Medicaid: The Linchpin in State Strategies to Prevent and Address Opioid Use Disorders

STATE Health & Value STRATEGIES
Driving Innovation Across States

Authored by Manatt Health

A grantee of the Robert Wood Johnson Foundation

March 2018

Executive Summary

The nation's opioid epidemic claimed more than 42,000 lives in 2016, and more than 2 million people in the United States have an opioid use disorder (OUD)—with nearly another 10 million at risk due to misuse of these drugs. Yet, only 1 in 5 people suffering from an OUD receive treatment. The federal government has responded to the crisis by declaring a public health emergency[1] and making over $500 million of OUD-targeted funding available to states last year.[2] More recently, in its Bipartisan Budget Act of 2018, Congress added $3 billion a year in opioid funding for 2018 and 2019 ($6 billion in total funding); the president's budget calls for $10 billion across multiple agencies for addressing the opioid crisis. While critical, these dollars (and the programs they fund) pale in comparison to the scale and scope of resources that the Medicaid program brings to states to combat the opioid epidemic. Indeed, today, Medicaid covers more than 1 in 3 people with an OUD and program spending for people with an OUD in 2013 (*before* Medicaid expansion in many states) was more than $9 billion.

Beyond the substantial and essential funding it brings to states, Medicaid provides access to prevention, treatment and recovery services for those with an OUD, as well as comprehensive coverage for the full array of physical and behavioral health services to treat co-occurring conditions, increasing their odds of long-term recovery. Medicaid also provides a structured system of accountability for providers, as well as accountability and access for those enrolled, with multiple touch points throughout the health care delivery system—community health centers, emergency rooms, inpatient and outpatient care settings—as well as data systems that can help to identify those with addiction and engage them in treatment.

While recent federal efforts to provide OUD-specific grant funding are an essential contribution, the profound economic and social consequences of addiction require substantial and sustained investment in coverage and treatment through the Medicaid program. In short, Medicaid is an existing, robust and stable base from which states are battling, and will continue to battle, the opioid epidemic and substance use disorder (SUD) issues more broadly. This is particularly true in states that have expanded Medicaid; Medicaid expansion enables these states to provide a wider range of services to a larger group of people suffering from an OUD.

The multitude of tools available to state Medicaid programs—including enhancing coverage and benefits for those who are at the highest risk of, or already grappling with, an OUD or other SUD, as well as leveraging Medicaid's purchasing power to require providers and plans to promote best practices in SUD treatment—is outlined in a previous State Health and Value Strategies brief.[3] A third brief in this series on Medicaid and the opioid crisis is forthcoming and will discuss state strategies to address opioids and other SUDs pursued under Section 1115 waivers.

In this issue brief, data from three states—New Hampshire, Ohio and West Virginia—highlight Medicaid's role as the linchpin in states' efforts to combat the opioid epidemic. Key findings include:

- **Medicaid spending on comprehensive health care services for people with an OUD dwarfs the other federal grants available to states for OUD treatment and prevention.** In 2017, New Hampshire spent $80 million on Medicaid services (all services, including addiction treatment) for enrollees with an OUD; in comparison, the state received $5.2 million in opioid-specific federal grants from sources other than Medicaid. In Ohio, the state spent at least $390 million on Medicaid addiction treatment services alone for people with an OUD in 2017, and received $32.4 million in other federal grants.
- **Medicaid is addressing addiction along with a multitude of coexisting conditions that, if left untreated, perpetuate the cycle of addiction.** A substantial portion of spending for Medicaid enrollees with a SUD is for

services to address significant physical and behavioral health issues, many of which co-occur with addiction. In West Virginia, three-quarters of Medicaid spending on enrollees with an OUD is for services other than direct treatment of addiction.

- **Opioid addiction now dominates among substance use disorders in some states.** In two of the states we examined, among the Medicaid enrollees identified as having a SUD, the majority had an opioid addiction (alone or in combination with other SUD diagnoses). In New Hampshire and West Virginia, 80 percent and 64 percent of those with a SUD, respectively, had an OUD diagnosis.
- **Expansion adults account for a large share of Medicaid enrollees with an OUD.** In New Hampshire and West Virginia (both of which have expanded Medicaid), more than half of Medicaid enrollees with an OUD are in the expansion group and more than two-thirds are ages 26 to 44.

