Ending Addiction
Changes Everything

EHB RECOMMENDATIONS FOR STATES

CRITICAL ADDICTION PREVENTION AND TREATMENT BENEFITS FOR ESSENTIAL HEALTH BENEFITS (EHB) BENCHMARK PLANS

JULY 2013

The *Patient Protection and Affordable Care Act* (ACA) requires certain health plans[*] to cover Essential Health Benefits (EHB),[1] which include addiction benefits. However, no blueprint for optimum or even effective services is provided in either the law or its regulations.

We offer the following recommendations, which are based on a large body of research and identify those addiction-related benefits that have been shown to improve patient outcomes and can be expected to reduce the costly burden to states of risky substance use and untreated addiction.[2] These benefits can be expected to reduce not only health care costs, but also costs to other government systems including justice, education, child welfare, social services and public safety.

In 2012, CASAColumbia® (formerly The National Center on Addiction and Substance Abuse at Columbia University) released *Addiction Medicine: Closing the Gap between Science and Practice*, a five year national study that examined the science of addiction and how to effectively prevent and treat it. The primary finding is that a wide range of evidence-based screening, intervention, treatment and disease management tools and practices are available to effectively reduce risky use of addictive substances and prevent and treat addiction; however, the gap between what works and what patients actually receive is substantial.[†]

The key points of our recommendations are:

- Providing evidence-based addiction prevention and treatment benefits will have a positive impact on health outcomes and can be expected to lead to cost savings

- The critical addiction prevention, treatment and management services to include in your EHB-benchmark plan are:
  - Screening and brief intervention
  - Diagnostic evaluation, comprehensive assessment, and treatment planning
  - Stabilization/withdrawal management (in a range of levels/settings)
  - Addiction treatment: (a) pharmaceutical therapies and (b) psychosocial therapies (in a range of levels/settings)
  - Monitoring, support and continuing care

- The addiction prevention, treatment and management benefits in your EHB-benchmark plan must be analyzed to ensure compliance with the parity and non-discrimination requirements of the *Patient Protection and Affordable Care Act* (ACA)

[*] Non-grandfathered health insurance plans in the individual and small group markets both inside and outside of the health insurance exchanges; Medicaid benchmark plans; Medicaid benchmark-equivalent plans; and Basic Health Programs.

[†] To fully understand the available tools for effective interventions and for treatment, the gap between the need for such interventions and treatments and the actual standard of care and the driving forces behind this substantial gap, CASAColumbia conducted: a thorough review of more than 7,000 scientific articles, reports, books and other reference materials; secondary analysis of five national data sets; interviews with 176 leading experts in a broad range of fields relevant to the report, two statewide surveys of addiction treatment providers in New York; and an online survey of 1,142 members of professional associations involved in addiction care and other research.

Background

Each state must design an EHB-benchmark plan containing the 10 enumerated categories of mandatory "essential health benefits," which include mental health and addiction* treatment services.[3] The mental health and addiction benefits must also comply with the *Mental Health Parity and Addiction Equity Act* (MHPAEA).[4] Since most states' "base-benchmark plans" are small group plans which were not previously subject to parity,[5] these plans need to be evaluated for parity compliance and where they fall short, benefits must be added. The U.S. Department of Health and Human Services (HHS) has clarified that states will not be held financially responsible for adding addiction benefits to bring their EHB-benchmark plan into compliance with parity.[6]

Though HHS has issued regulations for complying with these ACA requirements,[7] the regulations do not give states clear direction on which specific benefits to include for addiction prevention and treatment. Further, the purpose of the EHB regulations is to define a *minimum* benefit package for compliance purposes; they do not provide a blueprint for optimum or even effective services, nor do they identify evidence-based best practices. In designing your state's EHB-benchmark plan, you should consider these factors and their impact on health outcomes and state expenditures in addition to the extent to which the EHB-benchmark plan complies with the law.

