licensed or certified in accordance with requirements set forth in the Code of Virginia pertaining to psychiatrists, psychologists, social workers, nurses, licensed professional counselors and certified substance abuse counselors who are directly supervised by a licensed or certified health care professional representing one of the above disciplines.

Under Medicaid covered services, recipients have a "free choice" of providers so long as the provider is enrolled with the Medicaid program.

VII. UTILIZATION REVIEW

If a decision is made to cover substance abuse services under Virginia's State Plan for Medical Assistance Services, a

statewide utilization review system must be developed and implemented by means of an agreement between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Medical Assistance Services.

Utilization review is essential to guard against unnecessary and inappropriate use of Medicaid covered services, prevent excess payments, and to facilitate an assessment of the quality of services provided.

Federal regulations detail the requirements of state utilization review processes. Each state must:

1. Implement a statewide community mental health services surveillance and utilization control program that:

a) safeguards against unnecessary or inappropriate use of community substance abuse services and against excess payments;

b) assesses the quality of community substance abuse services;

c) provides for control of utilization of Medicaid services. (CFR 456.3)

2. Establish and use written criteria for evaluating appropriateness and quality of community mental health services. (CFR 456.5)

3. Establish a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services. (CFR 456.6)

4. Provide for the ongoing evaluation of the need for, and timeliness of, community substance abuse services on a sample basis. (CFR 456.22)

5. Design and conduct a post-payment review process that allows state personnel to develop and review the following: recipient utilization profiles, provider service profiles, and exceptions criteria. The review process would focus on quality assurance issues. The process must identify exceptions so the state agency can correct inappropriate utilization on the part of either recipients or providers. (CFR 456.23)

It is expected that Virginia's substance abuse program utilization review would:

1. Conduct pre-payment authorization and/or post payment review to determine appropriateness of services;

2. Provide audits of pre-payment treatment plans and review client in treatment to determine appropriateness for remaining in that service;

3. Monitor and audit community services boards internal utilization review procedures; and,

COMMUNITY SERVICES BOARD ADMINISTRATIVE COST

If Medicaid coverage for Substance Abuse Services becomes an option, additional administrative requirements must be addressed. These requirements may vary depending on existing capabilities of an individual Board. Functions that would be added include cost accounting and cost reporting, billing claims not previously submitted on behalf of the Substance Abuse client and/or data entry functions if the Board has automated billing capabilities. These anticipated costs amount to approximately 3% of the total Medicaid covered services or $338,333.00.

DMHMRSAS COST

In the section regarding Utilization Review, the functions of the UR coordinator were outlined. The process would require DMHMRSAS Central Office staff under agreement with the Department of Medical Assistance Services to perform utilization review functions. The manager for these positions would be located in Richmond with the utilization review coordinators placed in the localities, preferably in existing satellite offices. It is estimated that the utilization review needs would require one manager and six to nine utilization review coordinators. Table III (Appendix III) reflects the salary and benefits costs for these positions along with other operational costs. These costs are reimbursable by Medicaid at the same ratio as provided services.

To promote the most effective and appropriate use of available services and facilities, DMHMRSAS must have procedures for the on-going evaluation of the need for and the quality and timeliness of Medicaid Services. Utilization Review Cost will amount to $497,132 or $248,566 in annual State general fund dollars.

In addition to utilization review costs, Central Office Fiscal and Reimbursment staff needs will include one accounting manager and one support staff which will cost $104,739.00 annually. The total Central Office Administrative Cost for DMHMRSAS inclusive of Utilization Review and Fiscal/Reimbursement is expected to be $353,305 in annual state general fund dollars.

DMAS SYSTEM COST

Due to the addition of a new service, the Department of Medical Assistance Services will require automated system changes. These will amount to $400,000. The system cost represents one-time software changes.

Table IV (Appendix IV) summarizes all administrative costs required to implement substance abuse service coverage by Medicaid.

4. Provide technical assistance to community services boards through site visits.

Virginia's utilization review activities would be coordinated where feasible, with existing Substance Abuse quality assurance, management information system, and evaluation activities.

VIII. Cost Analysis of Medicaid Covered Services

The process of drawing down federal Medicaid funds requires the state to provide "match" money that equals the amount of federal funds. If Virginia opts to add substance abuse coverage to its Medicaid Plan, a portion of existing funding for services now being provided by the local Community Services Boards could be used as the state matching funds.

