The LEWIN GROUP®

HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—**WITH REAL-WORLD PERSPECTIVE.**

New Hampshire Medicaid Expansion Study Phase III: An Analysis of Health Benefit Design Options for Current and Newly Eligible Medicaid Beneficiaries

Final Report

Prepared by:
The Lewin Group and DMA Health Strategies

September 2013

Table of Contents

Executive Summary

Under the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states may opt out of the Medicaid expansion provision of the ACA without putting existing federal Medicaid funding at risk. The Lewin Group is working with the New Hampshire Department of Health and Human Services to explore the potential impacts of expanding versus not expanding its Medicaid program. To this end, Lewin issued reports in three phases:

Phase 1 (November 2012): Estimates of the direct impacts of expansion versus no expansion on the Medicaid program's enrollment and costs.

Phase 2 (January 2013): Estimates of the secondary impacts of the Medicaid expansion, including impacts on other state program expenditures, the uninsured, providers, the state economy, and the commercial health insurance market.

Phase 3 (September 2013): Explores, in five parts, which health benefits Medicaid should cover in its existing program, as well as in an expanded Medicaid program:

- **Part 1:** Compares New Hampshire's current Medicaid benefit package to the "Essential Health Benefits (EHB)" package mandated under the Affordable Care Act. States can select one EHB benchmark plan from several options. Since the state has not selected an EHB benchmark plan, for modeling purposes, Lewin used the state's commercial benchmark plan as the comparison plan;
- **Part 2:** Estimates the cost and benefit of various Medicaid benefit design options that the state could consider;
- **Part 3:** Reviews New Hampshire's current Medicaid mental health benefit to determine the extent to which it satisfies the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- **Part 4:** Develops an evidence-based Substance Use Disorder (SUD) benefit, as required under the ACA for newly eligible beneficiaries; and
- **Part 5:** Discusses potential savings and benefits to other cost centers as a result of the substance abuse benefit.

Key Assumptions

- All cost estimates and conclusions provided in this report assume a Medicaid fee-for-service (FFS) program, as these estimates are based upon our November 2012 report, which assumed the "baseline" scenario to be a FFS system, per state direction. However, the Phase I report includes an alternative scenario in which Medicaid operates within a managed care system; this alternative scenario results in additional savings. Phase II also identifies additional offsets under managed care.
- In estimating future costs, our model assumed that Medicaid would be expanded in January 2014. If that is not the case, the model can be updated to reflect a later implementation.

- Since the Phase I report was issued in November 2012, CMS proposed rules for Essential Health Benefits (EHBs), which are slightly different from the benefit design we used in Phase I. In this report, we adjust all estimates to reflect the new rules and regulations.
- This report does not quantify the impacts of a substance abuse benefit on non-health programs, such as the Department of Corrections and social programs, due to lack of available data. However, we are able to consider experiences in others states and strong evidence available in the literature to qualitatively discuss benefits and savings.

A. Key Findings

The key findings and recommendations for Parts 1 through 5 of this report are summarized as follows:

Part 1 – Comparing New Hampshire's Current Medicaid Benefit Package to the Affordable Care Act's Essential Health Benefits (EHB) Package

- For the Medicaid expansion population, the state will need to make changes to its traditional Medicaid benefits to meet the EHBs required under the ACA. These include:
  - Adding inpatient and outpatient substance abuse disorder benefits and offering mental health services at parity with physical health services; and
  - Excluding optional long-term care services and supports including nursing home and waiver long-term care services, non-emergency transportation, podiatry and adult dental services. While not required, the state still has the option of offering these services to the expansion population.

Part 2 – Cost Benefit of Various Medicaid Benefit Design Options

- The study examines the impact on spending for the Medicaid expansion under four options of benefit designs. Our analysis demonstrates that the state could provide a mix of these optional services to both the current and newly eligible Medicaid groups. The associated costs are shown in **Figure ES-1**.

Figure ES-1: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Under Various Benefit Design Options, in $1000s

Option	State Cost	Federal Cost	Total Cost
Baseline (Phase I): Current and newly eligible receive current Medicaid benefits only[1]	$85,488	$2,510,922	$2,596,410
Option 1: Provide Medicaid and Benchmark optional benefits to newly eligible, and Medicaid benefits only to currently eligible	$78,974	$2,455,329	$2,534,145
Option 2: Provide Medicaid and Benchmark optional benefits to both newly eligible and currently eligible	$67,395	$2,443,750	$2,511,145
Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only	$75,155	$2,373,046	$2,448,201

[1] Baseline refers to estimates on the cost of the Medicaid Expansion to 138% FPL as presented in our Phase I report.

Option	State Cost	Federal Cost	Total Cost
Option 4: Provide Benchmark optional benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible	$63,576	$2,361,467	$2,425,043

Part 3- Extent to which Current Medicaid Benefit Satisfies Health Parity Requirements

- To comply with federal requirements, the state may need to modify service and financial limits for some current Medicaid enrollees to ensure that the mental health and substance abuse benefits offered to individuals enrolling under Medicaid expansion are ". . . offered at parity with medical services in the plan."[2] Our findings include:
  - Areas of Compliance: Inpatient services, physician services, emergency department services, and pharmacy services for behavioral health would likely be considered to be in compliance with MHPAEA; and
  - Areas Requiring further Action: Psychotherapy by other licensed practitioner services and Community Mental Health Center (CMHC rehabilitation) services are both subject to visit or financial limits, which would need to be modified to comply with MHPAEA. However, more specific guidance from CMS may be required to determine if any changes are needed, particularly since the CMHC rehabilitation option benefits are available to any enrollee diagnosed with serious mental illness or serious emotional disturbance.

Part 4 – Medicaid Benefit for Substance Abuse Option

- In considering a state substance abuse benefit, which New Hampshire has not previously offered, we recommend an option based on: 1) relevant national standards; 2) approaches taken by other states; and 3) the substance abuse treatment services established by the New Hampshire Bureau of Drug and Alcohol Services. The option includes the following set of services and supports that cover the entire continuum of substance use disorder care services:
  - Medically managed detoxification (level IV – hospital detox)
  - Medically monitored detoxification (level III – non-hospital)
  - Screening and Brief Intervention
  - Outpatient Counseling
  - Outpatient Detoxification
  - Intensive Outpatient Treatment
  - Community Stabilization Supports (30 to 60 days of support for people in early recovery in their own homes or in residential treatment)
  - Methadone maintenance
  - Peer Recovery Support

[2] Mental Health for America (2013). Fact Sheet: Medicaid Expansion. Retrieved from http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/fact-sheet-medicaid-expansion/fact-sheet-medicaid-expansion.

Part 5 – Savings and Benefits to Other Programs

- Offering a substance abuse benefit may also result in savings in other programs. Lewin's review of the literature finds that offering substance use disorder benefits results in savings in other programs, including medical costs.[3] While we are unable to accurately forecast the impact of a substance abuse benefit on non-health programs, such as those under the Department of Corrections, the research indicates that a substance abuse benefit can help reduce costs in Medicaid and other programs in the following ways:
  - **Reductions in costs for other medical care**: studies show that a substance abuse benefit led to reduction in other medical expenditures among Medicaid enrollees. In fact, there were savings even when factoring in the cost of providing the substance abuse treatment;[4,5]
  - **Reduced recidivism and imprisonment**: A 2003 meta-analysis reviewed 11 studies and found that the benefit-cost ratios associated with substance abuse treatment were between 1.33 and 23.33, and that the economic benefits were overwhelmingly due to reductions in criminal activity;[6] and
  - **Other societal impacts**: A major study in California showed that substance abuse treatment demonstrates a 7:1 return on investment for medical care, mental health care, criminal activity, earnings, and government transfer program payments. These estimates cite an average substance abuse treatment regimen costing $1,583, producing a societal benefit of $11,487.[7]

This report was prepared by The Lewin Group for the New Hampshire Department of Health and Human Services. The evaluation of mental health and SUD benefits conducted in Parts 3, 4, and 5 of this report was primarily performed by Richard Dougherty, Ph.D., and Wendy Holt, M.P.P, of DMA Health Strategies.

---

3 Cartwright WS (2000). Cost-Benefit Analysis of Drug Treatment Services: Review of the Literature. Journal of Mental Health Policy and Economics, 3:11-26

4 State of Colorado (2010). Medicaid Outpatient Substance Abuse Treatment Benefit: Performance Audit. Department of Health Care Policy and Financing. Retrieved from http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/$FILE/2079SubstanceAbuseFinalReport12132010.pdf

5 Wickizer TM, Krupski A, Stark K, Mancuso D & Campbell K (2006). The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State. The Milbank Quarterly 84.3: 555-76

6 McCollister KE & French MT (2003). The Relative Contribution of Outcome Domains in the Total Economic Benefit of Addiction Interventions: A Review of the First Findings. Addiction, 98:1647-59. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16430607

7 Ettner SL, Huang D, Evans E, Ash DR, Hardy M, Jourabchi M & Hser Y (2006). Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself'? Health Services Research, 41.1: 192-213. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16430607

I. Introduction

Following the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states now have the option to opt out of the Medicaid expansion provision of the ACA without compromising their current federal Medicaid funding. As a result of this ruling, The Lewin Group has worked with the New Hampshire Department of Health and Human Services to explore the potential impacts of expanding versus not expanding its Medicaid program. In Phase I of our analysis, released in November 2012, we provide estimates on Medicaid enrollment and costs under the option of not expanding Medicaid compared to the option of expanding Medicaid under various program design options. Phase II of the study, released in January 2013, estimates the impact of Medicaid expansion in areas outside of Medicaid, including other state programs, the uninsured, providers, the state economy, and the commercial health insurance market.

This report represents Phase III of the study, which examines options for the New Hampshire Medicaid program to consider in establishing a benefits plan for its Medicaid expansion population under the ACA. The Deficit Reduction Act of 2005, section 1937 of the Social Security Act, provides states with flexibility to design Medicaid benefit packages under the State plan. There are a number of options available to the state in selecting a Benchmark Plan, including the option to offer the current Medicaid benefits package to newly eligible beneficiaries, while adding newly required services per federal regulations. In addition, the state could offer different Benchmark Plans to targeted populations to appropriately meet their needs.

There is no default Benchmark Benefits Plan for the Medicaid expansion population. The state must submit a state plan amendment (SPA) detailing its choice for the Medicaid Benchmark as part of the Medicaid expansion process. The options available to New Hampshire for determining a Benchmark plan are as follows:

- Traditional Medicaid benefit package;
- Blue Cross Blue Shield PPO under FEHBP;
- A plan offered to state employees;
- Largest commercial HMO in the state; or
- Other coverage appropriate for target population (as defined by the state and approved by HHS Secretary).

Regardless of the reference Benchmark Plan selected, the state must ensure that the ten statutory categories of essential health benefits (EHB) are covered, as well as family planning services and services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). The Benchmark Plan must also assure that mental health parity under the Mental Health Parity and Addiction Equity Act (MHPAEA) is met. The EHB benefits include the following ten broad groups of services:

- Ambulatory patient services
- Emergency services

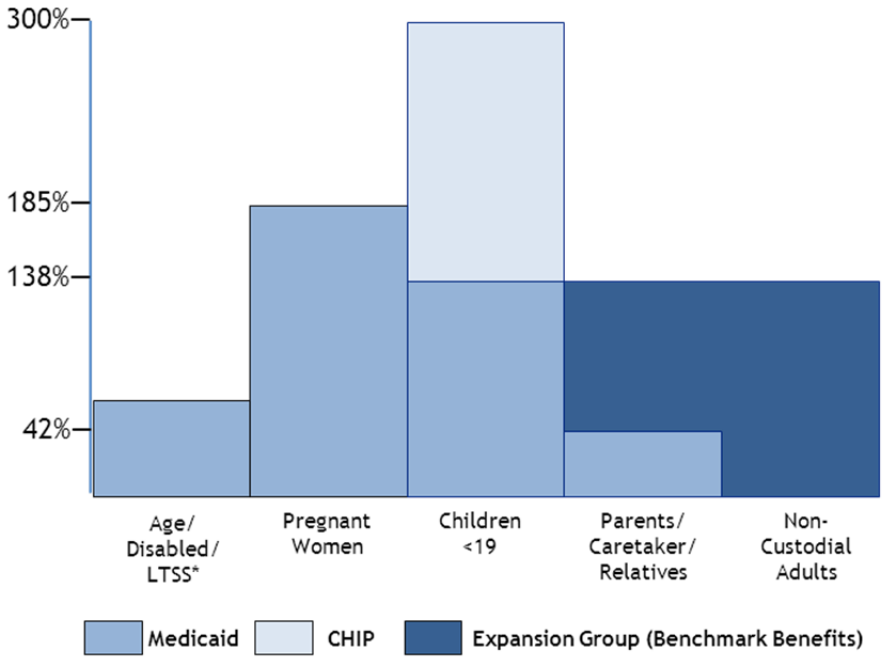
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

As of the release of this report, New Hampshire has not selected a Medicaid benchmark plan for its expansion population. However, the state has selected the Matthew Thornton Blue Health plan as its Health Insurance Marketplace benchmark benefits plan for individuals and small groups, which is a small group product HMO. However, it is also the largest commercial HMO in the state, which would qualify as a Medicaid Benchmark plan. For this report, we use the Matthew Thornton Blue plan for our comparison to the state's traditional Medicaid benefits package.