The recommendations in this letter go beyond HHS's regulations; they offer states data regarding which addiction benefits will improve patient outcomes and can be expected to reduce the costly burden to states of risky substance use and untreated addiction.[8]

Providing Evidence-Based Addiction Prevention and Treatment Benefits Will Have a Positive Impact on Health Outcomes and May Lead to Cost-Savings

Risky substance use and addiction are this nation's largest preventable and most costly health problems; together they constitute the leading cause of death and disability in the United States.[9] Addiction involving nicotine, alcohol, illicit drugs and controlled prescription drugs is a complex brain disease that affects 16% of Americans ages 12 and older—40 million people.[10] That is more than the number of people with heart disease (27 million), diabetes (26 million) or cancer (19 million).[11] Another 32% of the population ages 12 and older (80 million), while not addicted, use nicotine/tobacco, alcohol and other drugs in risky ways that threaten the health and safety of themselves and people around them.† Risky substance use and untreated addiction contribute to more than 70 other health conditions requiring medical attention including cancer,

* Defined in the law and regulations as "substance use disorder" but referred to here as addiction.

†Risky substance use involves any tobacco use, misuse of controlled prescription drugs, illicit drug use and alcohol use in excess of the Dietary Guidelines for Americans, 2010 for safe alcohol consumption. The guidelines define safe alcohol use as no more than one drink per day for women and two drinks per day for men, and no alcohol consumption for: (1) persons under the age of 21; (2) pregnant women; (3) individuals who cannot restrict their drinking to moderate levels; (4) individuals taking prescription or over-the-counter medications that can interact with alcohol; (5) individuals with certain specific medical conditions (e.g., liver disease, hypertriglyceridemia, pancreatitis); and (6) individuals who plan to drive, operate machinery or take part in other activities that require attention, skill or coordination, or in situations where impaired judgment could cause injury or death (e.g., swimming).

respiratory disease, cardiovascular disease, HIV/AIDS, pregnancy complications, cirrhosis, ulcers and trauma.[12]

Our health care system does little to effectively prevent risky substance use and addiction; health care providers do not routinely screen for these problems and only 11% of people in need of treatment involving alcohol and drugs other than nicotine receive any form of treatment.[13] In comparison, 70–80% of people with other chronic conditions (e.g., hypertension, diabetes or major depression) receive treatment.[14] Of those who do receive treatment for addiction, the vast majority do not receive anything that approximates evidence-based care. As a result, states spend approximately 16% of their budgets on risky substance use and addiction, and of every dollar they spend, 94 cents goes to shovel up the medical and surgical, justice and other social complications of these health problems, while only two cents goes to prevention and treatment of the disease.[15]

Research suggests that providing clinically-indicated, evidence-based prevention and intervention for risky use, and treatment and disease management services for addiction will not only improve your population's health, it likely will reduce short and long term health care expenditures.

Persons with untreated addiction are among the highest-cost health care users in America:[16] they have higher utilization rates, more frequent hospital admissions, longer hospital stays and require more expensive health care services.[17] Nearly 1/3 (32.3%) of all hospital inpatient costs are attributable to risky substance use and addiction involving tobacco, alcohol and other drugs.[18] A longitudinal study of patients treated for addiction in Kaiser Permanente's Medical Care Program found an average reduction of 30% in medical costs three years post treatment. Significant declines were seen in areas such as the number of inpatient hospital days and emergency department visits, which are high-cost services.[19] Addiction treatment not only saves lives and reduces health care costs, it also reduces social consequences and associated costs. For example, numerous studies have demonstrated that the monetary benefits of treatment for offenders, including reduced crime, recidivism and health care costs, outweigh the costs.[20]

Cost benefit studies of screening and brief interventions for risky use have also demonstrated significant cost-saving potential. Several large-scale studies have demonstrated the effectiveness of screening and brief interventions in reducing the consumption of addictive substances as well as the serious problems and costs that accompany such behavior, including visits to emergency departments, hospitalization, high-risk injection drug use, criminal activity and depression.[21] In fact, screening and brief intervention for risky alcohol use rank among the top most cost-effective prevention services available, higher than cervical cancer (Pap smears), cholesterol, obesity, depression or diabetes screenings.[22]

Critical Addiction Prevention, Treatment and Management Services to Include in Your EHB-Benchmark Plan