A cost analysis examines four areas:

- Direct Service Cost;
- CSB Administrative Cost; and,
- DMHMRSAS Administrative Cost.
- DMAS Systems Cost

Direct Service Cost

Table II (Appendix II) identifies major categories of potential substance abuse services as defined by the Core Taxonomy of Services used by the DMHMRSAS and the Community Boards.

- The base for calculations is financial data obtained from Fiscal Year 1990 budgets and performance contracts between DMHMRSAS and the Community Services Boards.

- The Department's analysis of current populations likely to be eligible for certain Medicaid covered services was calculated against the 1990 base to determine potential Medicaid coverage and costs for Fiscal Year 1991 and 1992.

- The total cost of potential Medicaid coverage would be $7.3 million beginning January 1, 1991, inclusive of inclusive of utilization review costs.

- Payment for the services would be on a fee for service basis.

- Approximately 11,000 - 14,000 persons would be eligible for Medicaid services.

As federal financial participation would be available for 50% of costs, there is a potential savings of $3.65 million. However, these savings must be compared with the potential increased costs that are likely to occur as current Medicaid enrollees are identified as needing substance abuse treatment.

Short term potential general fund savings are likely to be more than offset by future increases in general fund costs as the number of enrollees and demand for services increases.

IX. SUMMARY

It is possible to amend Virginia's Medicaid plan to add substance abuse treatment. It is projected that Medicaid revenues under this proposal are $7,333,500 for F.Y. 90-92. Since participation in the Medicaid plan requires states to match federal dollars, half of this amount or $3.65 million in general fund money would be required. The $3.65 million in services are amounts expended within the scope of existing Substance Abuse Services programs. However, these cost savings are expected to be more than offset by potential program use and growth.

The Secretary of Health and Human Resources and Department of Planning and Budget are now reviewing Medicaid's potential for community mental health, mental retardation and substance abuse services as part of the 1990-92 biennium budget process. The potential coverage of substance abuse treatment services by Medicaid is a complex issue with significant potential fiscal impact on the Commonwealth.

TABLE

POTENTIAL SCOPE OF SUBSTANCE ABUSE SERVICES

Service	Environments: Inpatient	Day Support	Outpatient
Case Management	As needed	As needed	
Evaluation and assessment	1 initial and 2 follow-up per year	1 initial and 2 follow-up per year	
Psychiatric assessment	2 initial and 2 follow-up per year	2 initial and 2 follow-up per year	
Psychological testing	One administration per year. Includes testing for intellectual functioning, neuropsychological functioning, and personality.	Two administrations per year. Includes testing for intellectual functioning, neuropsychological functioning, and personality.	
Acute/intensive stabilization (includes administration & management of medication)	14 days per incident, up to 21 with documentation.		
Medical detoxification (includes administration & management of medication)	14 days per incident, up to 21 with documentation.	1 hr/day, 7 days/wk (e.g., methadone)	1 hr/day, 7 days/wk (e.g., methadone)
Ambulatory detoxification		1 hr/day, 7 days/wk	1 hr/day, 7 days/wk
Social detoxification		1 hr/day, 7 days/wk	
Associated medical testing (i.e., EKG, EEG, blood tests, urinalysis, drug screen, breathalyzer, etc.)	As needed	As needed	
Rehabilitation			
Individual counseling	60 min/day, 7 days/wk	60 min/day, 7 days/wk	60 min/day, 7 days/wk (for methadone clients only)
Group counseling	3 hrs/day, 6 days/wk (maximum 7 clients per group facilitator)	3 hrs/day, 5 days/wk (maximum 7 clients per group facilitator)	
Concerned Person unit counseling	3 hrs/wk	3 hrs/wk	
Concerned Person individual counseling	3 hrs/wk	1 hr/wk	
Crisis management	3 hrs/admission	3 hrs/admission	
Pre-vocational counseling		5 hrs/wk	

Client needs will be established by utilization review.
These components are representative and may not be required.