In addition to the five Benchmark plan options listed above, the state could also select a benchmark-equivalent plan, which means that the benefits include all the specified EHB services and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages.

The benchmark benefits plans will be provided primarily to newly eligible adults, but could be extended to other groups of adults in Medicaid in order to have a consistent set of benefits for specific population groups. ***Figure 1*** illustrates Medicaid and CHIP eligibility and benefit types by eligibility category in New Hampshire under health reform in 2014. Under a state plan amendment (SPA), New Hampshire could provide benchmark coverage to all Medicaid-eligible adults regardless of income.

Figure 1: New Hampshire Eligibility and Benefit Plans



* Working disabled are eligible up to 450% FPL with share of cost requirement. People requiring nursing facility care are eligible up to 220% FPL. Both also include resource limits. Medicare enrollees up to 135% FPL are eligible for certain Medicaid benefits, however full benefits are available to only those below 57% FPL.

In the report to follow, we first detail New Hampshire's current Medicaid benefit design and compare it to the state's commercial Benchmark Plan, which includes Essential Health Benefit (EHB), per guidance from the Centers for Medicare and Medicaid Services (CMS). Here, we identify outlier benefits of each benefit design to gain an understanding of what is offered in the current benefit design and not in the EHB design, and vice versa. Next, we estimate the cost and benefit of various Medicaid benefit design options. We then review New Hampshire's current Mental Health benefit to determine the extent to which it satisfies the MHPAEA. Next, we develop an option for a Medicaid substance abuse benefit for the state. Finally, we discuss potential savings and benefits to other cost centers resulting from the mental health and substance abuse benefit, including reduction in substance abuse related medical care costs, reduced recidivism, and secondary impacts in areas such as educational attainment, employment opportunities, public health, and the state economy at large.

II. Current Medicaid Benefit vs. Essential Health Benefit (EHB)

To comprehensively and effectively compare New Hampshire's current Medicaid benefit to the Benchmark Plan, which includes all Essential Health Benefits (EHBs), Lewin developed a crosswalk to compare the two sets of benefits. The objective of doing so is to confirm the outlier benefits of each benefit design; that is, to identify which benefits are included in the current Medicaid benefit package and not in the EHB Benchmark Plan design, and vice versa. We also identify areas where benefit limitations exist. Here, for illustrative purposes, we use the Matthew Thornton Blue Health plan—the state's commercial benchmark plan—as the EHB Medicaid Benchmark plan.

In comparing the benefit designs of the two plans, Lewin identified the following EHB services that are included in the Matthew Thornton benchmark plan but are not included within the current Medicaid benefit package (benchmark outlier benefits):[8]

- Substance Abuse Disorder Outpatient Services
- Substance Abuse Disorder Inpatient Services (Medicaid covers inpatient detox for adults with other medical admission)
- Habilitation Services (shares same PT, OT and SP services as rehabilitation)
- Chiropractic Care[9]

To meet CMS requirements, these services must be covered under the Medicaid Benchmark plan for the Medicaid expansion population. If New Hampshire elects to use the current Medicaid benefit design to cover the newly eligible beneficiaries, the state must include substance abuse disorder outpatient and inpatient services, chiropractic care, and habilitation services. The requirements for mental health parity and substance abuse disorder services are addressed in Section C of this report.

To meet CMS requirements for habilitation services, New Hampshire will be required to extend any rehabilitation services offered in the Medicaid Benchmark plan to cover services under the new definition of habilitation services. CMS defines habilitation services as services focused on learning new skills or functions and requires that they be offered at parity with rehabilitation services. For example, a plan that covers physical therapy, occupational therapy, and speech therapy must cover these services in similar scope, amount, and duration for services defined as rehabilitation or as habilitation. However, if New Hampshire does not wish to offer an identical benefit package for both services categories, the state may decide which habilitative services it would prefer to cover and submit to CMS for review and approval.

---

8 Mental Health Inpatient Services are covered under the benchmark plan but have different scope of providers under current Medicaid benefit (psychiatric hospitals are not covered for non-aged adults under Medicaid). However, this is not considered an outlier, as the benefit coverage is the same.

9 While not an explicit EHB under federal regulations, chiropractic care is a benefit in the Mathew Thornton plan and has been included in the Medicaid benchmark plans in other states and is considered a rehabilitative service.

In addition, there are services that are covered under the current Medicaid benefit package that are not essential health benefits required to be in the Medicaid Benchmark plan (Medicaid outlier benefits). These include:

- Long-term/Custodial Nursing Home Care
- Private-Duty Nursing
- Adult Day Care
- Personal Care
- HCBS Waiver Services
- Non-Emergency Transportation Services
- Podiatry (limited coverage under Medicaid)
- Certain dental services for adults

New Hampshire will have the opportunity to determine which, if any, of these services to include in the benefit offered to the Medicaid expansion group.

Finally, there are services that are required to be covered under the Medicaid Benchmark plan that are not adequately covered by the commercial benchmark plan—Matthew Thornton Blue Health. These services include services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

For a full comparison of all reviewed services covered under traditional Medicaid and under the Matthew Thornton Plan, see ***Figure 2***, below.

Figure 2: Crosswalk of New Hampshire's current Medicaid benefit and the Matthew Thornton Blue Health Benchmark Plan to the List of Essential Health Benefits

Essential Health Benefits	Covered Under Traditional Medicaid	Covered Under Matthew Thornton Plan
Ambulatory patient services		
Primary Care	✓	✓
Specialty Care	✓	✓
Outpatient Surgery	✓	✓
Home Health Services	✓	✓
Hospice	✓	✓
Emergency services		
Emergency Room	✓	✓
Ambulance	✓	✓
Urgent Care Centers or Facilities	✓	✓
Hospitalization		
Inpatient	✓	✓
Bariatric Surgery	✓	✓
Maternity and newborn care		
Prenatal and Postnatal Care	✓	✓
Delivery and Inpatient Maternity	✓	✓

Essential Health Benefits	Covered Under Traditional Medicaid	Covered Under Matthew Thornton Plan
Mental health and substance use disorder services, including behavioral health treatment		
Mental Health Outpatient	✓	✓
Mental Health Inpatient	Limited Provider Scope	✓
Substance Abuse Outpatient	Not Covered	✓
Substance Abuse Inpatient	Not Covered	✓
Prescription Drugs		
Generic Drugs	✓	✓
Preferred Brand Drugs	✓	✓
Non-preferred Brand Drugs	✓	✓
Specialty Drugs	✓	✓
Rehabilitative and habilitative services and devices		
Physical Therapy	✓	✓
Occupational Therapy	✓	✓
Speech Therapy	✓	✓
Chiropractic Services	Not Covered	✓
Laboratory services		
Diagnostic Lab Tests	✓	✓
X-Rays	✓	✓
Diagnostic Imaging	✓	✓
Preventive and wellness services and chronic disease management		
Preventative Care (e.g., screening, immunizations)	✓	✓
Routine Vision Care (adult)	✓	✓
Routine Dental Care (adult)	Limited Coverage	Not Covered
Family Planning	✓	✓
Podiatry	Limited Coverage	Not Covered
Pediatric services, including oral and vision care		
Primary and Preventative Care	✓	✓
Routine Vision Care	✓	✓
Routine Dental Care	✓	✓

✓ = Covered Service

III. Cost and Benefit of Various Medicaid Benefit Design Options

If New Hampshire elects to expand the state's Medicaid program, then the state is met with a decision as to (1) what benefits to offer the Medicaid expansion population beyond the EHBs, if any, and (2) if current Medicaid benefits should be expanded to cover services not currently covered by Medicaid that are covered under the EHB package, such as substance abuse. With each option come different costs and benefits. Here, the Affordable Care Act (ACA) also creates a potential inequity where newly eligible individuals could receive a richer benefit package than current Medicaid eligibles. To assess costs of different benefit design options, Lewin has developed a model that estimates the cost of each benefit design. Estimated costs for each of the proposed benefit design options are presented below, followed by an overview of our methodology and major assumptions used.

Phase I: Baseline estimate

Our Phase I report on the cost of the Medicaid expansion in New Hampshire to all adults below 138 percent of FPL assumes that all current Medicaid benefits would be provided to both the current Medicaid eligibles and to the expansion population; the cost of new required benefits (i.e. substance use disorder benefits) for newly eligibles was not included in our estimates. Our Phase I report was developed in November 2012, prior to CMS issuing proposed rules for EHBs. The benefit design assumption used in Phase I is no longer compliant with federal rules and regulations, per new EHB and parity requirements. However, this is used as a baseline in estimating the cost of new benefit design options.

Under our Phase I assumption, we estimated total Medicaid costs in New Hampshire, including health care and administration, would increase by $2.6 billion from 2014 through 2020 (***Figure 3***). The federal government will pay 100 percent of the health care costs for newly eligible adults from 2014 through 2016. By 2020, the percent paid by the federal government will drop to 90 percent. However, the state will only receive the current federal matching rate for health care costs for new enrollees that are eligible under current Medicaid eligibility criteria. The additional cost of administering Medicaid eligibility and coverage for these new enrollees will be matched by the federal government at the current matching rate for program administration.

Figure 3: Impact on New Hampshire Medicaid Spending under Medicaid Expansion Under the ACA (2014-2020) – Baseline ACA Analysis [1/]

	2014	2015	2016	2017	2018	2019	2020	2014-2020
Change in Enrollment	44,169	51,548	59,157	59,895	60,674	61,455	62,237	
Total Costs ($1,000s)								
State Share	$3,603	$4,322	-$9,138	$9,143	$13,141	$17,371	$47,046	$85,488
Federal Share	$264,869	$316,152	$385,000	$379,322	$388,136	$396,936	$380,507	$2,510,922
Total	$268,472	$320,474	$375,862	$388,465	$401,277	$414,308	$427,553	$2,596,410

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained. Assumes current Medicaid benefits package for Newly Eligible.
Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model.

Below, we provide new estimates based on four benefit design options.

Option 1: Provide Medicaid and Benchmark outlier benefits to newly eligible, and Medicaid benefits only to currently eligible

Benefits Offered	Current Eligibles	Newly Eligible
Benchmark Outlier Benefits		
Substance Abuse	n/a	Covered
Chiropractic	n/a	Covered
Medicaid Outlier Benefits		
Long Term Service & Supports	Covered	Covered
Podiatry	Covered	Covered
Dental	Covered	Covered
All Other Medicaid Benefits	**Covered**	**Covered**

To update our Phase I cost estimate, we include the net cost of providing the additional benchmark outlier benefits to the newly eligible population, which include a substance use disorder benefit and chiropractic benefit. These benefits are in addition to all current Medicaid benefits for the newly eligible population. As mentioned above, CMS guidance on the EHB was issued after our Phase I report, so this analysis attempts to incorporate our most recent understanding of the ACA requirements for the Medicaid expansion.

Figure 4 shows the change in cost to the Medicaid program under expansion assuming the benefits structure for ***Option 1***. Our review of the literature, which is described below, found that Medicaid enrollees that used substance use disorder (SUD) services reduced their utilization of physical health services in excess of the actual cost of the SUD services provided. For these cost estimates, we based our assumption for medical cost offset on a study of the Colorado Medicaid program that showed that every dollar spent on SUD services resulted in a reduction of $1.45 on physical health spending.

Figure 4: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 1 Benefit Design, in $1000s

	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	2014-2020
Baseline PMPM	$696.84	$718.60	$741.85	$766.71	$792.46	$819.18	$846.94	
Option 1 PMPM	$702.62	$722.95	$743.07	$761.87	$784.06	$808.26	$835.74	
% Change	0.8%	0.6%	0.2%	-0.6%	-1.1%	-1.3%	-1.3%	
Dollar Impact ($1,000's)	$12,382	$9,855	$2,860	($11,564)	($20,424)	($27,024)	($28,194)	
Increased Cost due to Additional Benefits								
SUD Benefit	$12,270	$14,618	$16,193	$16,894	$17,627	$18,389	$19,185	**$115,175**
Chiropractic Benefit	$113	$134	$149	$155	$162	$169	$176	**$1,059**
Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset)								
State Share	$0	$0	$0	($578)	($1,225)	($1,892)	($2,819)	**($6,515)**
Federal Share	$12,382	$9,855	$2,860	($10,985)	($19,199)	($25,132)	($25,374)	**($55,593)**
Total	$12,382	$9,855	$2,860	($11,564)	($20,424)	($27,024)	($28,194)	**($62,108)**
Change in Medicaid Cost Under ACA with Expansion & Benefit Changes								
State Share	$3,603	$4,322	($9,138)	$8,565	$11,916	$15,480	$44,227	**$78,974**
Federal Share	$277,251	$326,007	$387,860	$368,337	$368,937	$371,804	$355,133	**$2,455,329**
Total	$280,854	$330,329	$378,722	$376,901	$380,853	$387,284	$399,359	**$2,534,303**

Assumes a similar 1.45:1 return on investment on offering substance use disorder services.
Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Option 2: Provide Medicaid and Benchmark outlier benefits to both newly eligible and currently eligible

Benefits Offered	Current Eligibles	Newly Eligible
Benchmark Outlier Benefits		
Substance Abuse	Covered	Covered
Chiropractic	Covered	Covered
Medicaid Outlier Benefits		
Long Term Service & Supports	Covered	Covered
Podiatry	Covered	Covered
Dental	Covered	Covered
All Other Medicaid Benefits	**Covered**	**Covered**

The state may elect to offer all Medicaid beneficiaries the same benefit package, meaning services such as HCBS, nursing facility care, mental health and substance use disorder services would be available to currently eligible and newly eligible beneficiaries. ***Figure 5*** shows the cost to the Medicaid program under expansion assuming current Medicaid benefits plus the additional benchmark outlier benefits for both the current and newly eligible populations.