In the report, *Addiction Medicine: Closing the Gap between Science and Practice*, CASAColumbia identified a list of critical addiction services that have been proven by research to effectively prevent risky substance use and treat and manage addiction. These evidence-based services are consistent with the recommendations of other leaders in this field who have reviewed the data,[23] including The Coalition for Whole Health's (CWH) *EHB Consensus Principles and Service Recommendations*,[24] which have the support of over 100 national and state-level mental health/addiction organizations.[25]

The critical addiction-related health services to include in your insurance plans are:

- **Routine Screening and Brief Intervention (SBI) in Health Care Settings, Including Primary and Urgent Care.** All patients should be routinely screened for all forms of risky substance use—including tobacco, alcohol, illicit drugs and controlled prescription drugs—at the initial visit to a primary care (including family and internal medicine and pediatric), obstetric, mental health or specialty care physician, and then routinely thereafter, and upon admission into a hospital, emergency department or trauma care center. Age-appropriate screening tools should be used. As a part of these services, patients (and their families if appropriate) should be educated about the health consequences of risky substance use, the disease of addiction and risk factors for both.

  For those who screen positive for risky substance use that does not meet the threshold of clinical addiction, a brief intervention (typically involving motivational interviewing techniques and substance-related education) is an effective, low-cost approach to reducing risky substance use.[26]

  Individuals showing signs of addiction should be referred for a full diagnostic evaluation.

- **Diagnostic Evaluation, Comprehensive Assessment and Treatment Planning.** For individuals showing signs of addiction, it is necessary to determine a clinical diagnosis including the stage and severity of the disease. If the disease is not present, they should receive a brief intervention. If the disease is present, a comprehensive assessment must be performed to evaluate co-occurring medical (including psychiatric) conditions and personal circumstances that may affect treatment success. The results of the diagnostic evaluation and comprehensive assessment create the foundation for an effective treatment plan that is individualized and tailored to the patient, identifies the pharmaceutical and behavioral therapies needed and the appropriate level/setting of care. Diagnosis and treatment planning should be conducted using standardized and validated instruments. Providing treatment, including specialty care as needed, is critical to managing the condition and preventing further health and social consequences.[27]

- **Stabilization.** As a precursor to treatment, the patient's condition should be stabilized via cessation of substance use, including medically-supervised withdrawal management (detoxification) when necessary. Stabilization alone is not treatment for

addiction. After stabilization, connecting patients with services to treat and manage their addiction is a critical step in assuring that stabilization services are clinically and financially effective.

All patients should be evaluated to: a) determine the presence and severity of withdrawal symptoms using standardized instruments, b) assess potentially complicating co-occurring medical—including psychiatric—conditions, c) detect (through the use of drug testing) any substances present or recently used in the patient's body and d) establish the patient's withdrawal history. A trained physician should determine the appropriate setting (e.g., patient's home, physician's office, non-hospital treatment facility, hospital, intensive outpatient/partial hospitalization program) for stabilization based on the results of the diagnosis and evaluation. Patients should be supported through withdrawal (with the use of medication when necessary) to re-establish a state of physiological stability. Once stabilized, all patients should receive addiction treatment immediately.

- **Addiction Treatment.** Qualified health care professionals should deliver evidence-based addiction treatments, accompanied by treatment for co-occurring health (including psychiatric) conditions. Depending on the severity of the patient's disease and the general health status of the patient, the use of medications, psychosocial therapies or both in combination may be necessary. All services necessary to coordinate addiction treatment with other health care services also should be covered.

    - ***Pharmaceutical therapies.*** Pharmaceutical therapies can be an important component of addiction treatment.[28] Individual factors, including genetic and biological characteristics and environmental and psychological risk factors, may determine how effective a certain type of pharmaceutical intervention will be for an individual with addiction. All FDA-approved medications designed to treat and manage addiction should be covered within the parameters of EHB.