Gravity of the U.S. Opioid Epidemic

Substance use disorders are a widespread problem in the United States,[4] with 7.5 percent of people age 12 or older having a SUD in 2016 and only a small minority receiving treatment.[5] OUD in particular is a growing crisis:

- Nearly 1 percent of the U.S. population age 12 or older had an OUD in 2016,[6] and this figure rises to more than 4 percent under a broader definition that includes prescription opioid misuse.[7]
- The highest rates of misuse are reported for people ages 18 to 25,[8] and the share of individuals with prescription opioid misuse or heroin use has doubled over the past decade.[9]
- Approximately two-thirds of OUD cases are associated with prescription pain relievers alone, and the others involve heroin, which may be used in combination with other opioids.[10]
- Nearly two-thirds of drug overdose deaths involve opioids, and the number of opioid overdose deaths now exceeds the number of people killed by guns or in traffic accidents.[11]
- Over the past decade, the national rate of opioid-related emergency department visits nearly doubled, and opioid-related inpatient stays increased by almost two-thirds.[12]
- Most states have seen an upward trend in opioid-related morbidity and mortality. Opioid overdose death rates are more than double the national average in West Virginia, Massachusetts and Ohio (both heroin and non-heroin opioids); New Hampshire, Rhode Island, Maine and Kentucky (non-heroin opioids); and Connecticut and the District of Columbia (heroin).[13]

Nearly two-thirds of drug overdose deaths involve opioids, and the number of opioid overdose deaths now exceeds the number of people killed by guns or in traffic accidents.

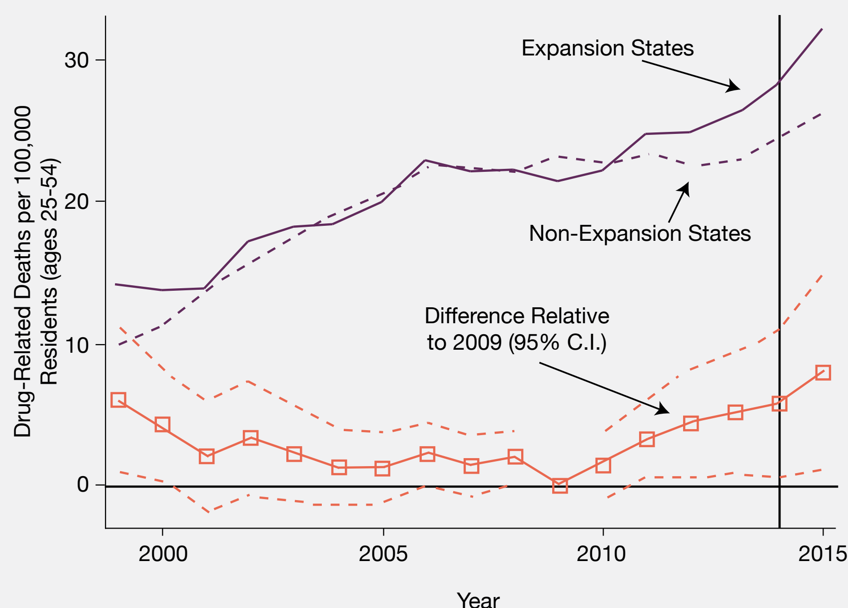
Substance use disorders have devastating and far-reaching social and financial consequences as well:

- Parental drug use is the second-most-common reason for foster care entry,[14] and it is on the rise—growing from less than 1 in 5 cases in the year 2000 to more than 1 in 3 cases today, with some state rates in excess of 50 percent.[15]
- More than half of state prisoners and nearly two-thirds of jail inmates have a SUD.[16]
- Although estimates vary depending on the methodology used, the overall economic burden of the U.S. opioid epidemic is substantial. The most recent figures range from $95 billion (reflecting decreased earnings and productivity along with increased health care, criminal justice, child and family assistance, and education costs) to more than $500 billion (including an additional valuation of lives lost).[17,18]

Has Medicaid Expansion Fueled the Opioid Epidemic?