Figure 5: Impact on New Hampshire Medicaid Spending under Medicaid Expansion Under the ACA (2014-2020) Option 2 Benefit Design, in $1000s

	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	2014-2020
Baseline PMPM	$696.84	$718.60	$741.85	$766.71	$792.46	$819.18	$846.94	
Option 2 PMPM	$705.16	$724.64	$743.52	$760.03	$780.85	$804.05	$831.42	
% Change	1.2%	0.8%	0.2%	-0.9%	-1.5%	-1.8%	-1.8%	
Dollar Impact ($1,000's)	$17,824	$13,675	$3,897	($15,943)	($28,225)	($37,425)	($39,069)	
Increased Cost due to Additional Benefits								
SUD Benefit	$17,543	$20,168	$22,037	$23,049	$24,112	$25,223	$26,388	**$158,520**
Chiropractic Benefit	$282	$312	$336	$352	$369	$387	$406	**$2,444**
Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset)								
State Share	$2,721	$1,910	$519	($2,768)	($5,126)	($7,093)	($8,257)	**($18,094)**
Federal Share	$15,103	$11,765	$3,378	($13,175)	($23,099)	($30,333)	($30,812)	**($67,172)**
Total	$17,824	$13,675	$3,897	($15,943)	($28,225)	($37,425)	($39,069)	**($85,266)**
Change in Medicaid Cost Under ACA with Expansion & Benefit Changes								
State Share	$6,324	$6,232	($8,619)	$6,375	$8,015	$10,279	$38,789	**$67,395**
Federal Share	$279,972	$327,917	$388,378	$366,147	$365,037	$366,603	$349,695	**$2,443,750**
Total	$286,296	$334,149	$379,759	$372,522	$373,052	$376,882	$388,484	**$2,511,145**

1/ Assumes a similar 1.45:1 return on investment on offering substance use disorder services.
Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM). Includes our estimates of "woodwork" enrollees beginning in 2014 as well as our estimates for those leaving Medicaid for other coverage options under the ACA.

Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only

Benefits Offered	Current Eligibles	Newly Eligible
Benchmark Outlier Benefits		
Substance Abuse	n/a	Covered
Chiropractic	n/a	Covered
Medicaid Outlier Benefits		
Long Term Service & Supports	Covered	n/a
Podiatry	Covered	n/a
Dental	Covered	n/a
All Other Medicaid Benefits	**Covered**	**Covered**

New Hampshire could elect to have current Medicaid eligibles continue to receive their current benefits, with no addition of EHB "outlier" services such as substance abuse services, while newly eligible receive only the benefits in the selected benchmark plan. ***Figure 6*** shows the cost to the Medicaid program under expansion assuming only benchmark benefits are provided to the newly eligible population. The estimates assume no change in benefits for the currently eligible groups.

Figure 6: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 3 Benefit Design, in $1000s

	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	2014-2020
Baseline PMPM	$696.84	$718.60	$741.85	$766.71	$792.46	$819.18	$846.94	
Option 3 PMPM	$698.34	$718.12	$737.91	$756.58	$778.64	$802.70	$830.05	
% Change	0.2%	-0.1%	-0.5%	-1.3%	-1.7%	-2.0%	-2.0%	
Dollar Impact ($1,000's)	$3,210	($1,073)	($9,246)	($24,193)	($33,601)	($40,771)	($42,536)	
Increased Cost due to Additional Benefits								
SUD Benefit	$12,270	$14,618	$16,193	$16,894	$17,627	$18,389	$19,185	**$115,175**
Chiropractic Benefit	$113	$134	$149	$155	$162	$169	$176	**$1,059**
Cost of Benefits Carved Out of Expansion Population								
LTSS	($3,620)	($4,509)	($4,995)	($5,211)	($5,437)	($5,672)	($5,918)	**($35,363)**
Private Duty Nursing	($122)	($152)	($168)	($176)	($183)	($191)	($199)	**($1,192)**
Podiatry	($2,821)	($3,513)	($3,892)	($4,060)	($4,237)	($4,420)	($4,611)	**($27,554)**
Dental	($3,620)	($4,509)	($4,995)	($5,211)	($5,437)	($5,672)	($5,918)	**($35,363)**
Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset)								
State Share	$0	$0	$0	($1,210)	($2,016)	($2,854)	($4,254)	**($10,333)**
Federal Share	$3,210	($1,073)	($9,246)	($22,983)	($31,585)	($37,917)	($38,282)	**($137,876)**
Total	$3,210	($1,073)	($9,246)	($24,193)	($33,601)	($40,771)	($42,536)	**($148,210)**
Change in Medicaid Cost Under ACA with Expansion & Benefit Changes								
State Share	$3,603	$4,322	($9,138)	$7,933	$11,125	$14,517	$42,792	**$75,155**
Federal Share	$268,079	$315,079	$375,754	$356,339	$356,551	$359,019	$342,225	**$2,373,046**
Total	$271,682	$319,401	$366,616	$364,272	$367,676	$373,537	$385,017	**$2,448,201**

1/ Assumes a similar 1.45:1 return on investment on offering substance use disorder services.
Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Option 4: Provide Benchmark outlier benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible

Benefits Offered	Current Eligibles	Newly Eligible
Benchmark Outlier Benefits		
Substance Abuse	Covered	Covered
Chiropractic	Covered	Covered
Medicaid Outlier Benefits		
Long Term Service & Supports	Covered	n/a
Podiatry	Covered	n/a
Dental	Covered	n/a
All Other Medicaid Benefits	**Covered**	**Covered**

New Hampshire could elect to have current Medicaid eligibles continue to receive their current benefits with the addition of EHB "outlier" services such as substance abuse services, while

newly eligible receive only the benefits in the selected benchmark plan. ***Figure 7*** shows the cost to the Medicaid program under expansion under this scenario. The projection assumes no reduction in benefits for the currently eligible groups and allocates additional substance abuse and chiropractic services to current populations.

Figure 7: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 4 Benefit Design, in $1000s

	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	2014-2020
Baseline PMPM	$696.84	$718.60	$741.85	$766.71	$792.46	$819.18	$846.94	
Option 1 PMPM	$700.88	$719.81	$738.35	$754.74	$775.43	$798.49	$825.73	
% Change	0.6%	0.2%	-0.5%	-1.6%	-2.2%	-2.5%	-2.5%	
Dollar Impact ($1,000's)	$8,652	$2,747	($8,209)	($28,572)	($41,402)	($51,173)	($53,411)	
Increased Cost due to Additional Benefits								
SUD Benefit	$17,543	$20,168	$22,037	$23,049	$24,112	$25,223	$26,388	**$158,520**
Chiropractic Benefit	$282	$312	$336	$352	$369	$387	$406	**$2,444**
Cost of Benefits Carved Out of Expansion Population								
LTSS	($3,620)	($4,509)	($4,995)	($5,211)	($5,437)	($5,672)	($5,918)	**($35,363)**
Private Duty Nursing	($122)	($152)	($168)	($176)	($183)	($191)	($199)	**($1,192)**
Podiatry	($2,821)	($3,513)	($3,892)	($4,060)	($4,237)	($4,420)	($4,611)	**($27,554)**
Dental	($3,620)	($4,509)	($4,995)	($5,211)	($5,437)	($5,672)	($5,918)	**($35,363)**
Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset)								
State Share	$2,721	$1,910	$519	($3,399)	($5,917)	($8,055)	($9,691)	**($21,912)**
Federal Share	$5,931	$837	($8,727)	($25,173)	($35,486)	($43,118)	($43,720)	**($149,455)**
Total	$8,652	$2,747	($8,209)	($28,572)	($41,402)	($51,173)	($53,411)	**($171,368)**
Change in Medicaid Cost Under ACA with Expansion & Benefit Changes								
State Share	$6,324	$6,232	($8,619)	$5,744	$7,224	$9,316	$37,355	**$63,576**
Federal Share	$270,800	$316,989	$376,273	$354,149	$352,650	$353,819	$336,787	**$2,361,467**
Total	$277,124	$323,221	$367,653	$359,893	$359,875	$363,135	$374,142	**$2,425,043**

Summary of Options 1 through 4

In sum, ***Option 4*** would serve as the least costly option for the state, where the substance abuse benefit and chiropractic benefit are extended to the current eligible population, while the newly eligible population receives the benchmark plan (including all EHBs) but does not receive current Medicaid outlier benefits such as LTSS, Dental, and Podiatry. A comparison of the state, federal, and total costs of all four options is presented in ***Figure 8***, below.

Figure 8: Summary of Options - Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020), in $1000s

Option	State Cost	Federal Cost	Total Cost
Baseline (Phase I): Current and newly eligible receive current Medicaid benefits only[1/]	$85,488	$2,510,922	$2,596,410
Option 1: Provide Medicaid and Benchmark outlier benefits to newly eligible, and Medicaid benefits only to currently eligible	$78,974	$2,455,329	$2,534,145
Option 2: Provide Medicaid and Benchmark outlier benefits to both newly eligible and currently eligible	$67,395	$2,443,750	$2,511,145
Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only	$75,155	$2,373,046	$2,448,201
Option 4: Provide Benchmark outlier benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible	$63,576	$2,361,467	$2,425,043

1/ Note: Our Phase I report was developed in November 2012, prior to CMS issuing proposed rules for EHBs. The benefit design assumption used in Phase I is no longer an option under federal rules & regulations.

Methodology highlights and assumptions

The pricing of new substance abuse and chiropractic benefits entailed the use of several sources of data. All assumptions use were conservative in nature, meaning most deviations from the model could yield even greater savings.

For the chiropractic benefit, our cost and utilization assumptions were based on the total fund savings of $100,000 per year when the state eliminated the chiropractic benefit from Medicaid.

Substance abuse costs and utilization assumptions, by category of aid basis, relied on available data from states such as Kansas, Massachusetts, North Carolina, and Pennsylvania. For all of these states, annual costs per SUD user were approximately $2,100, with that figure being less for children. The percentage of enrollees' utilization of these services varied per population.

The following statistics from neighboring Massachusetts were used as a benchmark for Medicaid member behavior in New Hampshire:

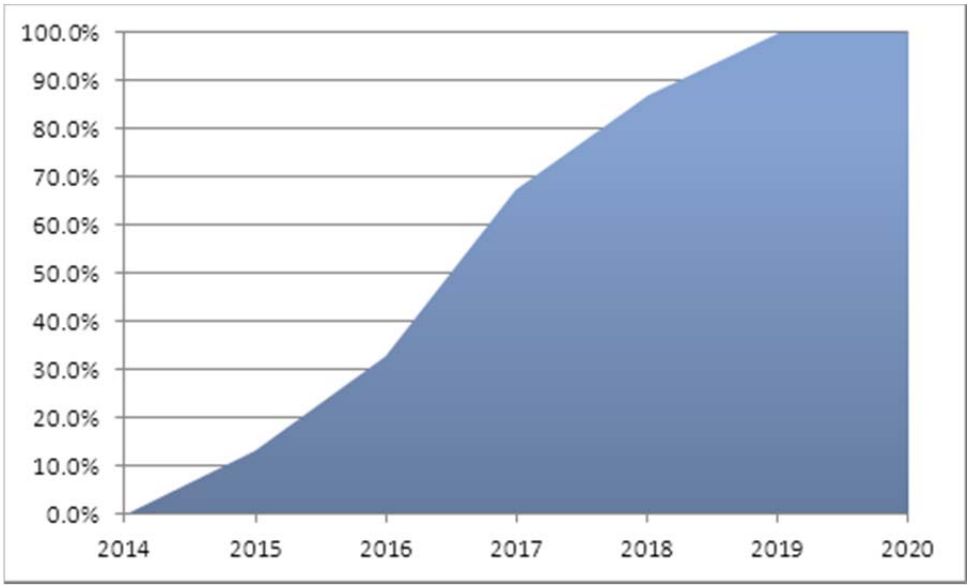
- TANF Adult: 8% of enrollees utilizing SUD benefits
- TANF Child: 1% of enrollees utilizing SUD benefits
- Disabled: 11% of enrollees utilizing SUD benefits
- Adults without children: 19% of enrollees utilizing SUD benefits
- Foster Care: 2% of enrollees utilizing SUD benefits

Cost per user, combined with the assumed percentage of population utilizing the SUB benefit, allowed us to model PMPM figures for New Hampshire Medicaid. These figures conservatively took into account economic differences between other states as well as the Medicaid fee schedules.

