CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND

Fiscal Years 1989 through 1996

Report to the Minnesota State Legislature

As required by Minnesota Statutes 254B.03, subdivision 8

March 1997

Minnesota Department of Human Services

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Contents

Consolidated Fund Milestones

1986 Legislature passes law authorizing the Consolidated Chemical Dependency Treatment Fund. Pilot projects begin in three counties and on one Indian reservation.

1987 Department of Human Services applies for "freedom of choice" federal Medicaid waiver to expand placement options for Medicaid enrollees.

Rule 25 is promulgated. Rule 25 sets forth assessment and treatment placement criteria as well as qualifications for Rule 25 assessors.

1988 Rule 24 is implemented. The Consolidated Fund begins. Rule 24 governs the administration of the Consolidated Fund, establishes the financial eligibility criteria for clients, and assigns to local agencies (counties and reservations) the responsibility for determining client eligibility and contracting with vendors for treatment.

Federal Medicaid waiver is granted.

1990 Legislation creates three tiers of Consolidated Fund clients to create a hierarchy of financial eligibility prioritizing Fund expenditures.

Rule 25 is amended to increase use of outpatient treatment and limit the use of repeated residential placements.

1991 Consolidated Fund placements were restricted to Tier I (entitled) clients in April due to limited funds.

1992 Limited appropriation made for Tier 2 clients; placements of Tier 2 clients restricted in May.

1993 Tier 2 eligibility restricted to adolescents, pregnant women, and parents with minor children in the home; appropriation reduced from previous year.

1996 Rate freeze at previous year's levels goes into effect.

Executive Summary

The Consolidated Chemical Dependency Treatment Fund has been in operation since January 1988. In State Fiscal Year 1995, there were 20,939 treatment placements through the Fund, the largest number ever. In 1996, the number of placements decreased to 20,025, the second highest total since 1989. Several factors affect Consolidated Fund placements. In recent years, the gradual transition to prepaid health plans for persons enrolled in Medical Assistance (MA) or General Assistance Medical Care (GAMC) and the provision of chemical dependency treatment through these plans has affected treatment placements through the Consolidated Fund. The status of the state's economy also has an effect on the numbers of individuals who meet income eligibility limits. Finally, the prevalence of alcohol and drug use disorders among the eligible population can affect need for treatment. Because the relative effects of these factors cannot be measured at this time, it is not possible to attribute short-term changes seen in Consolidated Fund treatment placement patterns to any one particular cause.

Financial eligibility criteria for the Consolidated Fund were first restricted in 1991 and further restricted in 1993. Entitled clients (Tier 1) include those persons enrolled in MA or GAMC, as well as those whose incomes meet income eligibility guidelines for MA. Tier 2 is defined as those persons whose incomes exceed MA income eligibility guidelines but are less than 60% of the State median family income (adjusted for family size). Beginning in 1993, the Tier 2 appropriation targeted funding to adolescents, parents with minor children in the home, and pregnant women. Counties pay for treatment for some clients who do not meet current financial eligibility criteria.

Men have consistently outnumbered women as Consolidated Fund clients, accounting for 70% of all treatment placements in the past four years. After declining steadily through 1993, adolescent placements increased sharply, up 86% in 1996 compared with 1993. This increase paralled the increase in adolescent substance use during this period documented by the Minnesota Student Survey.

Following a change in placement criteria designed to promote the use of lower-cost outpatient treatment when clinically appropriate, placement patterns shifted dramatically in 1991. Outpatient placements increased from 46% of primary treatment placements in 1989 to 56% in 1996. Treatment stays remained remarkably stable during the first six years of the Consolidated Fund's operation. However, in the past two years, stays in inpatient/residential facilities have declined somewhat. Primary inpatient treatment stays averaged 22 days in 1996, while the other residential programs, extended care and halfway house, typically lasted about eight weeks (56 and 59 days, respectively).

Average treatment costs for treatment placements declined for the first time in 1996. The average cost of a treatment placement in 1996 was $3,056. Outpatient treatment was by far the least expensive at an average cost of $1,313 per episode. In contrast, primary inpatient treatment cost $4,059. Extended care cost $5,996 and halfway house stays $3,348. The decline in costs from 1995 reflected the effects of both the freeze on rates and shorter lengths of stay.

Overview of the Consolidated Fund

Since the beginning of 1988 the Consolidated Chemical Dependency Treatment Fund has pooled a variety of funding streams to facilitate assessment and access to treatment services for persons with low incomes. Several factors affect Consolidated Fund placements. In recent years, the gradual transition to prepaid health plans for persons enrolled in Medical Assistance (MA) or General Assistance Medical Care (GAMC) and the provision of chemical dependency treatment through these plans has affected treatment placements through the Consolidated Fund. The status of the state's economy also has an effect on the numbers of individuals who meet income eligibility limits. Finally, the prevalence of alcohol and drug use disorders among the eligible population can affect need for treatment. Because the relative effects of these factors cannot be measured at this time, it is not possible to attribute short-term changes in Consolidated Fund treatment placement patterns to any one particular cause.

The benefits of the Consolidated Fund include:

- Standardized and simplified financial eligibility criteria.
- Standardized clinical assessment criteria to determine severity of alcohol and other drug problems.
- Client assessment and treatment placement decisions made by trained professionals without a financial stake in whether or where the client is referred to treatment.
- Standardized treatment placement criteria, with eligibility for different levels of care based on problem severity and treatment history.
- Placement of clients in the level of care and specific program believed to be most beneficial, rather than the placement limited by the idiosyncrasies of various funding sources.
- A competitive marketplace wherein all licensed treatment providers can negotiate a contract with their host county that allows them to serve public pay clients referred from anywhere within Minnesota.