      These medications include, but are not limited to:
        1. Campral (acamprosate), naltrexone formulations and Antabuse (disulfiram) for addiction involving alcohol
        2. Zyban (bupropion), Chantix (varenicline), and the five FDA-approved forms of nicotine replacement therapy (NRT), including patch, gum, lozenge, nasal spray and inhaler for addiction involving nicotine
        3. Naltrexone formulations, methadone, and buprenorphine formulations (including Suboxone) for addiction involving opioids

      The above medications have different mechanisms of action and should not be considered interchangeable members of the same "class." Physicians, using their clinical judgment, have the authority to prescribe medications that are not FDA-approved specifically to treat addiction, just as is the case when physicians treat other illnesses; these medications should also be covered.

      Benefits should include all clinical services required for patients to access the pharmacotherapies, such as physician visits for medical management of pharmaceutical therapies as well as coverage for treatment at licensed opioid treatment programs when required for access to a medication modality (e.g., methadone to treat addiction involving opioids).

- ***Psychosocial Therapies.*** Psychosocial therapies are critical components of almost every treatment regimen; when combined with pharmaceutical treatments they enhance treatment efficacy.[29] Psychosocial therapies must be tailored to individual patient characteristics, such as age, gender, and sexual orientation. Evidence-based psychosocial therapies include, but are not limited to:
    1) Cognitive-Behavioral Therapy (CBT)
    2) Motivational Interviewing (MI) and Motivational-Enhancement Therapy (MET)
    3) Community Reinforcement Approach (CRA)
    4) Contingency management/motivational incentives
    5) Behavioral couples/family therapy
    6) Multidimensional family therapy
    7) Functional family therapy

- ***Level/Setting and Length of Treatment*.** The appropriate level/setting of care should be determined by the results of a diagnostic evaluation and a comprehensive assessment, and should be documented in an individual treatment plan

  At a minimum, health plans should cover the following levels/settings of care where evidence-based services are provided:
    1) Outpatient treatment
    2) Intensive outpatient treatment
    3) Partial hospitalization
    4) Inpatient hospitalization
    5) A range of non-hospital residential treatment environments (including low-intensity, high-intensity, and population specific)

  The medically-indicated length of treatment varies depending on the severity and complexity of the patient's disease and other factors. Length of treatment should be flexible, contingent on periodic evaluation of the patient's progress. Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating cases of addiction that are chronic and relapsing.

  States also should keep in mind that many people with addiction have co-occurring health (including psychiatric) conditions; often these co-occurring conditions must be treated concurrently for any treatment to be successful. States should include addiction treatment services and levels/setting of care that allow for concurrent treatment of all health conditions.[30]

- **Monitoring, Support and Continuing Care.** Because addiction can be a chronic, relapsing disease, monitoring, support and continued care services are essential to help the patient maintain the progress achieved during the initial phase of addiction treatment and to prevent relapse. Ongoing pharmaceutical and psychosocial therapies are often indicated to manage the disease, as for persons with other chronic conditions like diabetes or hypertension. Follow-up appointments to monitor progress and disease management services to promote patients' adherence to a treatment regimen and management of their disease contribute to positive outcomes. As is the case with other chronic diseases (e.g., various cancers), periodic revisits to monitor the patient's status and to assure that a state of remission remains (or,

alternately stated, to assure that there are no early/undetected signs of relapse not well-appreciated by the patient) should be covered within the EHB.

Benefits should include the full range of services required to manage a chronic condition, including continued pharmaceutical and psychosocial therapy services, supervised by a physician and including follow-up appointments to monitor progress; disease management services to promote patients' adherence to a treatment regimen; and case management services to connect patients with resources, including peer support (e.g., AA/NA/Smart Recovery/etc.), auxiliary services—such as legal, educational, vocational, housing, child care and family supports as well as nutrition and exercise counseling. Peer support programs, like AA and NA, are an important adjunct to treatment; however, these programs do not constitute treatment themselves.

The Addiction Benefits in Your EHB-Benchmark Plan Must Be Analyzed To Ensure Compliance with the Parity and Non-Discrimination Requirements

The ACA specifies that the mental health and addiction benefits in state EHB-benchmark plans must comply with the parity requirements of the *Mental Health Parity and Addiction Equity Act* (MHPAEA),[31] and that the insurer cannot discriminate on the basis of age/disability/expected length of life in providing the benefits.[32]

The parity and non-discrimination requirements for EHB were enacted to promote more robust benefits for those with addiction and mental health conditions. Historically, health plans have discriminated against persons with addiction by limiting the type, level and amount of clinically-indicated care they receive. In fact, several base-benchmark plans selected by states contain discriminatory provisions, such as excluding methadone maintenance or residential treatment for addiction.[33] Limiting clinically-indicated benefits not only leads to poor health outcomes, it can increase costs over time (when patients receive insufficient care they are more likely to relapse, requiring subsequent treatment).