Our analysis of potential savings from implementing a substance abuse benefit leveraged results from several recent studies. Studies from Colorado, Washington, and California show a potential 600 percent return on investment (ROI). However, our estimates use a more conservative assumption based on national studies that find an approximate a 30 to 50 percent ROI. This means that for every $1.00 spent on substance abuse benefits, the state would see $1.30 to $1.50 in cost savings. Given this positive ROI, if utilization is higher than our assumed utilization rates, though costs would be higher, this would result in an even greater volume of savings.

Additionally, cost savings from the SUD benefit were assumed to be spread over a period of time. Many studies have examined a three year period, so the majority of savings were assumed to occur in the first three years after the benefit was implemented; if the substance abuse benefit was put into place in 2014, for instance, then savings would not be assumed until 2015. The cumulative effect of the savings, as shown in ***Figure 9***, would increase over the next couple years and then taper off until full savings is reached.

Figure 9: SUD Benefit – Distribution of Cost Savings Over Time



The net effect is a realistic allocation of cost savings over the projection period. Our model assumes that about 70 percent of the medical cost savings have been realized by the end of 2017. Note that utilization by currently or newly eligible members at a later time may shift this allocation or lead to greater cost savings in later years.

IV. Community Mental Health Center (CMHC) Rehabilitation Option & Satisfaction of Mental Health Parity

The purpose of this section is to review the current New Hampshire Medicaid behavioral health benefits and determine whether they meet the mental health parity requirements. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) establishes federal parity requirements that must be met by plans offered in health benefit exchanges and by plans offered to new Medicaid eligibles, under Medicaid expansion. This means that the mental health and substance abuse benefits offered to individuals enrolling under Medicaid expansion "must be offered at parity with medical services in the plan."[10] This means that mental health benefits must be at least equal to benefits provided for physical health coverage. Historically, health insurance plans have applied greater treatment limitations and higher cost-sharing to treatment of mental illness and substance use than for treatment of physical diseases. MHPAEA does not apply to Medicaid fee-for-service benefits.

Approach

To conduct the analysis, the guidance issued by CMS in the January 16, 2013 State Health Officials letter (SHO # 13-001, ACA #24) and The Interim Final Rule (IFR) published by DHS in February 2010 was reviewed. Because the rules are not final and do not address a number of issues, conclusions offered in this report should be considered preliminary and subject to further analysis once CMS provides additional guidance.

Using material submitted by the Bureau of Behavioral Health, New Hampshire's current Medicaid mental health benefits were reviewed (***Figure 10, Columns 1 and 2***). Discussions with state staff provided further understanding of those benefits. In addition, relevant documentation of New Hampshire's Medicaid Medical/Surgical and Pharmacy benefits was also reviewed. These include:

1. New Hampshire Medicaid Services: Recipient Information about: Recipient Responsibilities; Transportation; Service Limits: Co-Payments; Non-Covered Services; Prescription Drugs; Prior Authorization (accessed from http://www.dhhs.nh.gov/ombp/medicaid/documents/med77l.pdf on April, 29, 2013)
2. New Hampshire Department of Health and Human Services Generic Drug List, Revision effective data August 30, 2012. (accessed from http://www.dhhs.nh.gov/ombp/pharmacy/documents/generic.pdf on April 29, 2013)

Medical necessity criteria were not reviewed and thus no commentary is provided on whether they differ between mental health and substance abuse services and medical/surgical services.

Overview of key parity provisions

The core requirement of MHPAEA is that the financial requirements and treatment limitations for behavioral health services are no more restrictive or do not limit access more than

[10] Mental Health for America (2013). Fact Sheet: Medicaid Expansion. Retrieved from http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/fact-sheet-medicaid-expansion/fact-sheet-medicaid-expansion

substantially all medical/surgical services. The Interim Final Rule (IFR) published by DHS in February 2010 defines "substantially all" as two-thirds. Limits or restrictions can be in the form of quantitative limits on visits, financial limits on expenditures, procedural limits based on requirements for prior approval, and limits created by medical necessity criteria. The review within this report considers these quantitative, financial and procedural limits, but does not review medical necessity criteria or non-quantitative treatment limitations. Conclusions are summarized below within each of the major service areas. A final table documents the analysis benefit by benefit (***Figure 10, column 3***).

Mental health benefits that are likely to be in compliance with MHPAEA

If New Hampshire elects to extend its current Medicaid mental health benefits to new eligibles, *inpatient services*, *physician services*, *emergency department services*, and *pharmacy coverage* services would likely be considered to be in compliance with MHPAEA.

I*npatient services, physician services and emergency department services* are likely in compliance because they are equally available for all diagnoses, and do not distinguish between psychiatric and medical/surgical diagnoses. In addition, these services do not have a prior approval requirement. Inpatient and physician services do not have quantitative or financial limits. Use of out-of-state providers requires prior approval for any diagnosis.

- Criteria for prior approval should be reviewed to determine whether criteria for mental health or substance abuse admissions to out-of-state facilities are more restrictive than those for medical/surgical admissions.

Emergency services are included within a twelve visit annual limit on hospital outpatient services. There are provisions for waiver of this limit for medical necessity. Since mental health visits are not treated differently from medical/surgical visits they are not treated more restrictively than medical/surgical emergencies.

Medications: reviewing New Hampshire's list of generic and brand name medications by drug class, the proportion of brand name to generic medications in the Behavioral Health classes does not appear to differ in proportion from those of other medication classes. Many of the brand name drugs have generic options. One specific behavioral health medication has a requirement for prior approval and another has a quantity limit. The remainder of behavioral health medications does not require prior authorization and are subject to a $1.00 co-pay for generic or a $2 co-pay for brand name drugs regardless of whether the prescription is for treating a physical or mental health symptom. Clozaril, for example, is exempt from any co-pay. In comparing these restrictions and requirements to those for drugs in other classes, it is found that prior approval and quantity limits apply to several other drugs in non-behavioral health classes. The co-pay requirements are the same for all drug classes. It is concluded that, at this level of analysis, behavioral health drugs appear to be covered on the same basis as other drug classes. However, it is possible that psychotropic medications important for treating mental health conditions are not included in the formulary or are included only in the brand name category with higher co-pays.

- Analysis by a pharmacy expert would be needed to reach a more complete determination on the adequacy of the behavioral health formulary as compared to the adequacy of the formulary for other drug classes.

Some NH mental health benefits need to be changed to comply with MHPAEA

If New Hampshire extends its current Medicaid mental health benefits to new eligibles, the following benefits may need to be modified to comply with MHPAEA: *psychotherapy by other licensed practitioner services* and *Community Mental Health Center (CMHC rehabilitation) services*. Both of these services are subject to visit or financial limits. ***Exhibit 1*** shows limits applicable to medical/surgical benefits. CMS defines predominant as applicable to two-thirds or more of medical/surgical benefits. If physician visits constitute two-thirds of ambulatory medical/surgical benefits, since they are unlimited, New Hampshire would have to eliminate the limits on psychotherapy. However, if physician visits do not constitute two-thirds, then New Hampshire may be able to retain benefits on psychotherapy that are no more restrictive than those on the other ambulatory medical/surgical benefits. It is not clear how CMS expects two-thirds to be measured. CMS may provide more specific guidance in its final regulations. However, our preliminary review of New Hampshire utilization data, by category of service, suggests that physician visits constitute over two-thirds of all facility visits.

Psychotherapy by other licensed practitioners is currently subject to an 18 visit annual limit for adults and a 24 visit annual limit for children.

- To provide mental health psychotherapy at parity, New Hampshire will have to eliminate these limits.

Whether or not New Hampshire maintains limits on psychotherapy:

- If New Hampshire elects to provide such services under managed care, it must ensure that any authorization procedures or medical necessity criteria health plans use to manage *ambulatory mental health benefits* are no more restrictive than those used for most medical/surgical benefits.

Exhibit 1: NH Medicaid

Financial, quantitative or procedural limitations applicable to medical/surgical services

1. Physician visits – no limit
2. Hospital outpatient visits – 12 visits per year
3. OT, PT, ST – overall 20 visit limit for any combination of these therapies
4. Podiatrist – 4 visits per year
5. Limits on dental and vision care services
6. Prior approval required for private duty nursing

CMHC services include 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Psychiatric Services, Case Management, and Community Based Rehabilitation Services.[11] CMHC services are unlimited for enrollees with a serious mental illness (SMI) or serious emotional disturbance (SED). An annual limit of $4,000 is set for individuals who formerly had SMI or SED and an annual limit of $1,800 is set for those who do not meet criteria for SMI or SED. CMHC's also deliver targeted case management for mental health, which is restricted to people with severe mental illness and a need for long term care and case management.

CMHC emergency services are a supplement to hospital emergency services. As a result, they do not have obvious counterparts on the physical health side. Thus, limits on these services should be in compliance with MHPAEA. However, it is desirable for people in psychiatric crisis to have access to emergency stabilization services whenever they are needed.

[11] This is a CMHC service, but may not be eligible to be reimbursed by Medicaid.

CMHC assessment and evaluation, individual and group therapies, and psychiatric assessments are comparable to services provided by physicians and licensed psychotherapists. Because physician services are not subject to limitation, CMHC psychiatric services should not be limited. Since CMHC assessment, evaluation, individual and group therapies are ambulatory mental health services comparable to psychotherapy, whatever determination is made for psychotherapy should apply to these services.

Benefits whose compliance with MHPAEA is uncertain

CMHC case management, community based rehabilitation services, and targeted case management is rehabilitation services. Health plans often cover rehabilitation services on a time limited basis, with the expectation that functionality is recovered over time. In New Hampshire Medicaid, physical, occupational and speech therapies are subject to a combined 20 visit limit. Medicaid enrollees with physical or developmental problems that require additional rehabilitation may qualify for additional case management and long term services and supports under a Home and Community Based Waiver, based on a comprehensive service plan. Our preliminary analysis suggests that CMHC community rehabilitation services can be limited in ways that are no more restrictive than the limits on other rehabilitative therapies.

- New Hampshire may wish to evaluate how the financial limitations placed on people not currently assessed to have SED or SMI compare to the 20 visit rehabilitation therapy limit. It these limits cover fewer than 20 visits, they should be expanded to include at least 20 visits. Establishing a limitation based on visits will make it easier to demonstrate parity between mental health and physical health therapies.
- New Hampshire may wish to consult final regulations for MHPAEA to see if additional guidance is provided about parity in rehabilitation services.

The medical necessity criterion of SMI or SED used to establish eligibility for unlimited rehabilitation, case management and targeted case management services appear to be similar to the criteria that apply to determination of eligibility for waiver services for people with physical and developmental disabilities. No CMS guidance was found regarding how to consider services provided under waiver. A preliminary analysis suggests that New Hampshire can make a reasonable argument that it is offering long term mental health rehabilitation services and supports on a comparable basis to those offered under waiver to people with physical and developmental problems. It is possible that final regulations will provide additional guidance on this issue.

- New Hampshire may wish to compare its SED and SMI criteria to those used to determine eligibility for its Home and Community Based Service waivers and eliminate any inconsistencies in criteria for community rehabilitation, case management or targeted case management services that are more restrictive than those for waiver services. New Hampshire may wish to revisit this issue once CMS has issued final regulations.
- New Hampshire may wish to revisit this issue once CMS has issued final regulations.

Institution for Mental Disease (IMD) Services for children and elders are currently used solely for New Hampshire State Hospital services. If this benefit is extended to new eligibles, it should

comply with parity requirements, as there are no prior approval requirements or limits placed on the service. It is not entirely clear how to think about the prohibition on coverage for adults under age 65. On one hand, similar prohibition on the medical/surgical side does not appear to exist. On the other hand, Medicaid reimbursement for adults receiving services in Institutions for Mental Disease (IMDs) has long been prohibited by federal rules for non-elderly adults, and adults do have access to inpatient psychiatric services from other hospitals. However, if the state hospital offers a distinct kind of inpatient care, not otherwise available, then parity questions might arise.

Another category of IMDs is private psychiatric facilities and skilled nursing facilities with more than 16 beds that serve 51 percent or more of people with behavioral health conditions. Medicaid regulations prohibit a skilled nursing facility considered to be an IMD from billing for either its Medicaid behavioral health patients or any Medicaid non-behavioral health patient.

As of May 13, 2013, CMS has not yet issued draft guidance on how the Medicaid restriction on IMD services for non-elderly adults will be treated in Medicaid Alternative Benefit Plans. Some parties are urging that this restriction be lifted. Regulations addressing this matter are expected shortly.

- New Hampshire should consult these regulations when they are issued to better understand the options for coverage of IMD services.

