

# **7. Reimbursement Issues**

## Reimbursement Issue;

The development of the current system for treating alcoholics and alcohol abusers has been closely tied to funding and reimbursement policies of both private and governmental insurance programs. Since the acceptance of alcoholism as a disease over 25 years ago, an elaborate medically based treatment system for alcoholism has evolved. In some cases, development of treatment services has preceded reimbursement policy; in other cases, however, treatment seems to have developed around what *is* reimbursable.

In recent years, a number of private insurance companies, employers, and the Federal Government have expanded benefits for alcoholism treatment. Reimbursement for acute medical care as well as inpatient treatment for alcoholism is currently available, although coverage is not universal. Non-hospital-based treatments, including outpatient care, aftercare, and non-medically-oriented residential care, are less frequently reimbursed, although there is a trend toward developing such benefits (341). Thirty-three States currently mandate some form of coverage by health insurers for alcoholism treatment (283).

Recent emphasis on expanding insurance benefits for alcoholism treatment (see, e.g., 211) stems from a belief, supported by the evidence in chapter 6, that the costs of not providing alcoholism

**treatment are greater than the costs of providing such treatment** (11,216,274). Whether alcoholism treatment should be reimbursed at all, therefore, does not seem to be at issue. The essential question at this point seems to be whether current reimbursement policy supports the provision of the most cost-effective treatments. As discussed in chapter 6, several cost analyses have been conducted that indicate the beneficial effect of alcoholism treatment, yet several issues need to be addressed in greater depth: questions about whether ineffective treatments are being employed and concerns about whether lower cost treatment alternatives (such as nonhospital care) are available to treat alcoholics but are not being used.

The Nation's health care budget has expanded to almost 10 percent of the gross national product, and although efforts have been made to improve benefits for alcoholism treatment, increasing such benefits conflicts with needs to reduce health care expenditures. There is an obvious need to develop a more efficient treatment system to treat alcoholism—with such a system, it is less likely that services will be denied to a large number of people or that costs will be prohibitive. The issues of reimbursement policy are complex, however, and changes in policy not only affect alcoholic patients, but have widespread implications for the costs and treatment of all health problems.

### OVERVIEW OF FUNDING OF ALCOHOLISM SERVICES

The Federal Government has a substantial stake in the funding of alcoholism treatment services. An estimated two-thirds of the direct costs of alcoholism treatment programs are paid for through Federal, State, and local government programs (217; see table 7).

Federal programs include employee-benefit insurance packages such as the Federal Employees Health Benefit Plans; services provided by the Armed Forces and Veterans Administration (VA) hospitals, including the Civilian Health and

Medical Program of the Uniformed Services (CHAMPUS); and, until recently, programs funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (now incorporated in block grants to States). In addition, and most important for present considerations, the Medicare program pays substantial amounts for the treatment of alcoholism, as do most State Medicaid programs (217).

In fiscal year 1982, Medicare paid an estimated \$150 million to treat alcoholism and alcohol-based

Table 7.—Sources of Funding for Alcoholism Treatment Units in 1979<sup>a</sup>

Source of funding	Amount (millions)	Percent
<b>Government</b>		
NIAAA <sup>b</sup> . . . . .	\$71	7.5%
Other Federal <sup>c</sup> . . . . .	102	10.9
Third-party (other than private):		
State or local government fees for service . . . . .	38	4.0
Title XX . . . . .	35	3.8
Public Health Insurance and Welfare <sup>d</sup> . . . . .	80	8.5
State government . . . . .	206	21.9
Local government . . . . .	97	10.3
Total government . . . . .		66.9%
<b>Private</b>		
Third-party private health insurance . . .	\$184	19.6%
Donations . . . . .	22	2.4
Total private . . . . .		22.0%
<b>Other</b>		
Client fees . . . . .	\$94	10.0%
Other . . . . .	12	1.3
Total . . . . .	\$941	100.0%

<sup>a</sup>Reported by 4,311 alcoholism Treatment units that reported funding information to the National Drug and Alcoholism Treatment Survey (NDATUS)

<sup>b</sup>NDATUS reports that NIAAA figures were underreported by alcoholism treatment units.