Nearly all states will have to add some addiction benefits to comply with parity. Most states have selected (or defaulted to) a small-group plan as their base-benchmark plan. Small-group plans previously were not subject to MHPAEA and traditionally offer insufficient addiction benefits. States that have selected a large-group plan may also have to add benefits; although previously subject to MHPAEA, large-group plans often are not in compliance with parity.

Parity requires that the limitations placed on addiction benefits be no more stringent than those placed on medical benefits. The parity requirements apply to:

- Financial requirements (e.g., co-pays, deductibles, annual or lifetime dollar limits)
- Quantitative treatment limitations (annual or lifetime inpatient day or outpatient visit limits)
- Non-quantitative treatment limitations (e.g., prior-authorization, utilization review, fail-first policies, restrictions on out-of-network coverage, criteria for medical necessity)

The financial and quantitative parity requirements will shape what benefits are selected for the EHB-benchmark plan. When applying these requirements, states should consider that addiction is often a chronic disease and that addiction benefits should be comparable to benefits for other chronic diseases such as diabetes, heart disease or asthma. For example, insurers do not place blanket limitations on how long patients can take asthma medications or receive dialysis; similarly, limits on addiction treatment services undermine patient outcomes and, as a result, can increase costs over time.

While not related to benefit design, non-quantitative treatment limitations can violate parity by unduly limiting patient access to necessary services. States must remain vigilant about reviewing these limitations to ensure parity compliance in the future.

For more information about risky substance use and addiction, best practices for prevention, treatment and disease management, and the consequences of failing to address this disease adequately please see our reports:

Addiction Medicine: Closing the Gap between Science and Practice
Adolescent Substance Use: America's #1 Public Health Problem

For information about the financial impact of risky substance use and addiction on your state, including health care costs, please see:

Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets

Notes

[1] 45 C.F.R. 147.150. (2013)
111th Congress. (2010). Compilation of patient protection and affordable care act §1302(a). [Online]. Retrieved June 27, 2013 from http://www.govtrack.us/congress/bills/111/hr3590/text.
U.S. Government Printing Office. (2013). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. *Federal Register*, 78(37), 12834-12872.
[2] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2009). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: Author.
[3] 111th Congress. (2010). Compilation of patient protection and affordable care act §1302(b)(1). [Online]. Retrieved June 27, 2013 from http://www.govtrack.us/congress/bills/111/hr3590/text.
[4] 45 CFR 156.115(a)(3)
[5] Sarata, A.K. (2011). *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*. Washington, DC: Library of Congress, Congressional Research Service.
The Center for Consumer Information & Insurance Oversight. *The Mental Health Parity and Addiction Equity Act*. [Online]. Retrieved June 27, 2013 from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.
[6] U.S. Government Printing Office. (2013). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule. (2013). *Federal Register*, 78(37), 12844.
[7] U.S. Government Printing Office. (2013). Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. *The Federal Register,* 78(37), 12834-12872.
[8] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2009). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: Author.
[9] Centers for Disease Control and Prevention. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses: United States: 2000-2004. *Morbidity & Mortality Weekly Report*, 57(45), 1226-1228.
Centers for Disease Control and Prevention. (2010). *Online tools: Alcohol-Related Disease Impact (ARDI) software*. [Online]. Retrieved August 16, 2011 from http://www.cdc.gov.
Ezzati, M., Lopez, A. D., Rodgers, A., Vander Hoorn, S., Murray, C. J. L., & and the Comparative Risk Assessment Collaborating Group. (2002). Selected major risk factors and global and regional burden of disease. *Lancet*, 360(9343), 1347-1360.
Kochanek, K., Xu, J. Q., Murphy, S. L., Minino, A. M., & Kung, H.-C. (2011). *Deaths: Preliminary data for 2009*. *National vital statistics reports* (DHHS Pub No. (PHS) 2011-1120, Vols. 59). Hyattsville, MD: National Center for Health Statistics.

Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. *JAMA*, 291(10), 1238-1245.
World Health Organization. (2009). *Global health risks. Mortality and burden of disease attributable to selected major risks*. [Online]. Retrieved March 13, 2012 from http://www.who.int/healthinfo.
[10] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[11] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[12] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[13] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[14] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[15] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2009). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York: Author.
[16] Zook, C. J., & Moore, F. D. (1980). High-cost users of medical care. *New England Journal of Medicine*, 302(18), 996-1002.
The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (1994). *The cost of substance abuse to America's health care system: Report 2, Medicare hospital costs*. New York: Author.
[17] Clark, R. E., Samnaliev, M., & McGovern, M. P. (2009). Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatric Services*, 60(1), 35-42.
Curran, G. M., Sullivan, G., Williams, K., Han, X., Collins, K., Keys, J., et al. (2003). Emergency department use of persons with comorbid psychiatric and substance abuse disorders. *Annals of Emergency Medicine*, 41(5), 659-667.
Owens, P. L., Mutter, R., & Stocks, C. (2010). *Mental health and substance abuse-related emergency department visits among adults, 2007. HCUP statistical brief #92.* Rockville, MD: Agency for Healthcare Research and Quality.
Rockett, I. R., Putnam, S. L., Jia, H., Chang, C. F., & Smith, G. S. (2005). Unmet substance abuse treatment need, health services utilization, and cost: A population-based emergency department study. *Annals of Emergency Medicine*, 45(2), 118-127.
Substance Abuse and Mental Health Services Administration. (2010). *Mental health and substance abuse services in Medicaid, 2003: Charts and state tables* (HHS Publication No. (SMA) 10-4608). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
White, A. G., Birnbaum, H. G., Mareva, M. N., Daher, M., Vallow, S., Schein, J., et al. (2005). Direct costs of opioid abuse in an insured population in the United States. *Journal of Managed Care Pharmacy*, 11(6), 469-479.
[18] The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia). (2012). *CASA Columbia analysis of data from CASA Columbia's*

report: Shoveling up II: The impact of substance abuse on federal, state and local budgets. New York: Author.
[19] Walter, L. J., Ackerson, L., & Allen, S. (2005). Medicaid chemical dependency patients in a commercial health plan: Do high medical costs come down over time? *Journal of Behavioral Health Services & Research*, 32(3), 253-263.
[20] The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia). (2010). *Behind Bars II: Substance Abuse and America's Prison Population*. New York: Author.
[21] Baker, A., Lee, N. K., Claire, M., Lewin, T. J., Grant, T., Pohlman, S., et al. (2005). Brief cognitive behavioural interventions for regular amphetamine users: A step in the right direction. *Addiction*, 100(3), 367-378.
Baker, A., Kochan, N., Dixon, F., Heather, N., & Woadk, A. (1994). Controlled evaluation of a brief intervention of HIV prevention among injecting drug users not in treatment. *AIDS Care*, 6(5), 559-570.
Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2002). Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis. *Alcoholism: Clinical & Experimental Research*, 26(1), 36-43.
Madras, B. K., Compton, W. M., Avula, D., Stegbauer, T., Stein, J. B., & Clark, H. W. (2009). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months. *Drug and alcohol dependence*, 99 (1-3), 280.
[22] Maciosek, M. V., Coffield, A. B., Edwards, N. M., Flottemesch, T. J., Goodman, M. J., & Solberg, L. I. (2006). Priorities among effective clinical preventive services: Results of a systematic review and analysis. *American Journal of Preventive Medicine*, 31(1), 52-61.
Solberg, L. I., Maciosek, M. V., & Edwards, N. M. (2008). Primary care intervention to reduce alcohol misuse ranking its health impact and cost effectiveness. *American Journal of Preventive Medicine*, 34(2), 143-152.
[23] Institute of Medicine. (1997). *Dispelling the myths about addiction: Strategies to increase understanding and strengthen research*. Washington, DC: National Academy Press.
Substance Abuse and Mental Health Services Administration. (2011). *Description of a good and modern addictions and mental health service system*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
[24] The Coalition for Whole Health. (2012). *EHB Consensus Principles and Service Recommendations*. Downloaded May 31, 2013 from http://www.coalitionforwholehealth.org/wp-content/uploads/2012/01/EHB-Consensus-Principles-and-Service-Recommendations-final.docx
[25] The Coalition for Whole Health. *Organizations Endorsing the Coalition for Whole Health Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefits Package*. [Online]. Retrieved June 27, 2013 from: http://www.coalitionforwholehealth.org/wp-content/uploads/2011/09/Coalition-for-Whole-Health-EHB-sign-ons.pdf.
[26] National Institute on Drug Abuse. (2009). *Principles of drug addiction treatment: A research-based guide* (NIH Publication No. 09–4180) (2nd ed.). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.
Substance Abuse & Mental Health Services Administration. (2012). *Coding for SBI Reimbursement.*