Services for children in DCYF custody

Children in DCYF custody are all currently eligible for Medicaid. The special services for children in DCYF custody will therefore not be subject to MHPAEA. It is our understanding that the state may include children in DCYF custody in managed care, but, at least initially, does not plan to include these DCYF services in the managed care benefit. Therefore, a detailed analysis of this benefit was not conducted. However, should these services be included in managed care in the future, there would be several considerations in determining eligibility. The DCYF services appear to be enhanced services, many of them addressing behavioral health needs. Provision of extra MH/SUD services should not be a consideration for parity compliance.

- If there are enhanced medical/surgical services for foster children or for other populations with similar level of need, New Hampshire should ensure that its MCO does not establish any eligibility criteria or service limits for foster care mental health services are no more restrictive than for analogous medical services.

Figure 10: Mental Health and Substance Abuse Services in Medicaid and CHIP in New Hampshire
Mandatory and Optional State Plan Services (as of April 2013) Compared to MHPAEA Parity Act Standards

Mental Health - Medicaid

(1) Service	(2) Service requirements and limitations	(3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits [1/]
Mandatory State Plan Services		
Inpatient Hospital Services		
Inpatient Care	General Hospital covered. Prior authorization required for out of state hospital. No PA required for in state hospital.	No changes needed. Same coverage is available for medical and MH inpatient care
Outpatient Hospital Services		
Hospital Emergency Department	4 visit limit with override possible	No changes needed. Same limit applies for medical and MH emergencies
Physician Services		
Physician services including: • Psychiatric evaluation and diagnosis, • Individual, family, or group psychotherapy, • Electro-shock treatment, • Psychometric testing, and • Collateral contacts	No limit for physician services including psychiatrists	No changes needed. Psychiatrist services are treated the same as other physician services
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21		
Under EPSDT, a beneficiary may receive • Services in amounts greater than that otherwise covered under Medicaid • Services that can be covered under Federal Medicaid law but that NH has chosen not to otherwise cover	• Under age 21 • Service must be needed to treat a condition identified in an EPSDT screen • All services beyond those otherwise covered by NH Medicaid require prior authorization from Medicaid agency	No changes needed. Section 509 of CHIPRA specifies that state CHIP plans are deemed to satisfy MH/SUD parity if they cover EPSDT
Optional State Plan Services		
Inpatient Psychiatric Hospital Services (for persons under age 22 or over 64) IMD Benefit		
Evaluation, diagnostic, and treatment services in psychiatric hospital [3/]	• Must be under age 21 at admission or • Over 64 at time of service	The IMD issue is unsettled, but is expected to be addressed in regulations for the Alternative Benefit Plan due to be issued shortly.

(1) Service	(2) Service requirements and limitations	(3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits [1/]
Psychotherapy		
Practitioners licensed by the Board of Mental Health Practice • Evaluation, diagnostic, and treatment services	• Psychotherapy benefit 18 visits for adults 24 for kids. • Services provided by the CMHC fall outside this benefit	If NH determines that physician services constitute two-thirds or more of ambulatory medical/surgical services, then limits should be eliminated because substantially all ambulatory medical benefits have no quantitative limits. Final CMS guidance should be consulted. [2/]
Rehabilitation Services		
Community Mental Health Services • 24-hour Emergency Services • Assessment and Evaluation • Individual and Group Therapy, • Case Management, • Community Based Rehabilitation Services, • Psychiatric Services, and • Community Disaster Mental Health Support.	• Services up to $1,800 in Medicaid reimbursement per state fiscal year unless the individual has functional impairments which meet the criteria for Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED). SMI and SED have no set limit. Adults formerly meeting SMI criteria who are considered low utilizers have a $4000 state fiscal year limit. • Services from an out-of state provider must receive prior-authorization	CMHS emergency services are supplemental and therefore, any limits are likely acceptable, though unlimited access to emergency stabilization is desirable for people in mental health crises. If NH determines that physician services constitute two-thirds or more of ambulatory medical/surgical services, then limits on assessment and evaluation, individual and group therapy and psychiatric services should be eliminated because substantially all ambulatory medical benefits have no financial limits.[2/] Final CMS guidance should be consulted. Limits on community based rehabilitation services for people who do not have SED or SMI should be set to ensure that they are no more restrictive than limits on physical, speech or occupational therapy. Final CMS guidance should be consulted. Acceptable medical necessity criteria for case management, community based rehabilitation for people with SED or SMI appear to be no more restrictive than those for eligibility for Home and Community Based Waiver services for people with physical and developmental problems. Final CMS guidance should be consulted. No changes required in prior approval for out-of-state providers if the same procedures and criteria apply to ambulatory medical services

(1) Service	(2) Service requirements and limitations	(3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits [1/]
Targeted Case Management for Individuals who have a SMI or SED		
• Crisis intervention monitoring, • Coordination of assessment and certification of eligibility for mental health services, • Development of an individual service plan and service mobilization, • Oversight of services • Periodic review of service plan, monitoring, linkage, and advocacy	• Beneficiary must have a severe mental illness and be in need of long-term mental health services and case management.	Medical necessity criteria for targeted case management for SMI/SED appear to be no more restrictive than criteria used for other disabling conditions that are eligible for Home and Community Based Waiver services. Final CMS guidance should be consulted.

Services for children in DCYF custody [4/]

(1) Service	(2) Service requirements and limitations	(3) Changes Needed to Comply with Parity if included in Managed Care Benefits [1/]
Optional Services		
All of these services would need to be vetted through DCYF. They are restricted to children in DCYF custody.		Currently not planned to be included in managed care benefit. If these benefits are included in the future, MCOs cannot impose additional limits on mental health services that exceed those for medical/surgical services. However, limits included in the state plan can remain.
Therapeutic foster care • Client-centered family mental health counseling, • Individual counseling, • Crisis intervention and stabilization, • Medical care coordination	• Prior authorization required • No specific limits	MCO prior authorization and medical necessity criteria can be no more restrictive than for specialized foster care for children with significant medical conditions.
Intensive Day Therapy, package of services including: • Case management, • Occupational therapy, • Physical therapy, • Speech therapy, and • Nursing services.	• Prior authorization required, with services authorized for two-month periods with a limit of six months total • Services must be provided for a minimum of four hours, five days per week	N/A not a behavioral health service. This would be considered as a potential point of comparison for MH/SUD service policies.
Intensive Day Programming (children): Based on clinical assessment, each child receives an individually-designed program of individual, group, and/or family system therapy and counseling	No specific service limits	No changes are likely to be needed because there are no specific limits. If this program requires prior approval, then the MCO process and criteria would need to be no more restrictive than for specialized medical services for foster children or similar high need populations.
Crisis Intervention • Therapeutic and intensive counseling	• Prior authorization required • Limited to six-year period without regard to the 12 visits/year limit	We are not entirely clear what this service is or how the six year period limit works. If this program requires prior approval then the process and criteria would need to be no more restrictive than for specified medical services for Foster children or similar high need populations.
Home-Based Therapy services • Psychotherapy and mental health counseling and therapy	• Prior authorization required • No specific service limits	MCO prior authorization process and criteria can be no more restrictive than those for any home based medical service for foster children or other high need populations.

Footnotes:
1/ MHPAEA applies only to alternative benefit plans for the newly eligible, not to Medicaid fee-for-service benefits. Medicaid managed care plans for current beneficiaries can retain limits or restrictions on mental health services that are part of the state plan, but any additional criteria or restrictions that MCOs create must comply with MHPAEA.
2/ Substantially all is defined as 2/3 or more of the benefits in the applicable category. Interim regulations define the following six benefit categories:

- Inpatient in-network
- Inpatient out of network
- Outpatient in-network
- Outpatient out-of-network
- Emergency services
- Pharmacy

3/ NH Medicaid only reimburses this category for care at NH State Hospital. No private psychiatric facilities are paid.
4/ DCYF services were previously available to children at risk as well as those in DCYF custody. However, in the past year, their services have been tightly restricted to only those children in custody. They are provided by providers other than CMHCs and billed directly to Medicaid. They are considered part of NH's rehabilitation option services and parallel many CMHC services, but have been customized for the DCYF population and are governed by DCYF service standards. These services will not be included in Step 1 of managed care, though they may be added subsequently.

V. Option for Substance Abuse Benefit Design

As New Hampshire has not previously offered a Medicaid substance abuse benefit, the following section provides an evidence-based option for such a benefit based on relevant national standards, how other states have designed Medicaid substance abuse services, and the substance abuse treatment services established by the New Hampshire Bureau of Drug and Alcohol Services.

Approach

Evidence and experience suggests that a SUD benefit should include the needed continuum of substance use disorder services that would meet the range of needs for different degrees of misuse, addiction and withdrawal. To provide an option for such a continuum, the Lewin Team consulted two sets of standards for SUD treatment—(1) the framework of the American Society of Addiction Medicine (ASAM) and (2) the Substance Abuse and Mental Health Services Administration's (SAMHSA) model for a Modern Addictions and Mental Health System. The continuum of services provided by the Bureau of Drug and Alcohol Services, whose admissions are governed by ASAM level of care criteria, are also identified. Discussions with personnel from the Bureau of Drug and Alcohol Services and the Department of Health and Human Services provided better understanding of the current scope of BDAS services and the Medicaid methadone benefit. The provisions of the MHPAEA and the benefits of New Hampshire's selected benchmark plan were also reviewed.

Standards for continuum of substance abuse services

ASAM recognizes six dimensions that determine the nature of an individual's need for SUD treatment. These include: Immediate Risk of Intoxication and Withdrawal; Co-occurring Biomedical Conditions; Co-occurring Emotional/Behavioral Conditions; Readiness to Change; Relapse Potential; and Support System (the individual's social, family and environmental supports, (such as housing, job, etc.). The ASAM framework provides criteria for determining the level of SUD treatment needed to address different degrees of misuse, addiction and withdrawal. ASAM defines five levels of care that can together meet the range of needs for detoxification and treatment found among individuals with SUDs, as shown in ***Figure 11***.

Figure 11: Description of ASAM Levels of Care

ASAM Level of Care	Level of Care Description
0.5: Early Intervention	Education, risk advice and services to people who may be at risk of developing a SUD
I: Outpatient Treatment	Encompasses modalities of outpatient substance abuse counseling, opioid treatment (methadone), suboxone treatment from a physician, and community support.
II: Intensive Outpatient/ Partial Hospitalization	**II.1 Intensive outpatient treatment** At least 6 hours a week of structured outpatient counseling and psychoeducation. **II.5 Partial hospitalization** 20 or more hours of clinically intensive programming per week, for people who require structure and support to achieve and sustain recovery.

ASAM Level of Care	Level of Care Description
III: Residential/ Inpatient Subacute Treatment	**III.1 Clinically Managed Low-Intensity Residential Services** At least 5 hours a week of treatment directed toward applying recovery skills and preventing relapse. Often provided in a halfway house or group home. **III.5 Clinically Managed Medium-Intensity Residential Services** Highly structured recovery environment with medium-to-high intensity professional clinical services and a therapeutic "community". For clients with difficult or abusive interpersonal relationships, criminal justice histories, little or no work history, and limited education. **III.7 Medically Monitored High-Intensity Residential/Inpatient Treatment** Medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians in a non-hospital twenty-four hour rehabilitation facility.
IV: Medically-Managed Intensive Inpatient Treatment	Medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians with the full resources of a general acute care hospital or psychiatric hospital.

Substance Abuse and Mental Health Services Administration. SAMHSA's standards for a Modern Addiction System identify services needed by people with SUD in the following 11 categories:

- Healthcare Home/ Physical Health
- Prevention (including Promotion)
- Engagement Services
- Outpatient Services
- Medication Services
- Community Support (Rehabilitative)
- Other Supports (Habilitative)
- Intensive Support Services
- Out-of-Home Residential Services
- Acute Intensive Services
- Recovery Supports
-

Some services, such as health care homes and physical health, are not SUD treatment services but support the need for treatment of substance use problems to be integrated with physical health and primary care. Prevention and certain supportive services fall outside the range of what is traditionally considered within the scope of Medicaid and health insurance. However, the remainder of the categories encompasses the services included in the ASAM framework and some additional approaches for which evidence of efficacy is developing.

Examples of Medicaid substance abuse benefits in other states

Substance abuse services being offered by other states are examined to illustrate varying degrees of richness in substance abuse benefits. Based on an analysis performed by the National Association of State Alcohol/Drug Abuse Directors (NASADAD) in 2012, the range of coverage of Medicaid substance abuse services across ten states is presented in ***Figure 12***. About half of the states shown cover screening/brief intervention services (ASAM 0.5), while nearly all of these selected states cover ASAM I through IV for certain populations or within certain service categories. A number of states, for example, cover Level III residential treatment only for youth under age 21. Lastly, methadone treatment is covered to some extent by all 10 states, though the service categories in which treatment is covered vary.