The Consolidated Fund is comprised primarily of a direct legislative appropriation, federal block grant funds, a county match and maintenance of effort obligation, and the federal financial participation (FFP) in Medicaid. Under the Consolidated Fund, the state legislative appropriation is allocated to counties under a formula based on population, income, and welfare caseload, and to Indian reservations based on population only. Counties are required to maintain expenditures for treatment services at previous levels to the extent those funds are needed to meet treatment demand. Counties and reservations which expend their full allocations (and maintenance of effort for counties) can access a reserve fund comprised primarily of federal funds.

Alcohol/drug abuse assessments and financial eligibility determinations are conducted by county and reservation personnel. Eligible clients are placed in treatment according to uniform patient placement criteria articulated in Rule 25 (Minnesota Rules, parts 9530.6600-9530.6650). The county pays 15% of the treatment costs until its allocation is expended. Then the county pays 100% of the costs until the maintenance of effort obligation is met. When counties draw on the reserve fund, their share returns to 15%.

Client Financial Eligibility

This report covers the first eight full fiscal years of operation of the Consolidated Fund (July 1988 through June 1996).[1]

Financial eligibility criteria for service under the Consolidated Fund have changed since its inception. For the first two and one half years the financial eligibility criteria remained the same as originally conceived. Client eligibility was generally considered close to the ideal of universal access for persons without private health insurance. All clients with incomes up to 115% of the state median family income (adjusted for family size) were eligible for treatment through the Consolidated Fund; those with incomes between 60% and 115% were responsible for some portion of treatment costs on a sliding fee scale.

The 1990 legislative session resulted in a restructuring of financial eligibility. Three "tiers" were defined. Tier 1 became the "entitled" group and included persons enrolled in Medical Assistance (MA) or General Assistance Medical Care (GAMC) as well as those who met the MA income eligibility guidelines.[2] Tier 2, the "low income" group, was defined as those persons whose incomes exceeded MA income eligibility guidelines but fell below 60% of the state median family income adjusted for family size. Tier 3, the "sliding fee" group, was defined as those persons with incomes between 60% and 115% of the state median family income, adjusted for family size.

Eligibility for the Consolidated Fund has been restricted since 1991 due to State budget problems (see the chart on page 3). The tier structure went into effect for fiscal year 1991. In April of that year, due to a state budget deficit, eligibility for the Consolidated Fund was restricted to Tier 1. For fiscal year 1992, a total of $5 million was appropriated for Tier 2 clients; when these funds were all obligated in May, Tier 2 placements were restricted. In fiscal year 1993, Tier 2 funding was restricted to "targeted populations," defined as adolescents, pregnant women,[3] and parents with minor children at home; $2.195 million was appropriated for the targeted populations. In fiscal year 1994 this appropriation was increased to $2.545 million. These sums were sufficient to serve the targeted Tier 2 populations.

Since April of 1991, sliding fee clients have not had access to chemical dependency treatment through the Consolidated Fund. Since May of 1992, low income adults who are not in the Tier 2 targeted groups have also been denied access to treatment through the Fund. In some cases, however, counties have paid the cost of treatment for people in these groups.

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[1]Unless otherwise indicated in this report, all years refer to state fiscal years.

[2]The Consolidated Fund entitlement is broader than that of MA and GAMC since Consolidated Fund clients are not required to spend down assets if they meet the income eligibility guideline.

[3]Although designed to ensure access to treatment for pregnant women, Tier 2 income limits are actually less generous than MA income limits for pregnant women (who are considered two persons for purposes of determining family size); therefore, this definition of targeted populations did not increase access for pregnant women.

Consolidated Fund Eligibility

<table>
<tr><td></td><td colspan="4">Fiscal Year</td></tr>
<tr><td>2nd half 1988
1989
1990</td><td>1991</td><td>1992</td><td>1993</td><td>1994-
1996</td></tr>
<tr><td></td><td colspan="4">TIER 1 ENTITLED CLIENTS: enrolled in MA or GAMC or meet income eligibility guidelines for MA</td></tr>
<tr><td>Up to 60% of state median family income, adjusted for family size

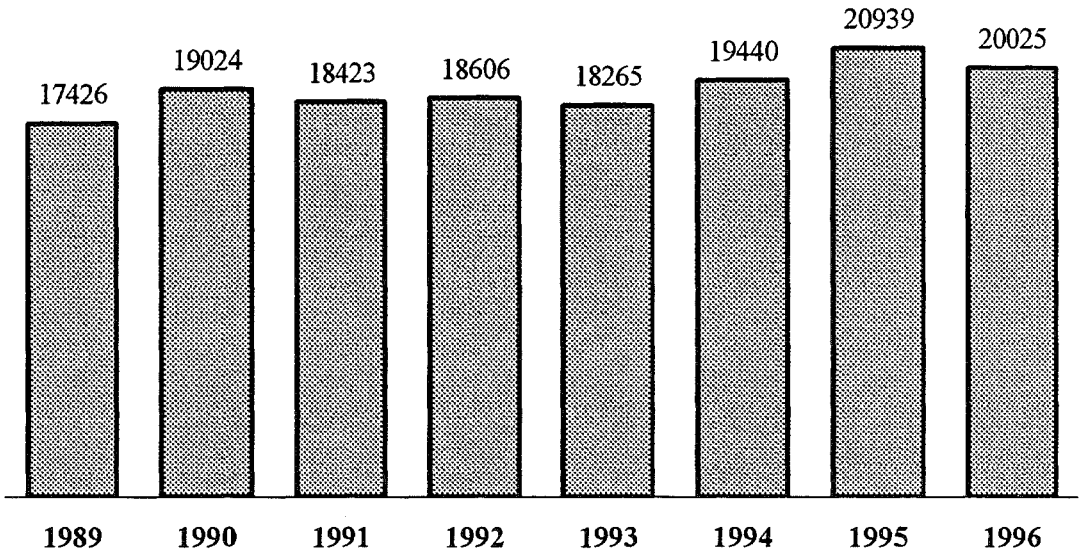
Funded in full</td><td colspan="4">Funded in full</td></tr>
<tr><td></td><td colspan="4">TIER 2 ELIGIBLE CLIENTS: incomes exceed MA income eligibility guidelines but are less than 60% of the state median family income, adjusted for family size</td></tr>
<tr><td></td><td>In April 1991 eligibility was restricted to Tier I</td><td>$5 million appropriated for Tier 2; placements cut off May, 1992</td><td colspan="2">Tier 2 funding restricted to targeted groups defined as adolescents, pregnant women and parents with minor children at home</td></tr>
<tr><td></td><td></td><td></td><td>$2.195 million appropriated</td><td>$2.545 million appropriated</td></tr>
<tr><td>Between 60% and 115% of state median family income, adjusted for family size (client payments on a sliding fee scale)

Funded in full</td><td colspan="4">TIER 3 ELIGIBLE CLIENTS: Between 60% and 115% of state median family income adjusted for family size
(client payments on a sliding fee scale)</td></tr>
<tr><td></td><td>In April 1991 eligibility was restricted to Tier 1</td><td colspan="3">No funds available for Tier 3</td></tr>
</table>

Summary of Consolidated Fund Placements

Fiscal years 1989 and 1990 were the only two full years the Consolidated Fund operated as originally conceived. Placements increased 9% in 1990 as compared with the previous year (see the graph below).[4] This increase represents the effect of increasing financial eligibility and simplifying access for publicly-funded health care services. It is not possible to determine for certain whether this effect would have leveled off completely in 1991 since funding was restricted to Tier 1 clients in April; however, the numbers suggest that any continued increase would have been much smaller. In 1992, placements increased very little (1%), an effect of the reduction of available Tier 2 funding. In 1993, placements actually declined slightly from the previous year (2%) reflecting the restriction of Tier 2 funding to targeted populations. In 1994, placements increased from the previous year by 6%, bringing the total number over 1990 levels for the first time. The increase was due primarily to an increase in Tier 1 clients (see the table on page 8). In 1995, placements again increased, almost 8% over the previous year, also due exclusively to an increase in Tier 1 clients. In 1996, the upward trend was reversed, with placements down 5% from the previous year.

Treatment placements by fiscal year



Changes in Consolidated Fund placements need to be interpreted in the context of changes in eligibility criteria. The following table breaks down placements by eligibility group.

[4]Placements are based on authorized first date of service occurring within the fiscal year. Individual clients may have multiple placements, because of unsuccessful treatment, because of a treatment plan that includes a continuum of care such as inpatient treatment followed by outpatient treatment or a halfway house placement, or because reauthorizations for lengthy stays are required every six months.

Annual Placements by Eligibility Groups

Fiscal Year	Tier 1	Tier 2	Other
1990	15,435	2,880	708
1991	15,113	2,497	812
1992	15,945	2,381	288
1993	16,552	747	966
1994	17,423	954	1,063
1995	19,164	947	828
1996	18,237	979	809

Note: Since Tiers 1 and 2 were not distinguished in 1990, 1990 numbers are an estimate based on reported income and family size. Although the combined reduction for Tiers 1 and 2 in 1991 is accurate, some error may exist as to that portion of the combined reduction attributable to either tier.

Tier 1 placements increased steadily between 1991 and 1995 (approximately 4% to 6% annually until 1994 followed by a 10% increase in 1995). In 1996, the trend was reversed as Tier 1 placements decreased by 5%. The large Tier 2 reduction seen in 1993 corresponds with the reductions in available funding and eligibility for Tier 2 clients. The increase in Tier 2 placements in 1994 leveled off for the next two years.

Placements classified as "other" include Tier 3 clients in 1990 and 1991, but reflect almost exclusively county-paid placements since 1992. These placements more than tripled in 1993 as compared with the previous year. When Tier 2 funding was restricted to targeted populations, cutting off access to treatment for low income adults without children, it appears that counties paid for treatment for at least some of these clients solely with county funds. The "other" funding category also includes placements of MinnesotaCare clients. Placements of MinnesotaCare enrollees totaled 32 in 1993, 260 in 1994, 282 in 1995 and 490 in 1996. Eligibility for MinnesotaCare was limited during this period to adults with dependent children whose family incomes did not exceed 275% of the federal poverty guideline or single adults with incomes no higher than 135% of the federal poverty guidelines.

Consolidated Fund clients whose income falls below 60% of the state median income (adjusted for family size) are not required to spend down assets as required for enrollment in Medicaid. Therefore, the entitlement under the Consolidated Fund is broader than that for MA. The table below shows the actual enrollment of Consolidated Fund clients in public assistance or publicly subsidized programs.

Public Pay Enrollment

	1995	%	1996	%
Medicaid (MA)	2,571	12.3	2,351	11.7
AFDC Medicaid	1,452	6.9	962	4.8
General Assistance Medical Care (GAMC)	6,890	32.9	6,340	31.7
MinnesotaCare	282	1.3	490	2.4
Other	9,744	46.5	9,862	49.2
TOTAL	20,939	99.9	20,025	99.8

Client Profiles

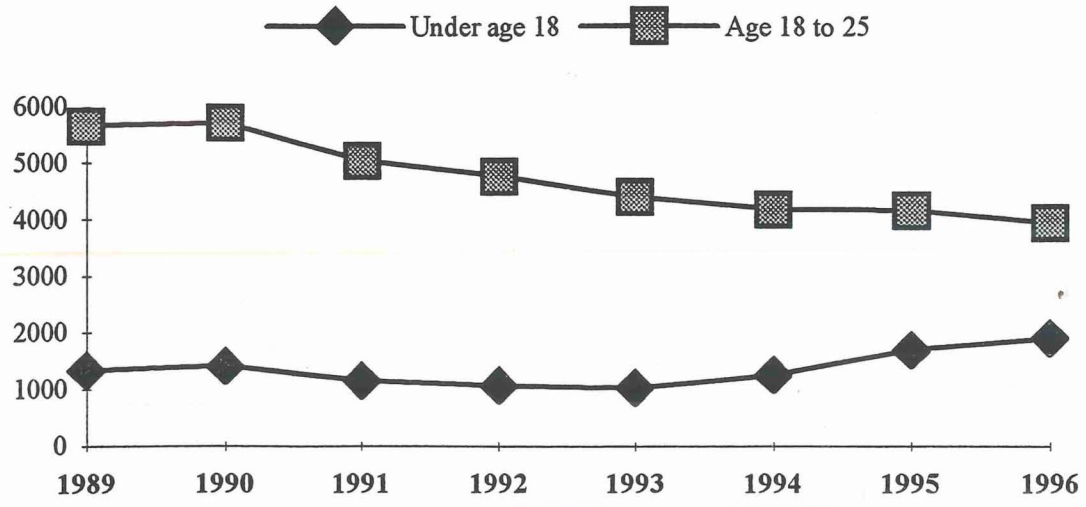
Age

After a decrease in placements from 1989 through 1993, adolescent placements have shown a steep increase (86%) from 1993 through 1996. The increase in adolescent placements parallels the rise in marijuana and other illicit drug use reported by adolescents in the Minnesota Student Survey.[5] In contrast, the numbers of young adults (18 to 25) served through the Consolidated Fund have steadily decreased since peaking in 1990. The eligibility of young adults (especially males) has been affected by changes since April of 1991, but it is not clear if eligibility is the only factor contributing to this decline. Placements for adults ages 26 to 44 increased steadily from 1989 through 1995, showing the first decline in 1996. For adults ages 45 to 59, placements have generally increased over time. For adults over age 60, the pattern is mixed, but generally placements have declined. The table below illustrates these admission patterns by age; the graph depicts contrasting trends for adolescents and young adults.

Treatment Placements by Age

	Under 18	18 to 25	26 to 44	45 to 59	60+
1989	1,329	5,655	9,072	1,233	357
1990	1,413	5,730	10,128	1,387	365
1991	1,156	5,059	10,519	1,373	315
1992	1,067	4,779	10,983	1,495	282
1993	1,026	4,403	11,193	1,428	221
1994	1,244	4,188	12,089	1,692	226
1995	1,692	4,166	12,951	1,889	241
1996	1,904	3,948	11,968	1,988	217

Treatment Placements for Adolescents and Young Adults

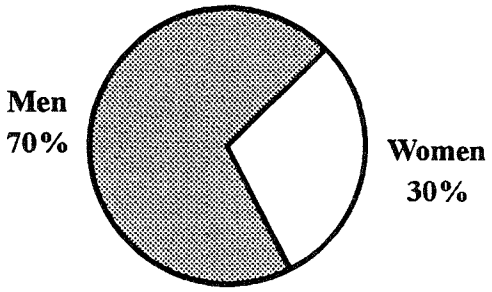


[5] *Perspectives on Youth: Minnesota Student Survey 1989-1992-1995.* Minnesota Department of Children, Families and Learning, December 1995.

Gender

The gender breakdown of Consolidated Fund clients has been remarkably stable over time. Through 1992, 72% of clients were male. With the change in targeted Tier 2 groups in 1993 which tended to favor women (parents with minor children in the home), the proportion of males dropped to 70% and remained at that level through 1996. Although some fluctuations in gender rates can be explained by payer source and financial eligibility criteria, the fact is that men outnumber women more than two to one in almost all chemical dependency treatment populations. While this is often interpreted to mean that women in need of treatment are underrepresented in treatment, this is not the case. The predominance of males in treatment is consistent with epidemiological studies of the general population which find the prevalence of alcohol and drug use disorders as much as four times higher among men than women.[6]

1995-1996 Treatment Placements by Gender



Race/ethnicity

At least three factors influence the rate of treatment placements among population groups:

- The number of persons with alcohol and other drug use disorders identified as in need of treatment.
- Financial eligibility for publicly funded treatment or another means to pay for treatment (private insurance or self-pay).
- A willingness to enter treatment (which may be influenced by internal characteristics such as motivation to discontinue alcohol/drug use as well as external characteristics such as availability of appropriate care).

These factors must be considered in interpreting differences between groups and differences over time. These considerations are especially important in examining differences among racial/ethnic groups. Minority status in U.S. society is highly correlated

[6]Regier DA, Myers JK, Kramer M, Robins LN, Blazer DG, Hough RL, Eaton WW & Locke BZ (1988). One-month prevalence of mental disorders in the United States. *Archives of General Psychiatry, 45*, 977-981, 1988.

with poverty and unemployment, known risk factors for substance abuse. In Minnesota, people of color (with the exception of American Indians) are highly concentrated in the Minneapolis-St. Paul metropolitan area. Inner cities have also been disproportionately affected by the availability of illegal drugs, particularly crack cocaine.