[Online]. Retrieved on June 27, 2013from http://www.samhsa.gov/prevention/sbirt/coding.aspx.
[27] National Institute on Drug Abuse. (2009). *Principles of drug addiction treatment: A research-based guide* (NIH Publication No. 09–4180) (2nd ed.). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.
The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. New York: Author.
[28] Amato, L., Davoli, M., Perucci, C. A., Ferri, M., Faggiano, F., & Mattick, R. P. (2005). An overview of systematic reviews of the effectiveness of opiate maintenance therapies: Available evidence to inform clinical practice and research. *Journal of Substance Abuse*, 28(4), 321-329.
National Institute on Drug Abuse. (2009). *NIDA Info Facts: Treatment approaches for drug addiction.* [Online]. Retrieved November 28, 2006 from http://www.nida.nih.gov.
[29] Arias, A. J., & Kranzler, H. R. (2008). Treatment of co-occurring alcohol and other drug use disorders. *Alcohol Research & Health*, 31(2), 155-167.
Carroll, K. M. (1996). Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental & Clinical Psychopharmacology*, 4(1), 46-54.
Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance abuse treatment. Treatment improvement protocol (TIP) Series 35* (DHHS Pub. No. (SMA) 99-3354). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
Cepeda-Benito, A. (1993). Meta-analytical review of the efficacy of nicotine chewing gum in smoking treatment programs. *Journal of Consulting & Clinical Psychology,* 61(5), 822-830.
National Institute on Drug Abuse. (2009). *NIDA Info Facts: Treatment approaches for drug addiction.* [Online]. Retrieved November 28, 2006 from http://www.nida.nih.gov.
National Institute on Drug Abuse. (1995). *Integrating behavioral therapies with medication in the treatment of drug dependence.* (NIH Pub. No. 95-3899). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.
[30] Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders. Treatment improvement protocol (TIP) Series 42* (DHHS Pub. No. (SMA) 05-3992). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment*, 30(1), 79-84.
Moggi, F., Ouimette, P. C., Moos, R. H., & Finney, J. W. (1999). Dual diagnosis patients in substance abuse treatment: Relationship of general coping and substance-specific coping to 1-year outcomes. *Addiction*, 94(12), 1805-1816.
Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Bethesda, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[31] 111th Congress. (2010). Compilation of patient protection and affordable care act §1311(j). [Online]. Retrieved June 27, 2013 from http://www.govtrack.us/congress/bills/111/hr3590/text.
111th Congress. (2010). Compilation of patient protection and affordable care act §2001(c)(3). [Online]. Retrieved June 27, 2013 from http://www.govtrack.us/congress/bills/111/hr3590/text.
[32] 111th Congress. (2010). Compilation of patient protection and affordable care act §1302(b)(4). [Online]. Retrieved June 27, 2013 from http://www.govtrack.us/congress/bills/111/hr3590/text.
[33] Coalition for Whole Health. (2012). RE: CMS-9980-P, ACA Standards related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans.

Ending Addiction
Changes Everything

www.casacolumbia.org