Figure 12: Medicaid Program Coverage of Substance Abuse Services Across Ten States (2012)

State	CA	CO	IL	IA	MD	MA	MI	NY	VT	VA
Carve Out?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Screening/Brief Intervention (ASAM 0.5)	No	No	No	Yes	Yes	Yes	Yes	ED only	No	Yes
Outpatient Testing and TX (ASAM I)	Rehab/ clinic	Yes	Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Methadone Treatment (ASAM I)	Clinic	MD, Clinic, EPST, under Waiver	Rehab	Yes	Yes	Yes	Clinic	MD, Clinic, under Waiver	Rehab	MD, Clinic, Other Prac.
Intensive Outpatient/Partial Hospitalization (ASAM II)	Rehab/ clinic	No	Clinic	Yes	Yes	Preg. womn	Yes	Yes	Yes	Yes
Short-Term Residential/Inpatient TX (ASAM III)	Gen. In-patient	< 21 yrs	< 21 yrs	Yes	< 21 yrs	No	In-patient	< 21 yrs	Yes	< 21 yrs
Long-term Residential/Inpatient TX (ASAM III)	Gen. In-patient	< 21 yrs	**No**	Yes	< 21 yrs	No	In-patient	No	Yes	< 21 yrs
Med. Managed Inten. Inp. Hosp. TX (ASAM IV)	Un-known	Inpat. Detox	No	Yes	Detox only	Yes	No	Detox only	Detox only	Preg. womn only

Evidence-based guidance

Under federal regulations, New Hampshire will be required to provide a Medicaid SUD service benefit for its expansion population. This benefit will need to comply with essential health benefit requirements, include benefits at least equivalent to those in New Hampshire's selected benchmark plan, and conform to the requirements of MHPAEA. New Hampshire is not required to add such benefits to its state Medicaid plan services enrollees whether they remain in its fee for service system or enroll into a managed care program. However, the state has the option to provide a single SUD benefit that is consistent for all beneficiaries.

This section outlines an evidence-based option for a Medicaid substance abuse benefit, including justifications for the benefits option. ***Figure 12*** lists relevant New Hampshire Medicaid benefits, identifying what changes would be needed to carry out this option.

Figure 13 lists evidence-based SUD treatment services that provide an optimal continuum of care. This set of services includes each ASAM level thereby providing a continuum of services able to meet the full scope of need for detoxification and substance abuse treatment. This set of services, if implemented according to recommendations, is likely to meet parity requirements. Further, it provides at least the scope of services outlined in New Hampshire's selected benchmark plan.

Figure 13: Potential SUD Treatment Medicaid Benefit

1) Medically managed detoxification (level IV – hospital detox)
2) Medically monitored detoxification (level III – non-hospital)
3) Screening and Brief Intervention
4) Outpatient Counseling
5) Outpatient Detoxification
6) Intensive Outpatient Treatment
7) Community Stabilization Supports (30 to 60 days of support for people in early recovery in their own homes or in residential treatment)
8) Methadone maintenance
9) Peer Recovery Support

Services required to meet applicable standards

Medically managed detoxification (inpatient detoxification), outpatient counseling and detoxification, intensive outpatient, and methadone maintenance are likely to be considered necessary to provide SUD services at parity with medical/surgical services. Medically managed detoxification is within the scope of general hospital services and the other services are already established as defined levels of care in the network of New Hampshire's Bureau of Drug and Alcohol Services.

Medically managed detoxification (level IV – hospital detox). This level of care is needed by people in acute stages of withdrawal who need close monitoring and the ability to treat any medical problems that arise. Services include medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians with the full resources of a general acute care hospital or psychiatric hospital. An interdisciplinary team and support resources allow for the coordinated treatment of any coexisting biomedical and emotional or behavioral conditions that need to be addressed.

Outpatient Counseling. This level of care is defined as eight or less hours per week of organized, outpatient services by a licensed substance abuse professional designed to achieve permanent changes in an individual's substance using behavior.

Outpatient Detoxification. People whose acute withdrawal symptoms do not require continuous medical monitoring can be treated at the outpatient level. Licensed Opioid Treatment Programs can dispense Methadone for detoxification and properly trained and certified physicians can prescribe buprenorphine and monitor detoxification. Outpatient detoxification has been established as an effective and efficient method for acute withdrawal that minimizes undesirable symptoms and disruption of the patient's daily life. Physician

treatment with suboxone is particularly accessible for people who want to avoid the stigma of being treated in a known addiction program.

Both inpatient and outpatient substance abuse care are included in the Matthew Thornton benchmark plan and coverage of inpatient and outpatient care for substance abuse will need to be covered at parity with inpatient and outpatient care for other diagnoses to comply with MHPAEA. Since New Hampshire does not have prior approval or service limits for inpatient services or most outpatient services, then limits may not be applied for inpatient or outpatient substance abuse services. In addition, the state would need to ensure that any authorization procedures and medical necessity criteria for SUD treatment used by its managed care plans are no more restrictive than those used for medical/surgical services.

Methadone Treatment. In 2002, the Centers for Disease Control and Prevention (CDC) noted that "Methadone Maintenance Treatment is the most effective treatment for opiate addiction."[12] Methadone blocks the euphoric and sedating effects of opiates and relieves craving. Daily dosing often allows individuals to maintain their employment and family responsibilities. CDC studies have shown the benefits of methadone treatment include: reduction or cessation of injection drug use; reduced risk of transmitting or becoming infected with HIV, hepatitis B or C, bacterial infections, endocarditis, soft tissue infections, thrombophlebitis, tuberculosis, and STDs; reduced risk of death; reduced criminal activity; improved family stability; and improved pregnancy outcomes. The CDC cited several studies that found it to be cost-effective. Methadone treatment is the only substance abuse service currently covered by New Hampshire Medicaid and it has no service limits.

Intensive Outpatient Services. Intensive outpatient services are offered at least three (3) hours per day at least three (3) days per week. They include structured individual and group addiction activities and services that are designed to assist people to begin recovery and learn skills for recovery maintenance. There are no more than two consecutive days between offered services. Medical and psychiatric services are made available by referral. This level of care is generally offered on a short-term basis to help people to establish sobriety after detoxification, or when greater support is needed than less frequent outpatient care can provide. This level of care is important in reducing relapse and the need for 24 hour services.

Intensive outpatient services are rehabilitation services, which are often provided on a short-term, time-limited basis. Since New Hampshire limits speech, occupational and physical therapy to 20 visits, it may not be able to establish a lower limit on intensive outpatient services. As such, the state could consider the program model used in BDAS intensive outpatient programs and set any limit to allow for treatment to be completed in conformance with the planned program design. According to the Substance Abuse and Mental Health Services Administration, intensive outpatient programs may be designed to operate as long as 12 to 16 weeks with a frequency of 3 to 5 days per week.[13] Completion of a program of that length

---

[12] Methadone Maintenance Treatment (2002), Centers for Disease Control accessed from http://www.cdc.gov/idu/facts/methadonefin.pdf on May 10, 2013.

[13] Center for Substance Abuse Treatment, Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

would necessitate considerably more than 20 visits. In addition, evidence suggests that New Hampshire allow for enrollees to return to this level of care if they experience a relapse or are experiencing difficulties in a less intensive outpatient program.

Additional SUD services

Our SUD benefit design option includes some additional services that can strengthen and round out the New Hampshire SUD treatment system, which are based on evidence-based guidance.

Medically Monitored Detoxification (Level III, non-hospital). Depending on the stage of withdrawal and the types of any co-occurring medical problems, patients addicted to alcohol or other drugs may need a medically monitored period of detoxification. While this level of care can be provided in a general hospital, it can also be provided in a freestanding facility with staffing that meets appropriate standards for medical monitoring, nursing and other clinical care. The majority of people requiring 24 hour oversight for detoxification can be treated in Level III.[14] This level of care is significantly less expensive than hospital services. When delivered by a provider also offering outpatient and supportive community services, linkage to aftercare may be strengthened.

New Hampshire does not currently license this level of care. Adding it to covered services would require the BDAS to develop appropriate staffing, facility and operations licensing standards and a process for conducting licensure reviews. It may be challenging for New Hampshire to develop procedures that change practice to move most detoxifications into Level III facilities, since prior authorization is not routinely required for Medicaid inpatient services. Having different authorization procedures for detoxification services may be construed as being out of compliance with MHPAEA parity rules. Consultation with other states, such as Massachusetts, that manage this benefit, and building upon the widely accepted ASAM placement criteria may help address this challenge.

SUD Screening and Brief Intervention (SBIRT) is an evidence based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. It consists of three components: screening for alcohol misuse or abuse; brief intervention from a health professional or licensed addiction professional for those whose screening shows risky use of substances; and referral for SUD treatment for those whose use warrants specialty treatment.

To include this service as a covered Medicaid benefit, the state would need to develop a method of paying for the screening and brief intervention component. Screening would utilize a validated screening tool administered in primary care, emergency departments, or in other relevant settings. The brief intervention is a short conversation, providing feedback and advice. In some models, this is a single intervention at the time of screening. In other models, up to five short (20 minute) interventions may be provided over a short time period to help individuals

---

[14] Massachusetts Medicaid behavioral managed care plan changed authorization standards for detoxification services in the early 1990s to limit hospital detoxification only to those patients requiring medical management. This reduced hospital detoxification as a percent of all 24 hour detoxification from 89% to 1%. Shepard, DS, Daley, M, Ritter, GA, Hodgkin, D, and Beinecke, RH, Managed Care and the Quality of Substance Abuse Treatment, The Journal of Mental Health Policy and Economics, 163-174 (2002)

set and begin to implement goals for reducing risky substance use. Screening and brief intervention can appropriately be conducted by trained staff who are not SUD clinicians, such as primary care providers and nursing staff. To promote development of this capacity, the state could consider establishing flexible billing methods that can be used in multiple settings and by any appropriately qualified and trained practitioner. New Hampshire BDAS plans to apply for a SAMHSA grant that would support the development of SBIRT in a number of settings. This could help provide training and implementation support to initiate this new service.

SBIRT has a strong evidence base showing that it reduces healthcare costs, decreases severity of alcohol and drug use, and reduces risk of trauma and the percentage of at-risk patients who go without specialized substance abuse treatment. The following studies have shown evidence of cost savings:

- Multiple studies have shown that investing in SBIRT can result in healthcare cost savings that range from $3.81 to $5.60 for each $1.00 spent;[15]
- People who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20% fewer emergency department visits, 33% fewer nonfatal injuries, 37% fewer hospitalizations, 46% fewer arrests and 50% fewer motor vehicle crashes;[16]
- In 2002, researchers analyzed more than 360 controlled trials on alcohol use treatments and found that screening and brief intervention was the single most effective treatment method of the more than 40 treatment approaches studied, particularly among groups of people not actively seeking treatment;
- Additional studies and reports have produced similar results showing that substance use screening and intervention help people recognize and change unhealthy patterns of use;[17]
- Studies have found that patients identified through screening as having unhealthy patterns of drug or alcohol use are more likely to respond to brief intervention than those who drink heavily.[18] The latter group is more likely to meet diagnostic criteria for a substance use disorders that needs more intensive treatment; and
- Studies on brief intervention in trauma centers and emergency departments have documented positive effects such as reductions in alcohol consumption,[19] successful

---

15 Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2000). Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. Medical Care, 38(1), 7–18.

16 Ibid.

17 Miller, W.R., & Wilbourne, P.L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction, 97, 265–277.

18 Fleming M (2000).

19 Gentilello, L. M. (2007). Alcohol and injury: American College of Surgeons Committee on Trauma requirements for trauma center intervention. Journal of Trauma, 62, S44–S45.

referral to and participation in alcohol treatment programs,[20] and reduction in repeat injuries and injury hospitalizations.[21,22]

Peer Recovery Support: Peer support through organizations such as Alcoholics Anonymous and similar organizations has long been understood as an important component of recovery from SUD for many individuals. More recently, peers who have experienced SUD and recovery have begun to serve in other roles that are also demonstrating their value. In 2011, SAMHSA developed several new roles and definitions for peer services, including: Peer Recovery Support Coaching; Relapse Prevention/Wellness Recovery Support; Peer Navigator; and Peer-Operated Recovery Community Center. Peer services include services to help individuals and families initiate, stabilize, and sustain recovery; they are non-professional and non-clinical; and they provide links to professional treatment and indigenous communities of support. They are neither professional addiction treatment services nor mutual-aid support. New Hampshire BDAS recently created a certification for peer support staff that provides a foundation for building their services into the New Hampshire continuum of SUD services. These peers can be valuable in reaching newly insured vulnerable populations who are not familiar with the medical system or the SUD treatment system. If recruited from differing cultural groups, they can bridge between linguistic/cultural subgroups and the health care community. They can offer community education and public health approaches delivered from a respected member of the community. They can take on non-clinical tasks performed by clinical staff, allowing them to practice at the top of their licenses.

Research on peer recovery support services and peer-run organizations is promising and evidence is increasing. 2011 data from SAMHSA's Recovery Community Services Program grantees demonstrated positive outcomes at 6 month follow-up on abstinence, police involvement, employment, housing and mental health symptoms.[23] We recommend that New Hampshire HHS work with BDAS to identify services and programs where services of certified peer support staff can be incorporated into existing SUD program models or fill gaps in needed recovery services for high need groups. These services might initially be provided through state and block grant funds, but closely linked to Medicaid SUD services. Over time, their track record may provide sufficient justification for Medicaid to incorporate certified peer specialists or coaches directly into the Medicaid benefit.

