Many Americans who receive substance abuse treatment (SAT) services are low-income.

The Affordable Care Act (ACA) will dramatically increase Medicaid enrollment (Congressional Budget Office, 2013).

The ACA will require all state Medicaid programs to provide coverage for SAT (Buck, 2011).

There has been much research showing that Medicaid coverage design is strongly related to provider acceptance of Medicaid (Substance Abuse and Mental Health Services Administration, 2011).

However, the SAT system differs from the general health care system (Davidson, 1982):
- Mostly rely on block grants (D’Aunno, 2006)
- Private insurance makes up less than 25% of funding (Mark et al., 2007)
- Rely on paraprofessionals; less than 50% of SAT providers had physician/nurse on staff (McLellan, Carise, & Kleber, 2003)
- Lag behind on information technology (McLellan, Carise, & Kleber, 2003)

(Andrews, 2014)
Method: Data Sources

• State level: Medicaid policy information culled from Substance Abuse and Mental Health Services Administration (SAMHSA) report (Robinson, Kaye, Bergman, Moreaux, & Baxter, 2003)

• County level: demographic data drawn from 2000 Census (U.S. Census Bureau, 2000)

• Provider level: data drawn from 2004 wave of N-SSATS, which includes population of all SAT providers in US

(Andrews, 2014)
Method: Variables

• Explanatory variables:
  – Generosity of benefits: differences in cross-state reimbursement rates and number of possible SAT-related services covered
  – Scope of eligibility: number of “optional” groups covered
  – Intensity of oversight of state Medicaid program: states’ involvement in monitoring and regulating SAT providers’ provision of services

• Dichotomous variable measuring whether SAT provider accepted Medicaid in most recent fiscal year

• Compared providers that accept Medicaid with those that didn’t

(Andrews, 2014)
Findings

- 55% of private SAT providers accepted Medicaid

- SAT providers that accepted Medicaid were more likely to be located in states that:
  - Covered more SAT services
  - Extended program eligibility to greater number of optional populations
  - Did not require licensure or physician involvement

(Andrews, 2014)
• SAT providers that accepted Medicaid were more likely to be located in counties that:
  – Were smaller
  – Were lower-income
  – Had fewer racial and ethnic minority residents

• SAT providers that accepted Medicaid were more likely to be:
  – Larger
  – Non-profit
  – Multi-service

(Andrews, 2014)
Implications for Behavioral Health

- Decisions about who and what is covered and how that coverage is administered may influence SAT providers’ decisions regarding Medicaid acceptance.

- Expansion of benefits under ACA may not result in increased participation if regulatory polices serve as barriers.
  - Providers may want to participate but can’t meet certification requirements.

- To stay viable, SAT providers must be cognizant of Medicaid’s role and consider strategies to achieve certification.

(Andrews, 2014)
References


Prepared by H Goldstein (2014)
References, cont.