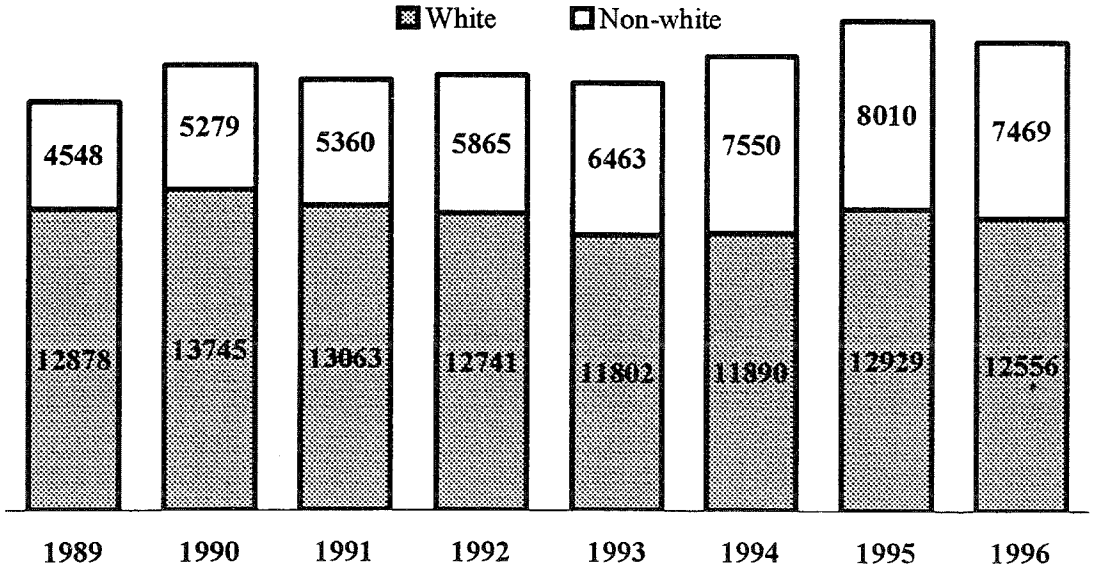
The following table illustrates changes in Consolidated Fund placements associated with race/ethnicity over time.

Treatment Placements by Race

	White	Black	Indian	Hispanic	Asian	Other
1989	12,878	1,813	2,352	280	49	54
1990	13,745	2,208	2,608	374	46	43
1991	13,063	2,367	2,467	389	90	47
1992	12,741	2,954	2,345	423	93	50
1993	11,802	3,530	2,315	454	87	77
1994	11,890	4,251	2,567	530	126	76
1995	12,929	4,555	2,623	612	159	61
1996	12,556	4,024	2,522	676	170	77

The most dramatic demographic trend over the years of Consolidated Fund operation is the increase in people of color. Placements for people of color increased proportionately from 26% of the total in 1989 to 37% of the total in 1996. People of color comprise about 6% of the state's total population.

Treatment placements by fiscal year



The number of Black placements increased 151% from 1989 to 1995 before declining in 1996. The proportion of Black placements has grown from 10% of the total in 1989 to 20% in 1996. (Blacks comprise about 2% of the state's population.)

The number of Hispanic placements also shows a steady increase totaling 141% since 1989. Consolidated Fund placements for Hispanics ranged from 1.6% to 3.4% of the total over the past eight years. Hispanics account for just over 1% of the state's population.

The number of Asian placements is very low overall (less than 1%), and low relative to their proportion of the state's population (about 2%.). The apparent increase in 1991 is due primarily to the requirement that treatment placements be reauthorized at six-month intervals. Asian clients are typically in methadone maintenance treatment which may last indefinitely (see page 14 for more on methadone treatment).

In contrast to the increases seen for other minority groups, the number of American Indian placements has been relatively stable over the years. Nonetheless, American Indian treatment placements remain disproportionately high relative to the number of Indians in the general population. While Indians comprise just over 1% of the state's population, they account for 13% to 14% of Consolidated Fund treatment placements annually.

The single most important factor in the increase in the number of Black placements appears to be the disproportionate effect crack cocaine has had on the urban African American community. According to client data available through the Drug and Alcohol Abuse Normative Evaluation System (DAANES), alcohol was the primary substance of abuse for every racial/ethnic group except African Americans; among African Americans crack cocaine dominated. Marijuana was the second most frequently cited substance as cause for treatment admission for every racial/ethnic group except African Americans, for whom alcohol was second and marijuana third. Cocaine was third among all groups except African Americans (for whom it was first) and Asians (for whom it was fourth). Among Asians, opiates account for a much higher proportion of placements than among any other racial/ethnic group.[7]

Primary Substance of Abuse in Treatment Placements by Race

	White	Black	Indian	Hispanic	Asian	Other
Alcohol	70%	35%	74%	62%	42%	47%
Cocaine/crack	6%	51%	4%	13%	7%	16%
Marijuana	17%	10%	18%	20%	26%	30%
Opiates	2%	3%	1%	3%	23%	3%
Other	5%	1%	3%	2%	2%	4%

It is as yet too early to determine whether the Twin Cities cocaine problem has begun to level off but treatment placements related primarily to cocaine abuse or dependence declined among all racial/ethnic groups in 1996.

[7] *Research News*, July 1994; available from the Department of Human Services Chemical Dependency Division.

Treatment Placement Patterns

Four levels of care are covered under the Consolidated Fund: primary outpatient treatment and three levels of residential care--primary inpatient, extended care and halfway house. Of the 398 Consolidated vendors (including 29 in neighboring States), 237 are primary outpatient, 69 primary inpatient, 34 extended care, and 58 halfway house programs. Appropriate placement is based on a clinical assessment conducted in accordance with Rule 25 criteria.

- **Primary outpatient treatment** is typically the placement of choice for clients who can function in their usual community environment despite their alcohol and drug problems. Outpatient is also used for clients living in a residential facility that controls access to alcohol and drugs. Outpatient treatment must consist of a minimum of 10 hours of services provided at a minimum rate of one hour per week.

- **Primary inpatient treatment** (or a combination of inpatient followed by outpatient) is used for clients who are chemically dependent, who are unable to abstain for seven consecutive days, who have lost or jeopardized their jobs or school enrollment, who lack family support, or who have been arrested or in treatment within the past year. Primary inpatient treatment programs must provide a minimum of 30 hours of rehabilitative services per week.

- **Extended care** is reserved for chemically dependent clients who typically have been in treatment at least three times and/or have serious physical, psychiatric, social and occupational problems. Extended care programs must provide an average of 15 hours of rehabilitative services per week including transitional services to help integrate the client back into the community.

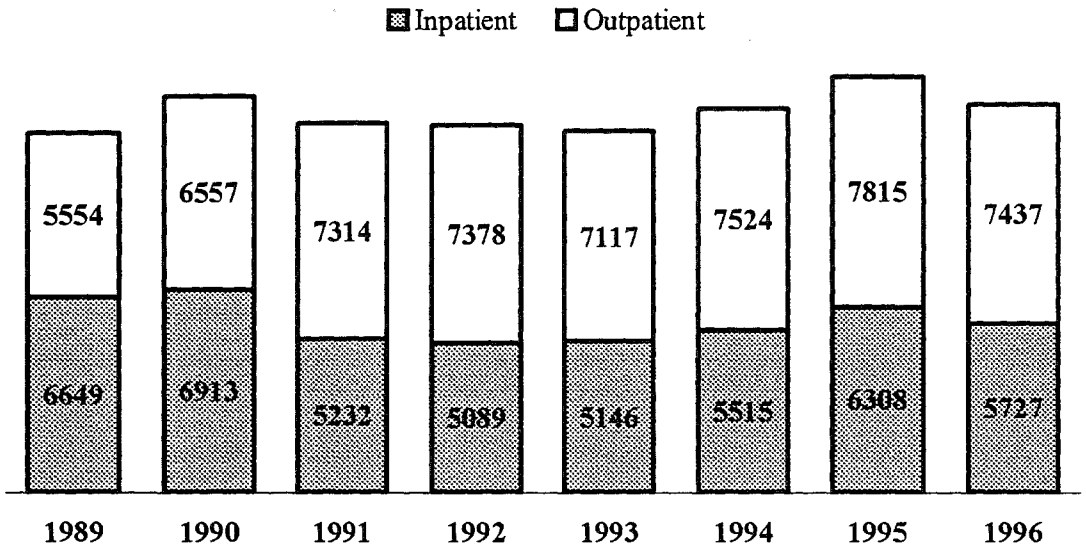
- **Halfway houses** are used for clients discharged from detox centers, primary treatment, or extended care programs who lack family and social supports and need a structured environment that controls access to alcohol and drugs. Halfway houses must provide a minimum of 5 hours of rehabilitative and transitional services per week.

Following a change in Rule 25 placement criteria designed to promote the use of lower-cost outpatient treatment when clinically appropriate, treatment placement patterns showed a dramatic shift in 1991 (see the graph and table on the next page). In 1989, outpatient treatment accounted for 46% of primary treatment placements (excluding combination inpatient/outpatient programs, extended care and halfway houses), while inpatient treatment accounted for 54% of primary treatment placements. In 1991, outpatient treatment increased to 58% of primary treatment placements and inpatient treatment declined to 42%. This pattern has remained relatively stable, moderating only slightly with outpatient treatment accounting for 55% of primary treatment placements in 1995 and 56% in 1996.

Treatment Placements by Level of Care

	Inpatient	Combination Inpatient	Outpatient	Combination Outpatient	Extended care	Halfway house	Outpatient Methadone[8]
1989	6,649	538	5,554	408	1,455	2,546	276
1990	6,913	461	6,557	338	1,504	2,716	535
1991	5,232	619	7,314	449	1,438	2,897	474
1992	5,089	558	7,378	410	1,572	3,094	505
1993	5,146	444	7,117	353	1,632	3,125	448
1994	5,515	417	7,524	336	1,704	3,416	528
1995	6,308	344	7,815	276	1,823	3,628	745
1996	5,727	381	7,437	269	1,748	3,715	748

Primary Treatment Placements by Fiscal Year



Methadone treatment is used sparingly in Minnesota, primarily because the use of a substitute drug (also addicting) is contrary to the predominant philosophy of abstinence-based programs in the State. Methadone is used on a maintenance basis to allay the withdrawal syndrome experienced by persons addicted to opiates (primarily heroin). Clients may remain on methadone indefinitely but a reauthorization for treatment through the Consolidated Fund is required every six months. The six-month reauthorization policy became effective in January 1991, but the practice had begun earlier by counties wanting to retain accountability for their placements. It is likely that this practice, rather than an actual increase in the use of methadone treatment, accounts for the increase in 1990 placements. Since the number of placements actually reflects reauthorizations for some of the same clients, the number of public clients on methadone maintenance is smaller than this table suggests (a maximum of approximately 300 annually). Methadone treatment placements account for a small percentage (less than 4% in 1996) of treatment placements reimbursed through the Consolidated Fund.

[8]Increase seen in 1990 primarily reflects institution of treatment placement reauthorizations every six months; methadone outpatient and combined inpatient and outpatient placements are not reflected on the graph.

Length of Stay

Length of stay is one of the factors in treatment costs. Authorizations for maximum lengths of stay are made by Rule 25 assessors. Lengths of stay in residential settings, regardless of level of care, remained virtually unchanged through 1994 and then declined in 1995 and 1996. Primary inpatient treatment lasted, on average, 22 days in 1996, while extended care and halfway house stays typically lasted about 8 weeks.

Some variation in length of stay exists by site. In 1996, primary inpatients typically stayed longer in Regional Treatment Centers (28 days) than in freestanding facilities (23 days) or hospitals (18 days). A different pattern was seen in 1996 for extended care patients. Extended care patients had shorter stays in Regional Treatment Centers (49 days) than in freestanding facilities (62 days). Freestanding extended care programs include programs designed for adolescents and young adults, often with histories of criminal behavior and social instability, and these factors may account for longer average stays.

Average Length of Stay (Days) by Level of Care and Setting

	1989	1990	1991	1992	1993	1994	1995	1996
INPATIENT	**25**	**24**	**24**	**24**	**24**	**24**	**23**	**22**
RTC	26	25	26	27	27	29	27	28
Hospital	21	20	21	22	21	20	19	18
Freestanding	28	26	25	24	24	24	24	23
EXTENDED CARE	**65**	**67**	**69**	**63**	**61**	**64**	**62**	**56**
RTC	54	53	57	54	52	56	56	49
Freestanding	76	79	81	74	70	67	67	62
HALFWAY HOUSE	**65**	**63**	**63**	**62**	**63**	**63**	**61**	**59**

Treatment Costs

The cost of a treatment episode is the product of the daily cost and the length of stay.[9] The cost of the average treatment episode is influenced also by changing rates in the use of available levels of care. Considering all levels of care combined, the average cost of a treatment episode rose from $2,580 in 1989 to $3,159 in 1995, an increase of 22% over seven years. Consolidated Fund rates were frozen in 1996 and the average cost of a treatment episode dropped to $3,056; the 3% decline in average cost per treatment episode reflects shorter average lengths of stay and a slight increase in outpatient treatment relative to inpatient).

Cost increases varied considerably by level of care, however. Examining increases before the rate freeze went into effect revealed relatively low increases for primary inpatient (14% from 1989 to 1995) to moderate increases over the same period for primary outpatient (24%) and halfway houses (33%), to much larger increases for extended care (66%).

Average Cost per Treatment Placement by Level of Care and Setting

	1989 $	1990 $	1991 $	1992 $	1993 $	1994 $	1995 $	1996 $
AVERAGE COST PER PLACEMENT	**2,580**	**2,683**	**2,702**	**2,799**	**2,884**	**2,992**	**3,159**	**3,056**
INPATIENT[10]	**3,681**	**3,745**	**3,907**	**4,035**	**4,155**	**4,174**	**4,200**	**4,059**
RTC	3,508	3,722	3,973	4,089	4,322	4,571	4,537	4,703
Hospital	3,803	3,815	3,960	4,489	4,420	4,193	4,313	4,107
Freestanding	3,715	3,671	3,831	3,728	3,963	4,072	4,207	4,060
OUTPATIENT[11]	**1,145**	**1,269**	**1,337**	**1,371**	**1,345**	**1,372**	**1,425**	**1,313**
RTC	1,141	1,287	1,422	1,503	1,366	1,535	1,485	1,539
Hospital	1,088	1,143	1,276	1,362	1,340	1,350	1,460	1,417
Freestanding	1,163	1,308	1,347	1,365	1,345	1,367	1,429	1,300
EXTENDED CARE	**3,942**	**4,868**	**5,767**	**5,919**	**5,750**	**6,159**	**6,534**	**5,996**
RTC	4,159	5,195	6,647	6,907	6,667	7,601	8,068	7,103
Freestanding	3,707	4,593	4,894	4,846	4,801	4,943	5,165	5,130
HALFWAY HOUSE	**2,589**	**2,765**	**2,936**	**3,035**	**3,237**	**3,363**	**3,452**	**3,348**

[9]Average costs are calculated on treatment episodes for which final payments are completed within the fiscal year.

[10]Excludes placements in inpatient/outpatient combination programs.

[11]Excludes inpatient/outpatient combination placements and methadone programs.

The smallest cost increase, seen for primary inpatient treatment, may reflect the sustained competition in the marketplace. The large increases seen for extended care, particularly at the Regional Treatment Centers, may reflect the few options available for chronically impaired clients as well as the high proportion of court-ordered clients. According to data available from the Drug and Alcohol Abuse Normative Evaluation System (DAANES), about 40% of clients in extended care settings are there as a result of commitment or other court order. Historically, Regional Treatment Centers have served a higher proportion of committed and court-ordered clients in their extended care programs compared with other sites (52% versus 35%).[12]

Extended care is the most expensive placement at an average cost of $5,996 in 1996. Setting is a significant factor in extended care costs. The average cost for extended care treatment in a Regional Treatment Center was $7,103 in 1996. In a freestanding facility the cost in 1996 was $5,130, this despite the fact that stays in freestanding sites were, on average, 13 days longer (62 versus 49). Daily rates for extended care programs in Regional Treatment Centers averaged $145 compared with $83 for extended care programs in freestanding facilities.

Primary inpatient treatment is the most expensive level of care following extended care treatment. In 1996, a typical inpatient treatment episode cost $4,059 for an average length of stay of 22 days. Setting is also a factor in the cost of inpatient treatment. However, unlike for extended care, Regional Treatment Centers have the lowest daily rate, $168, compared with $177 for freestanding facilities and $228 for hospital-based programs. The higher inpatient treatment episode rate for the Regional Treatment Centers is a result of their longer average length of stay (28 days) compared with 23 days for freestanding facilities and 18 days for hospital-based programs.

A halfway house stay typically lasted 59 days and cost $3,348 in 1996.

Primary outpatient treatment cost on average $1,313 in 1996, approximately one-third the cost of primary inpatient treatment. Outpatient programs in Minnesota vary widely in intensity and length of stay.

[12]*Research News*, October 1994; available from the Department of Human Services Chemical Dependency Division.

Total Treatment Expenditures

Consolidated Fund expenditures have generally risen steadily over time with the exception of two decreases from previous year expenditures seen in 1991 when eligibility was restricted to Tier 1 clients in April, and in 1996 when rates were frozen at previous year levels. In 1992, $5 million was appropriated for Tier 2, but Tier 2 placements were restricted in May. From 1993 through 1996 Tier 2 placements were limited to targeted groups of adolescents, pregnant women, and parents with minor children at home. In 1993, $2.195 was appropriated for this group; in 1994, the appropriation was raised to $2.545 million.

Public Expenditures by Source of Funds

Fiscal Year	Total expenditures[13]	State funds	Federal funds[14]	County funds
1990	$49,161,900	$26,314,300	$11,843,800	$11,003,800
1991	$47,841,500	$31,599,100	$5,367,100	$10,875,200
1992	$50,341,700	$26,908,000	$11,887,400	$11,546,200
1993	$51,329,400	$25,108,300	$14,245,700	$11,975,300
1994	$56,013,600	$29,213,200	$14,192,700	$12,607,700
1995	$63,312,200	$34,745,400	$13,656,500	$14,910,300
1996	$58,954,600	$38,399,000	$6,838,100	$13,717,500

[13]Expenditures reflect actual expenditures during a given fiscal year and may include payments for treatment initiated during the previous year as well as partial payments for treatment initiated in that year but completed in the next.

[14]Includes federal alcohol and drug abuse block grant funds and federal financial participation in Medicaid.

Future Considerations

The CCDTF legislation, Minnesota Statutes, Chapter 254B, was introduced in 1985 and implemented January 1, 1988. The legislation resulted from the recognition of a number of limitations of the existing delivery of chemical dependency treatment services. There were six public funding sources for treatment, each with its distinct eligibility requirements and each with restrictions on the types of treatment funded.

Because one of the funding sources was county social service dollars, access to certain services depended on where the client lived. Regional treatment centers (formerly state hospitals) had the broadest eligibility criteria; however this meant that sometimes clients received residential treatment when outpatient treatment may have been more appropriate. In fact, Minnesota was too dependent on residential treatment, in part, because this modality was all that was covered by some funding sources. Assessment of the need for treatment was typically conducted by treatment center staff who may have had a financial self-interest in filling empty beds.

The CCDTF legislation and the accompanying Rule 25 (standardized assessment and placement criteria) successfully addressed weaknesses of the existing system. Public funding sources were consolidated into a single, efficient treatment reimbursement system. Decisions as to what type of treatment a client received were based on the severity of a client's substance disorder and related problems rather than arbitrary eligibility considerations. With the lifting of funding restrictions, a wider range of services became available to clients. Assessment was also conducted by trained professionals who did not have a financial stake in the selection of the treatment site. With standardized placement criteria restricting the use of inpatient or residential care to the severely impaired, referrals to outpatient treatment increased, resulting in cost savings.

The Consolidated Fund won a national award recognizing innovations in government as a successful response to problems of the 1980s. The 1990s offers a new set of challenges and opportunities:

- A national movement toward Patient placement criteria offers more comprehensive models than the current Rule 25 criteria.
- Managed care as a health care purchasing strategy offers case management as a method of tailoring treatment services to the needs of individual clients.
- The statewide treatment outcomes monitoring system will yield information important to improving both assessment and treatment.
- The fact that payment for treatment and housing is currently bundled together for residential services means that treatment discharge may lead to loss of safe housing.
- The system is designed to treat chemical dependency as an acute illness rather than a continuing or chronic disorder.

The Department of Human Services has developed a plan to restructure the chemical dependency treatment delivery system in order to take advantage of these opportunities and address these challenges. A variety of stockholders have been invited to join the department in developing the specific components of the restructured system. Input is being sought from consumers, treatment providers, managed care organizations, and county social service agencies.

Funding from treatment will be separated from funding for housing so that the intensity and duration of treatment and the need for a supportive living environment can be customized for each client. Separating the treatment service dollars can allow for integration of these funds with other health care dollars in a managed care purchasing

strategy. This plan will provide chemical dependency clients access to a full range of health care services.

Development of continued service and discharge criteria will help treatment providers and health care purchasers focus their attention on the anticipated outcomes of treatment and what an individual client needs in order to achieve identified outcomes. Ultimately, new placement criteria will help those responsible for assessment and placement of clients to better match clients to the services they need. In conjunction with this effort, licensing regulations will be streamlined and focused to allow treatment providers maximum flexibility in addressing the needs of their clients. Providers will be expected to adjust treatment strategies that are not having the desired outcomes.

The Department anticipates a package of changes that address both the nature of services and the systems that support the provision of treatment. The result will be chemical dependency treatment that is more flexible and client-centered. These changes are necessary to improve client outcomes, reduce disruption to families, and improve cost-effectiveness.