Community Stabilization Supports: This program would cover a package of short-term supportive services that could include the clinical component of residential services or provide community-based care coordination and clinical support for others recovering in their own homes. Payment for these services should not include the costs of room and board, which is

---

[20] Gentilello,L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Annals of Surgery, 230, 473–483.

[21] Ibid.

[22] Soderstrom, C. A., DiClemente, C. C., Dischinger, P. C., Hebel, J. R., McDuff, D. R., Auman, K. M., et al. (2007). A controlled trial of brief intervention versus brief advice for at -risk drinking trauma center patients. Journal of Trauma, 62, 1102–1112.

[23] Hill, Tom, (September 26, 2011) Peer Recovery Coaches Promote Long-term Recovery from Addiction, accessed from http://www.facesandvoicesofrecovery.org/pdf/eNews/9.19.11_Peer_Coach_Pillars_of_Support_FINAL.pdf on April 30, 2013.

prohibited in Medicaid. However, the state could design a community stabilization service that could pick up the clinical components of BDAS short-term post detoxification services (ASAM Level III, clinically managed medium intensity residential) and also include the early months of transitional living programs (ASAM Level III, clinically managed, low intensity residential).

In addition, the state could support the clinical components of BDAS long-term extended care programs for pregnant women (ASAM Level III, clinically managed high intensity) for a period of time sufficient to support a safe and substance free pregnancy. The state could work with BDAS to establish service expectations that are consistent with BDAS service models, and include staffing and documentation requirements. This could be done by using a per diem rate for these services.

Figure 14: Summary of Medicaid SUD Benefit Option

Provider Type/Service	Service requirements and limitations	Additions to Create a Medicaid SUD Benefit
Mandatory State Plan Services		
Inpatient Care		
Level IV Detoxification	• Only covers detoxification provided an at an acute hospital as an acute care service [1/] • Out of state inpatient requires PA	Explicitly add acute SUD conditions as a covered inpatient service (Level IV Detoxification) Use the same process for out-of-state SUD admissions as for other out-of-state admissions
Level III Detoxification		Add coverage for this level of care once a licensure process is established
Outpatient Hospital		
Hospital Emergency Department	4 visit limit w override possible	Ensure that SUD conditions are covered emergency services subject to same limitations as for medical and MH emergencies
SUD Screening and Brief Intervention		Create a billing and payment code to appropriately reimburse this service by varied personnel in all hospital settings.
Physician Services		
Physician services	No limit for physician services including psychiatrists	Ensure that outpatient detoxification and other treatment for SUD conditions are covered physician services.
SUD Screening and Brief Intervention		Create a billing and payment code to appropriately reimburse this service.
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21		
Under EPSDT, a beneficiary may receive • Services in amounts greater than that otherwise covered under Medicaid • Services that can be covered under Federal Medicaid law but that NH has chosen not to otherwise cover	• Under age 21 • Service must be needed to treat a condition identified in an EPSDT screen • All services beyond those otherwise covered by NH Medicaid require prior authorization from Medicaid	Ensure that the EPSDT program addresses adolescent substance abuse screening, diagnosis and treatment

Provider Type/Service	Service requirements and limitations	Additions to Create a Medicaid SUD Benefit
Optional State Plan Services		
Outpatient or Community Based *SUD Outpatient and Intensive Outpatient Treatment*	• There is no discreet substance abuse benefit • The SA diagnosis does not preclude payment for any appropriate medically necessary service covered under NH Medicaid State Plan. • Licensed Alcohol and Drug Counselors are not currently recognized to provide any benefit under New Hampshire Medicaid unless it is under another dually held certification	Recognize Licensed Alcohol and Drug Counselors to provide SUD outpatient therapy Cover outpatient SUD treatment services and outpatient detoxification services without visit or financial limits If limits are set for intensive outpatient services, they should be no more restrictive than the limit on rehabilitation services. Any limit should be consistent with the optimal time in treatment for the program design.
Opioid Treatment Program Methadone Maintenance	No visit or financial limits	Continue this benefit
Post detoxification services (clinically managed medium intensity residential) Transitional living programs (clinically managed, low intensity residential). Long-term extended care programs for pregnant women (clinically managed high intensity) Short-term Community Stabilization Supports		Establish a benefit for short-term community stabilization that covers the clinical component of people in early recovery and pregnant women, whether they are in a residential program or recovering in a permanent housing situation. Criteria for continued community stabilization supports need to be consistent with criteria for recovery support provided for other chronic conditions.
Certified Peer Recovery Support Specialists		Incorporate these positions as billable staff in other Medicaid SUD services as appropriate. Consider establishing Peer Organization services as a covered benefit.

1/ In this instance, acute care service has been administered assuming that it must be an acute medical care service

Basis for SUD cost estimate

To estimate the cost for a SUD benefit in New Hampshire, we examine cost and utilization data from Medicaid programs in Massachusetts and Pennsylvania (***Figure 15***). These data provide information on the percent of enrollees using SUD services and the average annual claims costs per user across various eligibility groups in 2011. We also obtained 2011 average SUD costs per adult user in Medicaid programs in Kansas ($2,268) and North Carolina ($2,115), which we found to be similar to the other two states.

For our estimates, we use Massachusetts Medicaid utilization and cost data since the benefits offered in Massachusetts are similar to the option described above for New Hampshire, except for residential care which this option covers only room and board and not the clinical service. The Massachusetts data is also helpful because it provides usage rates for adults without children who are not currently eligible in New Hampshire but will become newly eligible under the Medicaid expansion. However, Massachusetts already covers this group to 133 percent of FPL. We would anticipate the same level of utilization for the newly eligible group in New Hampshire under the expansion. The Massachusetts utilization rates are adjusted to account for the difference in the prevalence of alcohol or illicit drug abuse or dependency between the two states. [24] SUD cost per user estimates for New Hampshire was adjusted to reflect the difference in Medicaid reimbursement rates between the two states. [25]

For this analysis, we were unable to breakout the cost for each type of service specified above. The cost per person for this benefit is dependent on the entire continuum of treatment that is available, where the cost for one particular service may be dependent on other services that are also available.

Figure 15: Substance Use Disorder Utilization and Cost for Massachusetts and Pennsylvania Medicaid Programs in 2011

Eligibility Category	Massachusetts		Pennsylvania		New Hampshire (Estimated) 1/	
	SUD Cost per User	Percent of Enrollees Using Services	SUD Cost per User	Percent of Enrollees Using Services	SUD Cost per User	Percent of Enrollees Using Services
TANF Adult	$2,052	7.97%	$2,568	5.26%	$1,546	7.08%
TANF Child	$1,592	0.85%	$1,157	1.14%	$1,199	0.84%
Disabled	$2,362	10.90%	$2,462	7.16%	$1,779	9.69%
Adults w/o children	$2,142	19.42%	n/a	n/a	$1,613	17.26%
Foster Care	$2,109	2.29%	n/a	n/a	$1,589	2.27%

1/ The utilization rates are adjusted to account for the difference in the prevalence of alcohol or illicit drug abuse or dependency between Massachusetts and New Hampshire and SUD cost per user estimates was adjusted to reflect the difference in Medicaid reimbursement rates between the two states.
Source: Colorado Behavioral Health Council, July 31, 2012

These SUD cost per user and percent of enrollees using services are used to develop the costs estimates for the Medicaid program under the various benefit design options presented above. The following section describes the potential medical cost offsets that could occur when SUD treatment is provided.

[24] SAMHSA, "2010-2011 NSDUH State Estimates of Substance Use and Mental Disorders"

[25] Stephen Zuckerman and Dana Goin, "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Urban Institute and Kaiser Commission on Medicaid and the Uninsured, December 2012.

VI. Savings to Other Programs Resulting from Substance Abuse Benefit

The National Survey on Drug Use and Health (NSDUH) identifies New Hampshire as a state with one of the highest rates of drug and alcohol use and abuse. [26] Substance abuse is viewed as one of the state's top public health concerns, and its social and economic consequences have received much attention in recent years.

According to a 2012 inquiry by the National Association of State Alcohol/Drug Abuse Directors, Medicaid covers at least a minimum level of substance abuse services in the majority of states.[27] Outpatient treatment, designated by the American Society of Addiction Medicine (ASAM) as coverage level 1, is covered by Medicaid in 43 states. Intensive outpatient and partial hospitalization (ASAM level 2) is covered in 37 states. Short-term residential and inpatient treatment (ASAM level 3) in 31 states; long-term residential treatment in 21 states, and medically managed intensive inpatient treatment in a hospital setting (ASAM level 4) in 32 states.

New Hampshire currently does not have a substance abuse benefit under its state plan, but there are certain services that individuals with a substance use disorder may access. Per the ACA, substance use disorder services are classified as one of ten essential health benefits. Therefore, the Medicaid benefits offered to certain newly eligible adults in New Hampshire must cover services for substance use disorders beginning in 2014. The state may also elect to offer this substance abuse benefit to current Medicaid eligibles.

Nationwide, substance abuse treatment is largely financed with public dollars. Estimates indicate that as much as 65 percent of treatment expenses are borne by public funding, either through states' Medicaid programs, through the Divisions of behavioral health, or through separate substance abuse treatment programs funded through federal grants and state funds.

To understand the impact of substance abuse treatment coverage by a state Medicaid program, the following sections present findings from recent literature discussing outcomes across several state and health plan initiatives to integrate a substance abuse benefit into its existing benefit structure. In recent years, researchers have sought to better understand the economic impact of substance abuse treatment, or the "cost offset" of such initiatives. Here, we examine direct medical savings of a substance abuse treatment program on health care utilization and direct medical expenses. These programs offer a range of supportive and therapeutic services to clients, with the intent of reducing drug and alcohol dependence, promoting recovery, and decreasing the incidence of relapse.

Additionally, we review recent studies of the impact that substance abuse treatment programs have on crime, prison recidivism, and inmate reintegration. Lastly, we present findings from the literature that discusses the empirical evidence of the broader societal impacts that

---

[26] Office of Applied Studies (2008). States in Brief: Substance Abuse and Mental Health Issues At-A-Glance. Substance Abuse and Mental Health Services Administration. Retrieved from: http://www.samhsa.gov/statesinbrief/2009/NEW_HAMPSHIRE_508.pdf

[27] Bureau of Justice Assistance (BJA) Drug Court Technical Assistance/Clearinghouse Project. (2012). Medicaid Coverage for Substance Abuse and Related Services for Drug Court Clients. American University. Retrieved from: http://www1.spa.american.edu/justice/documents/4143.pdf

substance abuse treatment programs may contribute. This includes the impact on families and the workplace.

Medical savings from treatment of substance abuse

Economic evaluations of substance abuse treatment programs have appeared in the literature for several decades. While focused on different study populations, programs, and treatment settings, most of the evidence suggests that treatment programs provide a short-term positive cost offset.[28]

In more recent years, the effect of substance abuse treatment on Medicaid expenses or other health care costs has been studied following the expansion of certain states' Medicaid programs to include a substance abuse benefit when one had not previously been offered. A recent robust evaluation was performed on Colorado's Medicaid Substance Abuse Benefit to offer outpatient substance abuse and addiction treatment services to all Medicaid enrollees. Another study examines the effect of treatment on Medicaid expenses among welfare clients in Washington State. Because most economic evaluations of substance abuse treatment to date have largely focused on private patients, these studies examining the potential cost offsets to providing treatment to Medicaid recipients are especially relevant.

Colorado's Substance Abuse Benefit was found to cost $2.4 million in first three years, while reducing medical costs by $3.5 million over the same period.

The Colorado Outpatient Substance Abuse Benefit was implemented in July 2006. In 2010, an evaluation was performed to fulfill a legislative mandate wherein the State Auditor reviewed the state's Department of Health Care Policy and Financing's (which oversees the state's Medicaid program) analysis of the benefit's costs and also performed an independent assessment of costs using the state's Medicaid and behavioral health data. Results showed the Substance Abuse Benefit cost the Colorado Medicaid program an additional $2.4 million in the first three years of the benefit's operation (fiscal year 2007 through 2009), while reducing medical costs by $3.5 million for the individuals receiving the benefit in that time period.[29] The auditors define "savings to the Medicaid program" as "the amount invested in Substance Abuse Benefit services less the reduction in medical costs directly resulting from, or 'caused by' those Substance Abuse Benefit services." Despite these findings, however, the evaluators point to the inability to conclusively attribute these savings to the Substance Abuse Benefit alone because of other possible confounding factors, such as environmental and lifestyle choices among the beneficiary population that may have also impacted their health status and thus, medical expenditures.