While some have suggested that Medicaid expansion has fueled the opioid epidemic, there is strong evidence to the contrary. As indicated by a recent U.S. Department of Health and Human Services (HHS) analysis, drug overdose deaths between 2013 and 2015 increased more in states that expanded Medicaid compared to those that did not.[19] A subsequent HHS statement clarified that correlation is not necessarily causation and noted the need for additional research before drawing conclusions.[20] A variety of currently available data points indicate that Medicaid expansion has not been a driving force behind the opioid epidemic:

Exhibit 1. Drug-Poisoning Mortality Rate for Ages 25-54 by Medicaid Expansion Status, 1999–2015



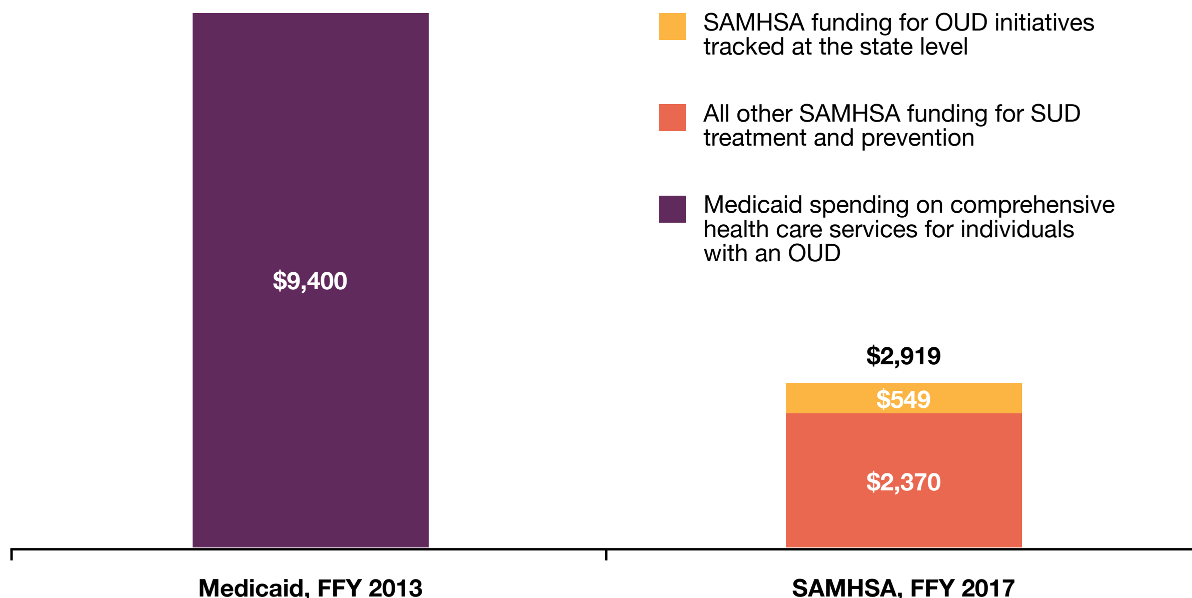
Source: Goodman-Bacon, A. and Sandoe, E.[23]

- Medicaid does not facilitate access to non-prescription drugs that have fueled the recent increase in opioid overdose deaths. Illegally made (non-pharmaceutical) fentanyl is presumed by the U.S. Centers for Disease Control and Prevention (CDC) to account for a large proportion of recent growth,[21] and heroin-related deaths have also been increasing at a rapid rate.[22]
- Many states have seen an upward trend in drug overdose death rates, but this uptick for expansion states started in 2010, four years before the Affordable Care Act's (ACA) Medicaid expansion began (Exhibit 1).[23]
- Similarly, while counties in Medicaid expansion states had higher growth in drug overdose death rates between 2010 and 2015, those rates grew less in places with the largest gains in Medicaid and other coverage under the ACA, a finding that is not consistent with Medicaid driving the epidemic.[24]

Medicaid: The Linchpin in State Strategies to Prevent and Address the Opioid Crisis

The federal government uses a number of different channels to support states in responding to the opioid crisis, but Medicaid is by far the most significant and impactful. Even prior to the ACA's expansion, in federal fiscal year (FFY) 2013, Medicaid spent $9.4 billion in federal and state dollars on comprehensive health care services for 636,000 individuals with an OUD.[25] In comparison, the entire SUD treatment and prevention budget of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) totaled $2.9 billion in FFY 2017,[26] with at least $549 million targeted at the opioid epidemic (Exhibit 2).[27] (See Appendix 1 for a summary of non-Medicaid federal grant sources that provide funding to states for OUD-related activities.)