Task Force Studying Mandated Insurance Coverage for Treatment of Substance Abuse pursuant to Senate Joint Resolution 169, 1989

Background Information

In the Commonwealth of Virginia, mandated coverage for inpatient substance abuse treatment has been the law for over ten years. There has been no provision for ambulatory services, however, other than the "mandated option." Consequently, a number of large corporations and businesses have elected to supplement their thirty-day inpatient coverage with variable amounts of outpatient coverage in order to provide their employees with a more comprehensive benefits package. At the same time, many businesses concerned with the rising costs of health care have opted not to purchase such additional coverage. Similarly, many individual subscribers have elected to forego this additional expense. What this means is that for a number of our citizens, treatment for addiction is limited to that which is rendered in the most costly and intensive setting there is, namely the hospital. The reality, however, is that many persons with addiction problems do not need to be admitted to the hospital and, in fact, can be treated quite effectively on an ambulatory basis.

Current Status of the Substance Abuse Treatment Delivery System

In the past few years, our experience in treating addictive disorders has grown and alternative levels of care have been developed. Treatment environments and modalities have become more varied and sophisticated with a greater attention being paid to individual need. In addition to the traditional 28-or 30-day inpatient model, we now have available day treatment, evening, weekend, after-school, and after-work programs, and a full range of a la carte outpatient services including individual, group, and family therapy. More recently still, a number of public and private clinics and individual practitioners have undertaken outpatient withdrawal from chemicals as well as provision of services to numerous special populations of drug abusers such as those who are seriously mentally ill, pregnant, or physically debilitated. Clearly, in the face of such expansion in the treatment delivery system, we must modify our statutes so that these treatment alternatives can be made available to subscribers. That is, we need to proceed with the important task of matching patients to treatments in the most clinically appropriate and cost effective way.

Context for the Task Force's Recommendations

The key to appropriate management of addictive disorders is to provide a "continuum of care" which ranges from very restrictive acute hospital service to nonrestrictive outpatient services. Patients should be able to be matched to treatment options based on their medical and psychiatric status as opposed to the limitations of their insurance. At the same time, it is critical that we look at issues of cost containment and that any revision of the current statutes be as "cost neutral" as possible. It is understood that to merely expand the mandate to include other levels of care would substantially increase health care costs to subscribers. In relation to

this important issue of promoting access to a full continuum of care and the related issue of making the current mandated coverage for substance abuse treatment more flexible, the task force has assumed the following role: first, identification of the various levels of care; second, definition of these levels in such a way as to provide consistency in terminology across providers, programs, and third party payors; and third, development of guidelines to be utilized in appropriately matching patients to treatment options.

There are a number of other related issues which have occupied the task force's thoughts and discussions and which need to be shared with the joint subcommittee. First, having only one level of care has, in the past, led to many patients being needlessly assigned to hospital-based treatment. Although having statutes which provide support for a full continuum of care is critical and should lessen the occurrence of inappropriate patient assignment, there still remain issues of clinical practice to be addressed. The task force feels that it is essential that a comprehensive assessment be done prior to assignment to any level of care and that the findings of this assessment should parallel the admission criteria for that level of care. The assessment should consist of three components - medical, psychiatric, and substance abuse. Each component of the assessment should be performed by a professional licensed or certified in that field. Standards for such evaluations should be uniform throughout the state in both the public and private domains. The objectives of this assessment are to (i) determine the need for services, (ii) triage the patient to the most appropriate service delivery system (e.g., chemical dependency unit, emergency room, or psychiatric unit), and (iii) ascertain the level of care within the substance abuse treatment system which is most appropriate given that the patient is deemed a candidate for services.

The task force also wishes to make a statement regarding foreseeable problems in terms of a patient's movement from one level of care to another. The task force perceives that wide gaps now exist in many programs' service delivery systems. That is, they offer some, but not all, levels of care. Since failure to have available a full continuum of care leads to admitting and/or holding patients at an inappropriate® level, programs should provide all levels of care either on an in-house basis or through a formal contractual arrangement.

A further point has to do with the amount of treatment which is deemed, by most clinicians on the task force, to provide an adequate basis for continuing sobriety. Most treatment agencies, as well as third party payors, are well aware of the very high relapse rate associated with incomplete treatment (leaving treatment against medical advice (AMA)), insufficient, or incorrect treatment. Premature termination of treatment is not cost effective since it frequently leads to repeated treatment efforts. Also, heavy substance use during periods of relapse often necessitates admission to a more intensive and more costly level of care. We therefore would like to make a statement regarding our belief in the concept of a minimal year of continuous care with that treatment being provided in the most appropriate setting given the patient's changing stat6us. While, at first glance, this may appear suggestive of a dramatic expansion of the mandate, this is, in fact, not believed to be so. Indeed, mock-up figures suggest that, with the capacity to convert inpatient days to coverage at alternative levels of care, most systems should be able to provide nearly a year of coverage at the appropriate level in lieu of a thirty-day inpatient stay.