<sup>c</sup>Includes sources such as the National Institute on Drug Abuse, Bureau of Prisons, Veterans Administration, Drug Enforcement Administration, Bureau of Community Services, Law Enforcement Administration, and National Institute of Mental Health.

<sup>d</sup>Includes sources such as CHAMPUS, Federal Employees Health Benefit Plan, Medicare and Medicaid, and local general assistance programs.

SOURCE: National Institute on Alcohol Abuse and Alcoholism, Alcohol, Drug Abuse, and Mental Health Administration, Department of Health and Human Services, *National Drug and Alcoholism Treatment Utilization Survey* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, June 1981).

disorders (99). Extrapolating from comparable figures for 1979 suggests that approximately 90 percent of this total was spent for institutional care alone; the remainder was paid to physicians for their services (80). In a 20-percent sample of elder-

ly Medicare patients, alcoholism was the 18th most frequent discharge diagnosis (269). Persons aged 65 and over accounted for over one-quarter of all discharges and over one-third of patient days of care in all non-Federal short-stay hospitals (212). Almost 9 percent of those aged 64 and over who used psychiatric facilities were diagnosed with alcohol disorders (223). The percentage of alcoholics aged 64 or over in VA hospitals is estimated to be 16 percent (223).

Ninety-five percent of those aged 65 and over are covered by Medicare (269). However, only 15 percent of all elderly problem drinkers appear to be receiving any type of treatment (259). For alcoholics receiving Medicare-funded inpatient treatment in 1977-78, the average charge per patient day was almost \$170, and the average length of stay was over 7 days, yielding a total average cost per discharge of nearly \$1,200 (269). Thus, the charges for alcoholism treatment under the Medicare program have been considerable and are potentially very large if inpatient treatment were widely used. These figures do not include treatment for patients in noninstitutional settings or for those with other primary disorders, although it is clear that alcoholism plays a central contributory role in a variety of ailments that affect the elderly, particularly cardiovascular disease, gastrointestinal problems, and cancer (85,276,347). Alcoholism and alcohol abuse, as noted above, may be the primary reason an individual comes to the hospital, may add medical complications to treatment, and may interfere with normal recovery processes. For elderly individuals, the latter problems may be severe, and very costly to the Medicare system.

## HISTORY OF BENEFITS FOR ALCOHOLISM TREATMENT

Insurance benefits for alcoholism treatment are increasingly being provided by private carriers and Government insurance programs. The development of such benefits is fairly recent. A review of how the current system evolved maybe useful for understanding the present policy debate about alcoholism treatment coverage under Medicare.

### Medicare

Medicare is a nationwide, federally administered health insurance program authorized in 1965 to cover the costs of hospitalization, medical care, and some related services for eligible persons over age 65. Since its inception, Medicare has not spe-

cifically provided benefits for the treatment of alcoholism. Rather, under the hospital insurance component of Medicare (Part A), alcoholism is treated as a psychiatric disorder under the general category of psychiatric health services; its hospitalization benefit for a psychiatric disorder in a psychiatric hospital is limited to 190 days per lifetime. For treatment of alcoholism in the psychiatric ward of a general hospital, on the other hand, the standard (physical illness) Part A Medicare reimbursement and coverage provisions apply: 90 days of hospital care in each benefit period with \$304 deductible, and 25-percent copayment after 60 days, as well as a lifetime reserve of 60 days with a 50-percent copayment. According to NIAAA (223), the original limitation on psychiatric care was to avoid Medicare's reimbursing "custodial care," since Medicare was intended only to insure against illnesses that *were* being actively treated.

The supplementary medical insurance component of Medicare (Part B) provides partial coverage for outpatient psychiatric services. The formula is complicated, but it results in a 50-percent coinsurance benefit with a maximum reimbursement of \$250 per year. For physical illness, however, Medicare pays 80 percent of a physician's reasonable charge after a \$75 deductible. Although outpatient psychiatric services are limited to a maximum reimbursement of \$250 a year, there is no limit on reimbursement for physicians' services for medical or psychiatric care while a patient is in a psychiatric ward of a general hospital. The original limit on coverage of outpatient care was consistent with such limits by private insurers.