Overall findings indicate that the cost of providing substance abuse services to 5,200 Medicaid clients during the 2007-2009 period cost an average of $464 per beneficiary, amounting to $2.3 million in claims costs, approximately $150,000 in administrative expenses and 0.5 full time employee (FTE) to provide administrative functions for the program. The reduction in medical

---

[28] Cartwright WS (2000). Cost-Benefit Analysis of Drug Treatment Services: Review of the Literature. Journal of Mental Health Policy and Economics, 3:11-26

[29] Services covered under Colorado's Medicaid Substance Abuse Benefit included: substance abuse assessment, individual and family therapy, group therapy, alcohol and/or drug screening, social and ambulatory detoxification, and case management. Services are provided on a fee-for-service basis.

costs associated with the Substance Abuse Benefit included reduced claims costs for the following Medicaid services: emergency room, inpatient hospitalization, other outpatient, physician, dental, pharmacy, mental health, laboratory, and capitated claims. Various cost trending methodologies were applied, each yielding results that indicate that the Substance Abuse Benefit was financially beneficial to the state. A comparison of Medicaid costs for beneficiaries who utilized the benefit to the overall Medicaid population indicated that Medicaid costs for those who used the benefit either increased at a lower rate or declined at a higher rate than the overall Medicaid population. This is particularly notable given that average annual Medicaid expenses for Substance Abuse Benefit clients is much higher than that for a standard Medicaid enrollee.

The Colorado evaluation also provides insight regarding client costs based on the type of therapy received. Total medical costs for Substance Abuse Benefit clients who received therapy services, including individual and group therapy, decreased at a faster rate (31 percent) than costs for benefit recipients who only received detoxification, assessments and case management. Research suggests that therapy treatment can be more cost-reducing because it acts as a positive influence to the overall health of the client.[30]

Colorado also learned that longer-term clients generally had higher average annual Medicaid cost compared to shorter-term clients. In particular, those who were enrolled in the entire 36 months of study had nearly twice the cost as those who were only enrolled for 10 months ($8,390 and $4,920 in Fiscal Year 2009, respectively). According to the state, the cost differential is likely due to the higher prevalence of disability and chronic or complex conditions among the longer-term clients.

In Washington State, the weighted annual average of savings for patients receiving inpatient, outpatient, and methadone substance abuse treatment was $2,520.

A Washington study evaluates the economic impact of substance abuse treatment on medical expenditures, primarily for those enrolled in Medicaid. The study population was comprised of persons in the General Assistance program in the state –generally low-income individuals ineligible or awaiting approval for federally-funded cash assistance programs. Medicaid was responsible for 75 percent of medical expenditures in this group, while other state funding contributed the remaining 25 percent.[31] The study found that the cost of medical care for General Assistance clients receiving inpatient treatment was, on average, $170 less per member per month than clients in the comparison group, who needed treatment but did not receive it. For those who received outpatient treatment or methadone maintenance, costs were $215 and $230 lower, respectively. The weighted annual average of savings for these three treatment groups was $2,520. The estimated cost savings associated with substance abuse treatment is 35 percent of expected cost in the first year of treatment, given that average annual medical expenses for untreated clients amount to nearly $6,500.

---

30 Ibid.

31 Wickizer TM, Krupski A, Stark K, Mancuso D & Campbell K (2006). The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State. The Milbank Quarterly 84.3: 555-76

The study also notes that the substance abuse treatment essentially "paid for itself" within the first year of treatment. While the average cost of treatment for public clients in the state is $2,300 per episode, the estimated offset of $2,520 within one year was more than sufficient to return the program's investment. Furthermore, because substance use disorders left untreated can lead to expensive acute or chronic conditions over time, the long-term savings of treatment may be even more pronounced.

Kaiser Permanente's outpatient chemical dependency treatment program showed a 30 percent decline in costs for Medicaid and non-Medicaid patients by the third year of treatment.

Another study observes a group of Medicaid-insured patients seeking treatment in Kaiser Permanente's outpatient chemical dependency treatment program for one year before the initial program visit and for three years following the start of treatment. Medical costs and utilization are compared to demographically-matched commercially insured patients entering the same program. The findings indicate that both Medicaid and non-Medicaid patients experience average declines in medical costs of 30 percent from the baseline period to the third year following treatment initiation.[32] Although Medicaid-insured patients on average incur medical costs 60 percent higher than non-Medicaid patients during the 1-year pre-intake period, both groups display declines in medical costs averaging 30 percent from the baseline period to the third year of follow up. Medical expenses reflect use of hospital days, ER visits, and outpatient visits.

Similarly, medical utilization and costs are examined for 18 months before and after intake of adult males entering an outpatient chemical dependency recovery program at Kaiser Permanente in Sacramento. The findings of this landmark study indicate a substantial decline in the use of medical care associated with substance abuse treatment, particularly in emergency department services and inpatient care. Inpatient, ER, and total medical costs declined by 35 percent, 39 percent, and 26 percent, respectively, in the 18-month post-treatment period.[33]

Our cost estimates of providing a SUD benefit in Medicaid for newly or currently eligible assume a resulting physical health care cost reduction based on these studies. We based on cost reduction assumption on the results of the Colorado Medicaid study that showed a return on investment of 1.45 to 1.0 over a three year observed period (i.e., $2.4 million cost for SUD services compared to $3.4 million reduction on physical health services).

Reductions in recidivism and imprisonment

A 2003 meta-analysis reviewed 11 studies and found that the benefit-cost ratios associated with substance abuse treatment were between 1.33 and 23.33, and that the economic benefits were

---

[32] Walter LJ, Ackerson L, & Allen S (2005). Medicaid Chemical Dependency Patients in a Commercial Health Plan: Do High Medical Costs Come Down Over Time?. J Behav Health Serv Res, 32(3): 253-63. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16010182

[33] Parthasarathy S, Weisner C, Hu TW & Moore C. Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis. J Stud Alcohol, 62(1): 89-97. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11271969

overwhelmingly due to reductions in criminal activity.[34] Substance abuse is one of a myriad of issues that lead individuals to partake in criminal activity. It is also a primary reason for the return of former inmates to correctional facilities after the initial release. Therefore, increased availability of substance abuse treatment may have the potential to deter crime and/or prevent recidivism.

Beginning in 2014, formerly incarcerated individuals with incomes below 133 percent of FPL will be eligible for Medicaid including substance use disorder services. Without this expansion in Medicaid eligibility, these individuals would not have access to substance use disorder services even if the services were to be included as a Medicaid benefit.

According to the National Center on Addiction and Substance Abuse, approximately 80 percent of inmates have a drug or alcohol abuse problem.[35] Studies by the New Hampshire Department of Corrections (DOC) indicate that the percent of former inmates released from prison and reincarnated within three years increased substantially between 2003 and 2005, from 40 percent to 51 percent, respectively.[36] Thirty-seven percent of recidivism in the state occurs due to a drug offense. According to the Justice Center at the Council of State Governments, no state dollars are appropriated to DOC for rapid drug testing or transitional substance abuse treatment in the state. The DOC does not contract with the community-based substance abuse treatment providers to facilitate rapid access to treatment following release. The Justice Center cites research indicating that effective addiction treatment is associated with an 18 percent reduction in recidivism, when used in conjunction with intensive probation or parole supervision.[37] The Center approximates that out of the 2,000 individuals released to parole or sentenced to felony probation in FY 2009, 700 were in need of addiction and/or mental health treatment services. The Center further estimates that an annual state investment of $2.4 million could have provided evidence-based treatment services to all 700 medium and high risk individuals on parole or probation.[38]

One study indicates that effective addiction treatment is associated with 18 percent reduction in recidivism.

According to Hammet et. al., some former inmates deliberately return to prison because they feel they can obtain better care in a correctional facility than in the community.[39] The literature cites a lack of programs to facilitate discharge planning, community linkages, and continuity of care for inmates leaving a correctional facility as a leading issue for prisoner reentry. A study on the risk of death for former inmates found that the adjusted risk of death among former inmates was 12.7 times that among other state residents, with a substantially elevated risk of

---

34 McCollister KE & French MT (2003). The Relative Contribution of Outcome Domains in the Total Economic Benefit of Addiction Interventions: A Review of the First Findings. Addiction, 98:1647-59. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16430607

35 Hammett TM, Roberts C & Kennedy S (2001). Health-Related Issues in Prisoner Reentry. Crime & Delinquency, 47.3: 390-409. Retrieved from http://cad.sagepub.com/content/47/3/390

36 Justice Center (2010). Justice Reinvestment in New Hampshire: Analyses & Policy Options to Reduce Spending on Corrections & Increase Public Safety. The Council of State Governments. Retrieved from https://www.nh.gov/nhdoc/divisions/publicinformation/documents/012010_justice_rein_analyses.pdf

37 Ibid.

38 Ibid.

39 Hammett TM et al. (2001)

death from drug overdose (the leading cause of death among former inmates during a two-year follow-up period).[40] Given that the DOC in New Hampshire is not appropriated funds to address many of the issues associated with community transition, the efficient transition to other public programs, such as Medicaid, after release, becomes a priority. The prolonged qualification process for the program may result in a significant gap between application and access to benefits. In some cases, this gap may span several months if the release is not eligible to apply for the program until after he or she has been released. Several corrections demonstration projects funded by the CDC have explored strategies to expedite the application process for inmates, such as allowing them to apply for Medicaid prior to release, and then holding the application so the releasee can be approved and enrolled on the day of release.

Other secondary societal impacts

The finding that substance abuse treatment "pays for itself" is consistent with other studies, especially when extended to savings in other realms, beyond health care spending. A study performed on the outcomes of the California Treatment Outcome Project (CalTOP), a large-scale demonstration project that collected outcomes data for 43 substance treatment providers in 13 counties in California, suggests that substance abuse treatment demonstrates a 7:1 ratio of benefits to costs when "costs" includes the client's costs of medical care, mental health care, criminal activity, earnings, and government transfer program payments. These estimates cite an average substance abuse treatment regimen costing $1,583, producing a societal benefit of $11,487.[41]

One study cites an average substance abuse treatment regimen costing $1,583 while producing a societal benefit of $11,487.

Evidence of detrimental secondary effects of substance abuse on families suggests that the value of substance abuse treatment extends much farther than the budgets of public programs. Having a family member with an alcohol or drug abuse problem adversely affects family dynamics and functioning.[42],[43] Further, it has been shown that family members of individuals with substance abuse disorders experience increased prevalence of medical and psychiatric afflictions, leading to increased medical utilization and cost, compared to family members of those without such disorders.[44],[45] Researchers at the Department of Psychiatry at the University of California, San Francisco sought to determine whether the family members of persons with an alcohol or drug dependence were more likely to be diagnosed with medical conditions than

---

40 Binswanger IA, Stern MF, Deyo RA, Heagerty PJ & Cheadle A (2007). Release from Prison — A High Risk of Death for Former Inmates." New England Journal of Medicine, 356.5: 536.

41 Ettner SL, Huang D, Evans E, Ash DR, Hardy M, Jourabchi M & Hser Y (2006). Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself'? Health Services Research, 41.1: 192-213. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16430607

42 Kern RM (1992). The Other Half: Wives of Alcoholics and Their Social-Psychological Situation. Symbolic Interaction, 15: 247–250.

43 Spear S & Mason M (1991). Impact of Chemical Dependency on Family Health Status. Substance Use & Misuse, 26.2: 179-87.

44 Thomas RG, Mertens JR & Weisner C (2007). The Excess Medical Cost and Health Problems of Family Members of Persons Diagnosed With Alcohol or Drug Problems. Medical Care, 45.2: 116-22. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17224773

45 Lennox RD, Scott-Lennox J & Holder H (1992). Substance Abuse and Family Illness: Evidence from Health Care Utilization and Cost-offset Research. The Journal of Mental Health Administration, 19.1: 83-95. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10171039

family members of persons with asthma or diabetes. Health services cost and utilization were compared for the family members of both groups for one year prior and two years after the initial diagnoses of the ailing family member. The results indicate that the family members of those with alcohol or drug dependence had higher total health care costs than members of the opposing group before and after the initial diagnosis of the index person. Further, members of the former group were more likely to be diagnosed with a substance use disorder themselves, as well as depression and trauma, than the diabetes and asthma family members.[46] Thus, the conclusion suggests that substance abuse is linked to certain patterns of health conditions and higher cost in not only the afflicted individuals, but also their family members.

The benefits of substance abuse treatment also extend heavily to the workforce. Lost productivity in the workplace accounts for nearly two-thirds of the costs of substance abuse.[47] The economic benefit of chemical dependency treatment to employers is widely available. In one particularly influential study, nearly 500 individuals receiving treatment at Kaiser Permanente's Addiction Medicine programs were given assessments before and after treatment initiation that sought to investigate measures such as work productivity, absenteeism, and conflicts with coworkers or management. Assessments performed after treatment began reported a substantial reduction in the number of beneficiaries who missed work, were late for work, who were less productive at work, and/or experienced conflicts with co-workers or management. At the mean benefit utilization rate and annual salary ($45,000), the net benefit of the substance abuse treatment was $1,538 when assessed after two months of treatment.

---

[46] Thomas RG, Mertens J & Weisner C (2009). Family Members of People with Alcohol or Drug Dependence: Health Problems and Medical Cost Compared to Family Members of People with Diabetes and Asthma. Addiction, 104.2: 203-14. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19149814

[47] Substance Abuse and Mental Health Services Administration (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. U.S. Department of Health and Human Services. Retrieved from http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf