Provider Rate Increases are Urgently Needed

TAADAS was invited to participate in The Public Health Workforce Workgroup convened by TennCare and TN Department of Mental Health and Substance Abuse Services (TDMHSAS). This workgroup was to analyze and make recommendations regarding workforce shortages for state funded programs under TDMHSAS and TennCare. TAADAS supports the workgroup report and the subsequent workforce supports and rate increases in their respective proposed budgets. TAADAS wants to reinforce the implications for substance use providers as they are facing particularly dire financial impacts and have a critical role in treatment and support of Tennesseans with substance use disorders (SUD). Funding to TDMHSAS has improved in the last few years, but these funds have not directly impacted the rate paid for residential treatment and providers take a financial loss for every day of services provided at state rates. TennCare rates are contracted by MCOs but those rates are not subject to routine review or cost of service revisions.

The role that behavioral health plays in everyone’s overall health is increasingly well documented. Behavioral Health is a part of healthcare. Randomized trials of Screening and Brief Intervention for substance use disorders show the intervention saves money and improves outcomes. 12, 13, 14, 15, 16, 17, 18

U.S. Level 1 Trauma Center: $3.81 cost savings for each $1.00 spent in intervention.
U.S. Primary Care Clinic: $4.30 cost savings for each $1.00 spent in intervention.

Increasing Need for Behavioral Health Services

Among adults aged 18 or older in the USA in 2019, 11.5 percent (or 28.8 million people) had either Severe Mental Illness (SMI) or SUD in the past year. 24 These individuals have higher healthcare costs and were not generally getting the care they require to address these issues even prior to the isolation and provider shortages imposed by the COVID-19 Pandemic.

10 percent of adults with SUD receive treatment each year, with 29 percent of those receiving care considering it “minimally adequate”. 5

Among the 9.5 million adults aged 18 or older in 2019 who had a co-occurring SUD and SMI in the past year, 48.6 percent (or 4.6 million people) received either SUD treatment at a specialty facility or mental health services in the past year and 7.8 percent (or 742,000 people) received both SUD treatment at a specialty facility and mental health services. 24

Pandemic stress increased the number of people seeking services at behavioral health providers but maintaining staffing levels to ensure that treatment is available has been a substantial challenge. Staff turnover is significant and those that remain are working longer hours. Stress and anxiety have increased 40 percent statewide since the beginning of the pandemic. Because of the intensity of the work and the risk of infection, treatment centers claim even higher rates of stress. Overdoses increased just as pandemic conditions made access to care more difficult. Drug overdose deaths in the U.S. are up 30% in 2020. 25 From March to June of 2020, Tennessee saw a 33% increase in nonfatal opioid overdoses compared to March to June of 2019. Drugs laced with Fentanyl are much more potent and deadly.

Substance Use Disorder Treatment Makes a Difference

According to research that tracks individuals in treatment over extended periods, most people in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. When relapse occurs many deem treatment a failure. This is not the case. Successful treatment for addiction, like most chronic diseases, is a process. For example, when a patient receives active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses in recovery signify a need for reinstated or adjusted treatment (chart right). 26
Workforce issues
TAADAS agencies employ many types of licensed and/or certified clinicians but Licensed Alcohol and Drug Counselors (LADAC) working towards a license and peers who may be Certified Peer Recovery Specialists (CPRS) are integral to a strong recovery focus. LADACs are not trained as generalist practitioners. They have a limited scope of practice focused on substance use disorders. Their training is targeted and specific. Depending on the amount of formal education, LADAC candidates can spend from 2000 – 6000 hours of supervised work in the field before licensure. Enabling LADACs who are licensed but who do not hold a master’s degree or those in an advanced LADAC track to bill TennCare could increase access to services and would help grow this field of practitioners and address workforce shortages.

Incentives are an important part of a hiring and retention package but some incentives are not viable for direct-care shifts. Direct-care workers are unable to work from home and their hours must be set. Job market analyses indicate that jobs requiring in-person work will need higher pay scales to remain filled. TennCare and TDMHSAS surveyed TAADAS and the TN Association of Mental Health Organizations (TAMHO) members for data on pay scales for their workforce report and found that substance use agency staff are not paid as well as the same position in a mental health agency. The chart right shows this 2021 survey wage data which is strikingly similar to the average rates of pay in 2010 (below) based on data from TAADAS member agencies representing each of the three grand divisions of the state:

- Technicians $16,375; $ 7.90 per hour
- Counselor I $24,500; $11.81 per hour
- Counselor II (licensed) $26,000; $12.47 per hour

Solutions and Strategies
In 2021, treatment agencies are competing with companies offering entry level salaries in excess of $12-18 per hour. Salaries are only one component of the increased cost of providing services. Agencies are bracing for inevitable cost increases in utilities, food, health care benefits, medicines, and technology that also contribute to the costs of providing treatment.

TAADAS found that Tennessee provider rates of reimbursement have not kept pace with inflation. The cost of providing services has greatly increased, yet the last rate increase for state-funded services such as residential treatment and detoxification was in 2009. Most TennCare rates have not been renegotiated since 2009 when a new MCO was added. Without a rate increase that recognizes the increased cost of providing these services, providers will not be able to hire and retain the staff needed to provide necessary services and will not be able to survive long term. With a 2% average cost of living increase annually since 2009, a provider would have had to reduce expenses by 24% to survive. A rate increase is vital to allow providers to pay their expenses, including competitive wages and address workforce shortages. Incorporating a mechanism for the regular review of rates is also needed to ensure that a workforce crisis is avoided in the future.

TDMHSAS’ budget proposal to increase provider rates to reflect cost of living adjustments is a huge step in addressing gaps in funding for services provided. TDMHSAS supports for community provider sign-on bonuses, a Public Behavioral Health Scholarship Program and an internship portal and TennCare’s investment of $50 million in workforce initiatives will offer more viable long term career opportunities. TennCare’s rate increase proposal, while needed, does not offer an across the board rate increase and does not apply to agencies solely licensed as SUD providers. In addition, if TennCare would recognize services provided by licensed LADAC I, especially services provided with clinical supervision, substance use treatment centers that serve both funders could use LADACs as staff. This would also foster an additional committed, recovery-focused pipeline of professionals to this field, ensuring increased viability of services for years to come.
REFERENCES
18. UKATT Research Team. Effectiveness of treatment for alcohol problems: findings of the randomized UK alcohol treatment trial (UKATT). BMJ. 2005 Sep 10; 331(7516):541.