The Medicare program essentially funds providers who are physicians or are under the direct supervision of a physician performing services incident to those of a physician. This has meant that many non-acute-care facilities and treatment centers that offer non-physician-based care have not been eligible for reimbursement under the generic statutes of the Medicare program. Until recently, many such programs were funded directly by NIAAA.

## Medicaid

The Medicaid program provides medical assistance to low-income individuals and families. Treatment costs are shared by the States and the Federal Government. Each participating State (all States except Arizona) must provide certain basic health services, according to Medicaid regulations. States, however, have substantial leeway concerning specific coverage and interpretation of regulations.

According to NIAAA, a major limitation in the Medicaid program (by statute) is the exclusion of Federal financial participation for care in psychiatric institutions for persons between the ages of 22 and 64 (216). With respect to other treatment settings, Medicaid may theoretically provide more options for treatment, although Medicaid statutes do not specifically mention alcoholism treatment. For example, States have considerable latitude in defining physician participation. Services need not be those incident to a physician's, and clinics may be reimbursed for the services of paraprofessional rehabilitation counselors (130).

In 1978, Medicaid provided 6 percent (\$5 million) of the total receipts of NIAAA-funded alcoholism treatment centers (100). Information concerning how much Medicaid provided to other alcoholism treatment services is not readily available (130). In one study, now several years old, the investigators found that 4 of the 45 State plans they reviewed referred specifically to treatment for alcoholism: 2 of the 4 allowed coverage, 1 explicitly excluded coverage, and 1 limited coverage to detoxification (37). Eight other States were found to have plans providing a relatively favorable environment for inpatient alcoholism treatment coverage, and 23 States were found to have plans providing a relatively favorable environment for outpatient services. Annual levels of reimbursement for alcoholism treatment, when reported, were generally low (e.g., in 1978: \$45,000 in Mississippi, \$800,000 in Maine, \$1,409,000 in Washington), except in New York (\$32.1 million). A survey conducted by NIAAA in 1976 (215) indicated that all State Medicaid

agencies reimbursed for inpatient care of organic illnesses related to alcoholism, and a majority reimbursed for outpatient care for such illnesses. However, a substantially lower proportion of State Medicaid agencies reimbursed for the treatment of alcoholism itself, especially when that treatment was not in a medical setting (130).

### Other Coverage

According to the the National Drug and Alcoholism Treatment Utilization Survey (NDATUS), State governments provided \$206 million in tax-derived funds to alcoholism treatment centers in 1980, or 21.9 percent of the total funds (217). Local governments contributed \$97 million, or 10.3 percent of the total. Although the States constitute the largest single source of funding for alcoholism services, they typically do not operate treatment programs directly; the States' role consists of allocating resources from various funding sources to local programs (215). In addition, some States (e.g., California) have developed statewide alcoholism health insurance programs for their employees; and increasingly, State legislatures are

considering mandating, or requiring as an option, insurance coverage for alcoholism treatment. By September 30, 1981, such legislation had been enacted in 33 States, had been defeated in 14, was being considered in 2, and had not been considered in only 1 State (283).

Prior to 1972, the explicit exclusion of alcoholism treatment was standard in private insurance policies, although treatment was often covered under other diagnoses (341). Even though progress has been made, very few plans cover alcoholism on the same basis as other illnesses (341). Generally, outpatient care must be provided at a hospital, and is subject to a 50-percent copayment provision as well as an annual maximum. There is often a lifetime maximum as well (341). These restrictions are reflected in the fact that while 21 to 85 percent of those served in NIAAA programs in 1976 had some form of health insurance, only 10 to 45 percent had coverage for alcoholism services (69). The demographic makeup of the NIAAA population makes it particularly likely to be underserved (332). Private health insurance provided 19.6 percent of the funding for alcoholism treatment units in the 1980 NDATUS (215).