Exhibit 2. Medicaid Spending for People with an OUD Compared to Non-Medicaid Federal Grants to States for OUD/SUD Treatment and Prevention (millions)



Note: *Medicaid spending includes all services (addiction treatment plus all other physical and behavioral health), and federal and state dollars. SAMHSA accounts for the majority of non-Medicaid federal grants to states for OUD/SUD treatment and prevention (see Appendix 1).*

Medicaid enrollment of, and spending for, people with an OUD has undoubtedly increased as a result of expansion. Although results were not focused on Medicaid alone, a recent study found that following implementation of the ACA, people with an OUD were less likely to be uninsured, less likely to report financial barriers as a reason for not receiving substance use treatment, more likely to receive treatment and more likely to report that insurance paid for treatment.[28] In Ohio, a recent study found that expansion adults with substance use disorders were more likely to report improvement in overall access to care than those without, and those improvements were even more evident for the subgroup of enrollees with an OUD.[29]

States have a wide range of Medicaid tools at their disposal to address the opioid epidemic,[30] and the program's reach continues to expand. For example, while states have long used Section 1115 Medicaid demonstration waivers as a tool to reform their behavioral health delivery systems, recent federal guidance has encouraged more states to use this authority to address the opioid crisis specifically. In West Virginia, for example, expanded benefits under the state's SUD waiver now reflect a full continuum of care, with access to peer recovery supports, residential treatment and medication-assisted treatment (MAT) that includes methadone.[31] A centerpiece of the federal guidance is encouraging states to apply for waivers, the "IMD exclusion," which generally prohibits federal financial participation for Medicaid services delivered by institutions for mental disease (IMDs). Since many residential drug treatment facilities are considered IMDs, this policy historically has limited the ability of states to provide the full spectrum of care to individuals with SUDs,[32] evidenced by the fact that 21 states covered no short- or long-term residential SUD treatment under Medicaid as of 2013 through 2014.[33] To date, 11 states have received an IMD waiver (California, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Virginia, Vermont, West Virginia), and nine states are under review (Alaska, Arizona, Illinois, Michigan, New Mexico, North Carolina, Wisconsin; this list also includes Massachusetts and Vermont, which are seeking to broaden the scope of their IMD waivers).[34]

MAT, which typically involves a combination of psychosocial therapy and medication regimens to help block cravings and withdrawal, is a particularly important component of recovery for many people with an OUD. Three different drugs are approved for OUD treatment, including methadone, buprenorphine and naltrexone, and most state Medicaid

programs cover some or all of these. A 2017 survey indicates that 49 responding states all covered buprenorphine, oral naltrexone and injectable naltrexone, and that 42 covered methadone or were considering doing so. In addition, 46 states reported that naloxone, a prescription opioid overdose antidote, was available in at least one formulation without prior authorization.[35]

Given that many individuals suffering from an OUD are low-income and are eligible for Medicaid, the program is a major source of financing for MAT:

- Medicaid accounted for 24 percent of prescriptions for buprenorphine nationally in 2016, and nearly double that amount or more in some states. In Ohio, for example, nearly 50 percent of buprenorphine prescriptions were paid by Medicaid in 2016.[36]
- Medicaid spending on MAT drugs has more than doubled over the past five years, to nearly $1 billion in 2016, and growth rates have been highest in expansion states.[37]

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Data gathered from New Hampshire, Ohio and West Virginia underscore the importance of Medicaid's role in combatting the opioid epidemic. Medicaid spending for people with an OUD in these states is substantially higher than the non-Medicaid funding available for this population (Exhibit 3).

- New Hampshire spent $80 million on Medicaid services ($34 million for addiction treatment plus $46 million for other physical and behavioral health services) for enrollees with an OUD in state fiscal year (SFY) 2017; in comparison, the state received $5.2 million in opioid-specific federal grants from sources other than Medicaid in FFY 2017.
- For people with an OUD, Ohio spent at least $390 million on Medicaid SUD treatment services alone, and received $32.4 million in other federal grants.

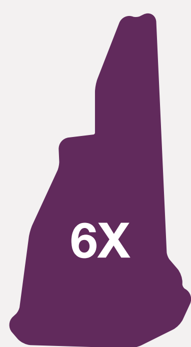
Exhibit 3. Federal Grants and Medicaid Spending for SUD and OUD Populations and Services in Selected States, 2017

	New Hampshire	Ohio	West Virginia
Non-Medicaid federal grants for SUD treatment and prevention[1]	$19,900,000	$109,300,000	$20,500,000
Substance Abuse Prevention and Treatment Block Grant	$7,000,000	$64,500,000	$8,400,000
Other federal grants for SUD	$13,000,000	$44,800,000	$12,100,000
Specific to OUD	$5,200,000	$32,400,000	$8,000,000
Not specific to OUD	$7,800,000	$12,400,000	$4,100,000
Medicaid spending for enrolles with any SUD[2]	$105,000,000	[3]	$541,300,000
SUD treatment	$39,000,000	[3]	$93,200,000
Other physical and behavioral health services	$66,000,000	[3]	$448,100,000
Medicaid spending for OUD population	$80,000,000	[3]	$338,900,000
SUD treatment[4]	$34,000,000	$390,100,000	$84,900,000
Other physical and behavioral health services	$46,000,000	[3]	$253,900,000
Medicaid spending for non-OUD population	$25,000,000	[3]	$202,500,000
SUD treatment[4]	$5,000,000	[3]	$8,300,000
Other physical and behavioral health services	$20,000,000	[3]	$194,200,000

Note: *Non-Medicaid grants are for federal fiscal year 2017 with the exception of a small amount of OUD-specific funds administered by the CDC, which are for federal fiscal year 2016. Medicaid spending includes federal and state dollars, and reflects state fiscal year 2017. Sums of components may not equal totals due to rounding.*

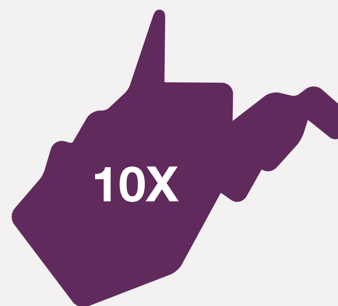
1. *See Appendix 1 for a description of SUD funding sources in this category.*
2. *Manatt analysis of unpublished data provided by individual states. Figures are not directly comparable across states due to differences in the methods used to identify enrollees with a SUD and OUD, or to categorize SUD treatment versus other services. However, amounts within each state provide an order of magnitude for comparing Medicaid versus non-Medicaid spending for individuals with a SUD and OUD.*
3. *Data not provided.*
4. *Ohio amount is an underestimate because spending for medication-assisted treatment drugs only reflects the expansion population and excludes spending for physician-administered drugs. State fiscal year 2017 spending for other SUD treatment services reflects the first six months of calendar year 2017 and 50 percent of calendar year 2016.*

In three states, **Medicaid SUD treatment spending alone** (excluding other physical and behavioral health services) for people with an OUD **ranged from more than six times to more than 12 times** the amount of non-Medicaid federal grant funds available for this population in 2017.



New Hampshire

Ohio



West Virginia

A substantial portion of spending for Medicaid enrollees with a SUD is for services to address significant physical and behavioral health issues that often coexist with addiction (Exhibit 4).[38]

Exhibit 4. Medicaid Spending for Enrollees with a SUD and OUD in West Virginia, 2017

	All Medicaid enrollees		Enrollees with any SUD		Enrollees with an OUD	
	Spending	Share of total	Spending	Share of total	Spending	Share of total
Total Medicaid spending	$3,502,600,000	100%	$541,300,000	100%	$338,900,000	100%
SUD treatment	$93,700,000	3%	$93,200,000	17%	$84,900,000	25%
SUD inpatient	$11,000,000	0.3%	$10,700,000	2%	$6,400,000	2%
SUD outpatient	$49,600,000	1%	$49,500,000	9%	$45,600,000	13%
SUD treatment drugs	$33,100,000	1%	$33,100,000	6%	$32,900,000	10%
Mental health services (excluding drugs)	$666,200,000	19%	$64,200,000	12%	$30,000,000	9%
Mental health inpatient	$288,000,000	8%	$28,700,000	5%	$12,800,000	4%
Mental health outpatient	$378,200,000	11%	$35,500,000	7%	$17,200,000	5%
Other services	$2,742,700,000	78%	$383,900,000	71%	$223,900,000	66%
Drugs (other than for SUD treatment)	$701,700,000	20%	$106,400,000	20%	$69,200,000	20%
Inpatient facility	$919,800,000	26%	$125,700,000	23%	$61,600,000	18%
Physician and other professional	$804,800,000	23%	$99,500,000	18%	$60,400,000	18%
Outpatient facility	$316,400,000	9%	$52,300,000	10%	$32,600,000	10%