One final point for consideration relates to the need for coverage for treatment of family members when it is an adolescent who is the identified patient. We know that treatment of adolescents is generally ineffective unless the family is treated simultaneously. When the family is neglected in the treatment process, this often leads to repeated

efforts at more intensive levels of care for the child. Thus, treating the family is viewed as a cost effective measure despite initial cost outlay. With these facts in mind, we believe that coverage should be extended to include family therapy, multi-family therapy and family education to the significant others of a child in treatment regardless of whether these family members have diagnosable psychiatric illness themselves.

The Treatment Environment

With all of these caveats in mind, we would like to set forth the recommended schema for the substance abuse treatment delivery system. The task force has, at this time, settled on a three-tier level of care system. These levels take into consideration several dimensions including physical setting, staffing patterns, range of services and format of their delivery. The INPATIENT level of care is comprised of all chemical dependency treatment where the patient stays overnight. The 24-hour environment is thus a defining feature. This level include both hospital-based and free-standing facilities. the term "residential" has been dropped since this has a very different meaning in the current state classification system and the proposed Medicaid scheme.

The second level of care is identified as DAY SUPPORT/INTENSIVE OUTPATIENT. Again, other terms previously utilized, including "intermediate care" and "partial hospitalization" are being eliminated since they carry connotations different from our intent. This level of care is defined by the fact that there is a clearly identifiable treatment program with a curriculum, a therapeutic milieu, and programmatic ground rules. Multiple services are provided on multiple days of the week for a minimum of several hours at a time. The staff is multidisciplinary.

The third and least restrictive level of care is traditional OUTPATIENT services. These are basically a collection of individual provider services including individual, group, and family treatment as well as complimentary addiction-related medical services.

As part of the levels of care concept, the task force has recognized that, while most, if not all, chemical dependency programs have psychotherapeutic and psychoeducational components, few have substantial medical and psychiatric components. It is therefore proposed that both inpatient and day support/intensive outpatient programs further be delineated as either ACUTE or NONACUTE based on their capacity to diagnose and treat complicated medical and psychiatric conditions. Using this rationale, whether or not a program is designated acute or nonacute has no direct relationship to setting but rather is determined by the specific services provided, the program's staffing, and its overall structure.

Definitions of the Treatment Environment

Inpatient

The most intensive level of care will be termed "inpatient." Inpatient treatment is easily identified by the fact that the patient spends the night. Two types of inpatient programs are identified, acute and nonacute.

Acute inpatient programs maybe housed in hospitals or in freestanding facilities. They have, as their main intent, diagnosis and medical and psychiatric stabilization. Length of stay is variable depending on individual patient need. Acute inpatient programs manage high risk chemical withdrawal and have the capacity to monitor patients very closely. Such programs are designed to identify and treat concomitant chronic conditions as well as acute exacerbations of medical and psychiatric problems related to chemical dependence.

Nonacute inpatient programs may provide chemical withdrawal but with less close supervision required. If the patient has serious psychiatric or medical problems, these would be relatively stable though still would require frequent monitoring. Impairment of social, familial or occupational functioning would be the prerequisite necessitating the patient's removal from the environment as would his or her failure to have made progress at a less intense level of care. At the nonacute level, a person's interpersonal and daily living skills should be sufficiently developed as to permit a satisfactory level of functioning in a therapeutic milieu.

Day Support/Intensive Outpatient

The second level of care, which we have termed "day support/intensive outpatient" is an intermediate level of care which is best defined by the fact that it has a structured program with a curriculum and an identifiable milieu. Treatment is provided by a multidisciplinary staff. Frequently, services provided at this level of care are similar, if not identical, top those provided in a nonacute inpatient program though rendered on an ambulatory basis. Patients need frequent monitoring but do not require 24-hour supervision. Patients deemed appropriate for this level of care include those whose medical and psychiatric problems are relatively stable, who have interpersonal and daily living skills which are sufficiently developed to permit a satisfactory level of functioning in a milieu-oriented program, and who have an adequate community-based support system. Patients should be free of harmful drugs and on no psychoactive medications other than those prescribed and/or approved by the program's physicians.

The acute dimension of the day support/intensive outpatient level of care is identical to the nonacute level in psychosocial services but also includes a full medical component potentially offering the following services: outpatient chemical withdrawal, management of psychoactive medications, history and physical and laboratory studies.

Outpatient

The least restrictive level of care is identified as "outpatient" and includes the traditional a la carte services such as individual, group and family therapy. Patients admitted to this level of care should be able to function relatively autonomously in their present social environment with a minimum amount of therapeutic support. Their medical and psychiatric problems should be relatively stable and they should have sufficient capacity to function in whatever treatment modality is prescribed.

RECOMMENDATIONS

The following are specific recommendations made by a majority of the membership of the task force studying revision of the thirty-day inpatient insurance mandate currently provided in the Commonwealth. The membership of the task force was in general agreement about the recommendations in principle, but differed slightly in the specific implementation of such recommendations.

The task force recommends that:

1. **A mechanism be established to allow for conversion of the current 30-day mandated inpatient insurance coverage for the treatment of substance abuse to cover other identified levels of care.** After considering a variety of models to accomplish such a conversion, the task force has decided to promote a ratio-based conversion which is anchored in our experience with costs and charges associated with the three levels of care to date. We feel that this represents a fairly uncontaminated situation since these programs have not, until now, be covered by the mandate and thus do not reflect a situation where treatment costs have been "driven" by the allowable limits. The recommended conversion rate is 1:3 inpatient to day support/intensive outpatient and 1:6 inpatient to outpatient. The mandated 30-day inpatient coverage would be convertible at the option of the provider and the subscriber.

2. **Deductibles and co-payments be the same in any category as for any other physical impairment.**

3. **Fourteen days of inpatient time be "carved out" of the 30-day mandate and preserved for acute management.** In this way, short-term hospitalization will remain an option for those who fail to made adequate progress at less intensive levels of care.

4. **The $80 indemnity clause be stricken from the statutes as this figure was based on rates more than ten years old and is presently disregarded.**

5. **The $1000 minimum which currently applies to the mandatory outpatient option be increased to a minimum of $2000.** The rationale for this evolves from our experience with inflation over the past decade.

6. **The mandated "option" for outpatient care be maintained as a means of upgrading coverage.** While inpatient days are available for conversion to ambulatory treatment, retaining the mandated option for outpatient services allows companies and individuals to supplement their coverage. In the event and individual needs to utilize the substance abuse benefit, the purchase of the optional outpatient coverage would allow for preservation of the mandated coverage.

Blue Cross
Blue Shield
of Virginia

Joan M. Gardner
Government Affairs Counsel

2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279
804/359-7288

November 17, 1989

Members of the Substance Abuse Insurance Task Force
SJR 169 Joint Subcommittee
Studying Mandated Substance Abuse Treatment and Prevention Programs

Blue Cross and Blue Shield of Virginia is proposing, for the consideration of the Task Force, the attached revision to Section 38.2-3412 of the Insurance Code of Virginia. The following notes also should be taken into consideration when assessing the attached revised statue for recommendation to the SJR 169 Joint Subcommittee:

- In order to best meet the desired results of the SJR 169 Task Force, any statutory changes should be made in conjunction with the Psychiatric mandate; consequently, all revisions are made to Section 38.2-3412 with the understanding that Section 38.2-3413 be omitted.

- The inpatient acute care benefit is revised to include intensive outpatient treatment but without extending that coverage to traditional outpatient services.

    - With the possible exception of the HMO situation, utilization of outpatient services is extremely difficult and costly to monitor, and currently cannot be done, except on an retroactive basis, by traditional commercial insurers.

    - The extent of current inpatient psychiatric expense is based on an approximate 16 day inpatient average stay. In attempting to equate uncontrollable outpatient costs with the full 30 day coverage allowed, a dramatic increase in costs would be assured.

- Although a conversion ratio of 1-3 for inpatient care to intensive outpatient care is included in the statute, due to the wide variance in inpatient charges among facilities across the state which prohibits the establishment of a conversion ratio with any reliability, provision was made for the use of any other cost equivalent ratios in an attempt to confirm that benefit costs would not increase on the account of an expansion of treatment settings.

- Paragraph B of Section 38.2-3412 is to be retained in its entirety, including the $1,000 minimum requirement.

  - Outpatient coverage is a standard benefit in our community-rated business segment (groups of 2 to 49 employees). Over 60% of those contracts include the $1,000 benefit. While the other 40% include a $2,000 benefit, the trend is for adjusting that benefit down to $1,000 due to the cost.

  - While the cost for that $1,000-$2,000 adjustment may be just slightly less than 1%, that calculation is based on the fact that the benefit is included in all such contracts. If, for these community groups, we decided to offer the benefit as an option, the expense associated with a $1,000 change in the benefit would be much more dramatic.

  - The vast majority of larger groups have chosen to include outpatient services in their health benefit program. However, fewer employers would choose that option if the minimum benefit and the related premium increment, was increased.

- Paragraphs C and D of Section 38.2-3412 would be retained, however, paragraph D would require some modification, such as the addition of a definition for "intensive outpatient treatment," and other similar clarifying statements.

- Due to the addition of alcohol and drug dependence in the major heading of 38.2-3412 and the omission of Section 38.2-3413, paragraph E would be deleted.

I am sure there will be many other comments concerning this recommendation and its rationale during the course of our final Task Force meeting.

Respectfully submitted,

Joan M. Gardner

JMG:bb
Attachment

Section 38.2-34.12. Coverages for mental, emotional or nervous disorders and alcohol or drug dependence.

A. Each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall in the case of benefits based upon treatment as an inpatient in a licensed mental hospital or a general hospital or licensed drug or alcohol rehabilitation facility, provide coverage for mental, emotional or nervous disorders and alcohol or drug dependence. The limits of the benefits shall not be more restrictive than for any other illness except that the benefits may be limited to thirty days of active treatment in any policy year. The thirty days of acute inpatient care specified in this section may include intensive outpatient treatment at a licensed mental health treatment center or alcohol or drug rehabilitation facility on a ratio of 1 acute inpatient day equating to 3 intensive outpatient treatment sessions, or on any other cost equivalent ratio, such that the benefit cost of intensive outpatient treatment does not exceed the benefit cost of acute inpatient care ~~for mental, emotional or nervous disorders shall include benefits for drug and alcohol rehabilitation and treatment necessary to restore any covered~~

~~person-to-satisfactory-emotional-and-physical-health,-whether-the-care-is provided-in-a-mental-or-general-hospital-or-other licensed-drug-and-alcohol-rehabilitation-facility.--However,-with-respect only-to-the-benefits-for-alcohol-and-drug-rehabilitation:-(i)-the-level-of coverage-available-may-be-different-from-the-coverage-that-is-payable-for-the treatment-of-other-mental,-emotional-and-nervous-disorders-if-the-benefits cover-the-reasonable-cost-of-necessary-services,-or-provide-an-eighty-dollar per-say-indemnity-benefit,-and-(ii)-the-benefits-may-be-limited-to-ninety days-of-active-inpatient-treatment-in-the-covered-person's-lifetime.~~

The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment is made.

B. Each insurer proposing to issue a group hospital policy or a group major medical policy in this Commonwealth and each corporation proposing to issue hospital, medical or major medical subscription contracts shall, in the case of outpatient benefits, make additional benefits available for the care and treatment of mental, emotional or nervous disorders subject to the right of the applicant for the policy or contract to select any alternative level of benefits that may be offered by the insurer or corporation. The additional outpatient benefits to be made available shall consist of durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. However, the coinsurance factor need not exceed fifty percent or the coinsurance factor applicable for physical illness generally, whichever is less. The maximum benefit for mental, emotional or nervous disorders in the aggregate during any applicable benefit period may be limited to no less than $1,000.

C. Subsection B shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. As used in this section:

"Outpatient benefits" means only those payable for (i) charges made by a hospital for the necessary care and treatment of mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, (ii) charges for services rendered or prescribed by a physician, psychologist or clinical social worker licensed to practice in this Commonwealth for the necessary care and treatment for mental, emotional or nervous disorders furnished to a covered person while not confined as a hospital inpatient, or (iii) charges made by a mental health treatment center, as defined herein, for the necessary care and treatment of a covered person provided in the treatment center.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician or a psychologist licensed to practice in this Commonwealth. The facility shall be: (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

E. *"Mental, emotional or nervous disorders"* as used in this section shall include physiological and psychological dependence upon alcohol and drugs. However, if the optional coverage made available pursuant to § 38.2-3413 is accepted by or on behalf of the insured or subscriber and included in a policy or contract, "mental, emotional or nervous disorders" shall not include coverage for incapacitation by, or physiological or psychological dependence upon, alcohol or drugs. (1976, c. 355, § 38.1-348.7; 1977, cc. 603, 606; 1978, c. 869; 1979, cc. 13, 399; 1986, c. 562.)

Appendix I

COMMONWEALTH OF VIRGINIA

DUDLEY J. EMICK, JR.
22ND SENATORIAL DISTRICT
ALLEGHANY, BATH AND BOTETOURT
WESTERN PART OF ROANOKE COUNTY;
CITIES OF CLIFTON FORGE,
COVINGTON AND SALEM
P.O. BOX 158
FINCASTLE, VIRGINIA 24090

COMMITTEE ASSIGNMENTS:
REHABILITATION AND SOCIAL SERVICES, CHAIRMAN
COURTS OF JUSTICE
FINANCE
TRANSPORTATION
RULES

SENATE

March 7, 1990

Ms. E. Gayle Nowell
Research Associate
Division of Legislative Services
General Assembly Building, 2nd Floor

Dear Gayle:

I would appreciate the following being added as my comments with regard to Senate Joint Resolution No. 169:

Virginia should be a leader in clearly distinguishing between the various forms of substance abuse. The term "substance abuse" is used disingenuously by a variety of publi and private agencies to obtain moneys for their use.

Alcohol is tolerated by our society, advertised in our society and used without addiction by a clear-cut majority of American citizens. Marijuana is an illegal substance used by a substantial number of citizens under the age of thirty-five without addiction. Cocaine and heroin are clearly in a different category and funds for use in control, regulation and education should be used in an entirely different manner than for alcohol and marijuana.

Until this state policy changes, then, with regard to the use of the generic term "substance abuse," immense amounts of moneys will continue to be wasted in programs that have no or little social benefit.

Sincerely,

Dudley J. Emick, Jr.

DJE,Jr.:dl

June 1, 1990

Ms. E. Gayle Nowell
Research Associate
Division of Legislative Services
General Assembly Building, 2nd Floor
Richmond, VA 23219

Dear Gayle:

I agree with the comments of Senator Emick, Chairman of the Rehabilitation and Social Services Committee, relating to problems with the inclusion of alcohol abuse with use and abuse of illegal substances.

It is my feeling that programs should target specific illegal substances if any significant positive impact is to be expected.

Sincerely,

Kevin G. Miller

/mam

1990 SESSION

LD4106128

SENATE JOINT RESOLUTION NO. 23

Offered January 17, 1990

Continuing the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs.

Patrons–Lambert and Miller, K.G.; Delegates: Hall, Thomas and Hamilton

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Referred to the Committee on Rules

WHEREAS, the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs was originally created in 1987 by SJR 171 and continued in 1988 (SJR 65) and 1989 (SJR 169); and

WHEREAS, the joint subcommittee has instigated and witnessed many changes in the approach to and implementation of better treatment and prevention efforts for substance abuse; and

WHEREAS, among these changes are the annual reports by the Department of Mental Health, Mental Retardation and Substance Abuse Services on the activities during the past year with regard to the provision of substance abuse services, the development of an interagency plan for treatment and prevention services which provides coordination between all state agencies involved in the treatment and prevention process, development of additional research capacity to provide data and insight into the cause of substance abuse and appropriate treatment of clients, and prevention efforts which include the endorsement and passage of an "abuse and lose" statute to provide the state with a meaningful method of discouraging young persons from abusing substances of any form; and

WHEREAS, in addition, issues of third party pay for substance abuse treatment, both public and private, have been investigated and implementation of recommendations through a pilot program in the public sector to determine the efficacy of such recommendations is imminent; and

WHEREAS, the joint subcommittee feels that the issue of substance abuse treatment and prevention is one which necessarily demands ongoing oversight and evaluation in order to provide more meaningful and immediate resolution of problems; now, therefore, be it

RESOLVED, by the Senate, the House of Delegates concurring, That the Joint Subcommittee Studying Mandated Substance Abuse Treatment and Prevention Programs be continued to provide oversight to a number of continuing study efforts on a variety of substance abuse issues and to provide the necessary linkage for the implementation of goals and objectives developed in the interagency planning process.

The membership of the joint subcommittee shall remain the same and vacancies shall be filled in the manner provided in the original enacting resolution.

The joint subcommittee shall complete its work in time to submit its findings or recommendations to the Governor and the 1991 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

The indirect costs of this study are estimated to be $5,860; the direct costs of this study shall not exceed $2,520.