## CURRENT DEVELOPMENTS IN BENEFITS FOR ALCOHOLISM TREATMENT

The current reimbursement system is undergoing rather significant change, as pressures brought about by rapidly escalating costs and reduced revenues have forced rethinking of reimbursement policy. The Medicare program, which is the responsibility of the Federal Government, has come under close scrutiny along with programs funded by other Federal legislation and programs funded by State and private agencies.

### New Medicare Guidelines

Policy with respect to Medicare reimbursement is currently undergoing change. A series of studies found that medically based inpatient care was far more expensive than nonmedically based inpatient or outpatient care (see reviews by 126, 223). Furthermore, as shown in chapter 5, research evi-

dence had not proven the superiority of the more expensive types of care.

As of September 1, 1982, the Health Care Financing Administration (HCFA) had implemented new Medicare guidelines specifying treatment of alcoholism in outpatient facilities and placing limits on inpatient treatment and treatment consultation with family members. Earlier guidelines had not specifically referred to hospital-based outpatient treatment; the new guidelines make it clear that such services are covered when reasonable and necessary and incident to a physician's services. Outpatient treatment in free-standing clinics is also made available, with the same restrictions.

The rules for inpatient treatment were relaxed somewhat in that patients need not be experiencing severe medical complications at the time of

admission to be eligible for inpatient medical detoxification; however, the probability of such consequences occurring is necessary for reimbursement. The new Medicare guidelines **also** require that coverage of alcohol detoxification and rehabilitation are to be addressed separately (i.e., a patient who requires the hospital setting for detoxification may not necessarily require it for rehabilitation). Presumably, this requirement will reduce the number of patient days spent in inpatient facilities.

The guidelines also require a closer look at the safety and feasibility of chemical aversion therapy in individual cases, a topic of some recent controversy. Currently, electrical aversion therapy is excluded from coverage on grounds of safety and ineffectiveness although the Public Health Service is coordinating an assessment of what is known about the technique (98). Family counseling is to be limited to those cases in which the primary purpose of the counseling is the treatment of the patient's condition. Despite the fact that inflation has effectively halved the benefits available under Medicare (131), no changes were made in reimbursement rates.

### Other Developments in Treatment Financing

There have been no changes in Medicaid regulations, but because of changes in Federal grants, States have more latitude in deciding how Federal funds are spent; at the same time, they have fewer funds. In fiscal year 1982, 35 percent of the sub-block grant for alcoholism, drug abuse, and mental health had to be allocated to alcoholism; in 1983 and 1984, funds may be transferred by the

States from alcohol and drug abuse to mental health (53). In fiscal year 1981, block grant allocations for alcohol, drug abuse, and mental health services were found to be 20 percent lower than the levels of predecessor categorical programs; in the first 6 months of the new block grant program, 15 percent of alcoholism, drug abuse, and mental health grants had been drawn by the States (110).

An interesting development is underway with respect to a major Federal health program, CHAMPUS. CHAMPUS has recently proposed rules\* to alter coverage of alcoholism treatment services. The proposals are based, in part, on several panels established by CHAMPUS to consider its mental health benefits. Under the proposed rules, alcoholism treatment will be reimbursed for emergencies or for complications on an inpatient basis. For rehabilitative care, treatment will be authorized in approved hospital-based or free-standing clinics. Included are a variety of treatments offered in residential or outpatient settings. Aversion therapy is specifically not authorized under the proposed rules.

With respect to private health insurance coverage, the trend is toward increased coverage in free-standing centers, provision of treatment equal to that for other diseases, and provision of coverage for family counseling and care. Model legislation to this effect has been developed by the National Association of Insurance Commissioners, although it has not been enacted (211). Under terms of the model legislation, coverage would be a required option rather than a mandated inclusion.

\*See *Federal Register*, 47(179):40644-40650.

## RESEARCH DEVELOPMENTS

It is obviously difficult to determine at this point the impact of the new Medicare regulations and other developments in treatment financing. The developments come, however, at the same time that HCFA and NIAAA are engaged in a joint alcoholism services demonstration project. The purpose of the project is to expand Medicare and

Medicaid benefits to alcoholism treatment providers with the emphasis on less costly settings, such as free-standing inpatient and outpatient facilities and halfway houses. The demonstration has also been designed to test the effectiveness of using nonmedical personnel in the treatment of alcoholism.

The project is a 4-year demonstration, with HCFA financing treatment costs and NM providing administrative and evaluative services. Seven States are participating in the program, and approximately 120 providers are treating 5,200 patients in the first year. Although the original intent of the demonstration was to fund programs not eligible under the Medicare and Medicaid formulas, there will be some overlap because of the recent changes in regulations.

Independent evaluation of the demonstration program is being conducted (see 99; 154), although at this point the specifics of the design have

not been agreed to by NIAAA and HCFA staff (154). Because of the way in which the demonstration projects were funded, the design will necessarily be quasi-experimental; that is, patients will not be randomly assigned to particular facilities, service providers, or treatment modalities. Instead, the research will track patients from their entry in the programs for a 2- to 3-year period. It maybe possible, as well, to collect comparison group data. The design calls primarily for collecting cost information about the use of medical services. Program experience for 2 years prior and 2 years subsequent to the inception of the demonstration project will be assessed.

## IMPLICATIONS OF CURRENT DEVELOPMENTS

Reimbursement systems, particularly the Medicare and Medicaid programs, have emphasized inpatient, medically based treatment for alcoholism. Although there may be some patients for whom such intensive treatment is necessary and appropriate, it is also true that there are many for whom it is not appropriate. In fact, because of the stigma and time required to be treated in an acute care facility, many will not seek such treatment.

The evidence does not seem strong enough, however, to support further restricting benefits for inpatient services. Since it would not be possible to restrict acute care admissions, the likely result of not funding residential or free-standing treatment settings would probably be to increase use of acute care facilities. This situation might result if alcoholic patients were admitted under other primary diagnoses.

The best strategies would seem to be ones that encourage early outpatient treatment and continuing aftercare service on an outpatient basis (260). Given both research evidence that does not clearly indicate the necessity of inpatient care and the lower cost of outpatient treatment, such a strategy might lead to better use of health care resources. The recent changes in Medicare guidelines appear to be consistent with this direction (see, also, 81). Reimbursement criteria for inpatient services are

tightened, while the availability of reimbursement for outpatient treatment is increased. The new guidelines also allow for nonmedically trained personnel to be more involved in treatment.

Although it appears that the new guidelines will have positive effects in making the treatment system more efficient, it may be difficult to determine, even in a crude way, the impact of these changes. They are being introduced nationwide and at a time when the health care system and the economy are undergoing major changes. There will be no comparative data on whether and how they are effective. In addition, because the responsibility for a majority of alcoholism treatment services has been transferred from the Federal Government to the States, national data may no longer be available. It may be unclear whether the new regulations simply make possible the treatment of a larger group of alcoholics and alcohol abusers, whether their use of the benefit represents changes in the diagnostic labels given patients, and whether they achieve the intended effect of the legislation.

In light of the above, the demonstration program being carried out by HCFA/NIAAA assumes even greater importance. It is unfortunate that this study is not being done in a more experimental way and that plans for data collection are not further developed at this point. The demon-

stration project represents an important opportunity to collect data about the optimum treatment for alcoholism. The failure to take advantage of

this opportunity may mean an even longer delay in understanding the impact of existing policy.

## CONCLUSIONS

Alcoholism treatment has evolved slowly but steadily over the last 30 years in conjunction with the medical system. Although the evidence is not without methodological problems, it seems clear that alcoholism treatment has demonstrable benefits. The hypothesis that alcoholism treatment is cost beneficial seems more strongly supported than alternative hypotheses. However, the Medicare system needs adjustment in order to encourage less costly and more effective forms of treatment.

The most recent changes in Medicare guidelines seem a necessary and correct step in this process.

It is possible, if inpatient treatment were further restricted, that alcoholic patients would be admitted to acute care hospitals under other primary diagnoses. The additional costs of such a development are clearly impossible to estimate. It would seem reasonable not to change eligibility standards further, however, until more information is available to indicate the effects of recent evolutionary changes in the reimbursement system. To the extent that research evidence can be developed (111, 144), reimbursement decisions can be made with more confidence.