Note: *Medicaid spending includes federal and state dollars, and reflects state fiscal year 2017. Sums of components may not equal totals due to rounding. Detailed categories in data provided by West Virginia were collapsed by Manatt into broad categories shown here. For the SUD treatment category, the "All Medicaid enrollees" spending is slightly higher than the "Enrollees with any SUD" spending because a small number of enrollees who use SUD services are not categorized as SUD enrollees.*

In New Hampshire and West Virginia, the majority of Medicaid enrollees with a SUD have an OUD (Exhibit 5).[39]

Exhibit 5. Characteristics of Medicaid Enrollees with a SUD and OUD in New Hampshire and West Virginia, 2017

	New Hampshire	West Virginia
Number of enrollees with any SUD	11,900	53,400
Eligible through expansion group	68%	55%
Male	52%	49%
Under age 19	2%	3%
Ages 19-25	13%	9%
Ages 26-44	65%	62%
Ages 45-64	20%	24%
Ages 65+	0.4%	2%
Pregnant	4%	3%
Among pregnant enrollees with any SUD, has OUD	89%	82%
Among all enrollees with any SUD, has OUD	80%	64%
Number of enrollees with an OUD	9,500	34,400
Eligible through expansion group	68%	58%
Male	51%	45%
Under age 19	1%	2%
Ages 19-25	14%	10%
Ages 26-44	70%	70%
Ages 45-64	15%	19%
Ages 65+	0.2%	1%
Pregnant	4%	3%

Note: *Reflects state fiscal year 2017. Sums of components may not equal totals due to rounding. Figures are not directly comparable across states due to differences in the methods used to identify enrollees with a SUD and OUD. However, amounts within each state provide an order of magnitude for understanding the characteristics of their Medicaid enrollees with a SUD and OUD.*

Conclusion

Combatting the nation's opioid epidemic requires a variety of strategies, ranging from prevention to treatment to long-term recovery support. Medicaid plays a vital role in these efforts, underwriting the cost of the full range of physical and behavioral health services required to effectively address the needs of people with opioid and other substance use disorders. In 2013, before the implementation of the ACA's Medicaid expansion, Medicaid's investment in services for people with opioid addiction was 17 times the amount of OUD dollars made available to states through SAMHSA, which accounts for the majority of non-Medicaid federal grants to states for this population. Today, with expansion in 33 states, that investment is significantly higher, and targeted to the population at greatest peril for opioid addiction. But whether states have expanded or not, Medicaid is providing the foundation for states to battle opioid addiction and mortality. No other source of funding or coverage for essential services comes close to the scale and scope of state Medicaid programs.

Appendix 1. Non-Medicaid Federal Grants for SUD Treatment and Prevention

SAMHSA is responsible for leading federal public health efforts to address substance abuse and mental health disorders, and it administers a number of programs, campaigns and grants specifically targeting OUD. In FFY 2017, the agency received approximately $4.3 billion in total budget authority, with $2.9 billion for SUD treatment and prevention.[40] Below is a summary of key SUD-related funding sources administered by SAMHSA that are tracked at the state level,[41] only some of which are specific to the opioid crisis. Opioid-related state funding administered by the CDC is described as well.[42]

- **Substance Abuse Prevention and Treatment Block Grant (SABG)**. The SABG provides funds on an annual basis to states for the purpose of planning, implementing and evaluating activities to prevent and treat substance use disorders. In general, states have broad flexibility in how to use SABG funds but are required to spend 20 percent on primary prevention activities. Annual allotments are determined by a statutory formula that takes into account each state's total personal income, resident population, total taxable resources and a cost of services index. Total FFY 2017 funding for the SABG was approximately $1.9 billion, and accounted for approximately 32 percent of state substance abuse agency funding and 23 percent of total state substance abuse prevention and public health funding.[43]
- **Opioid State Targeted Response (STR) Grant**. The 21st Century Cures Act authorized up to $1 billion over FFYs 2017 and 2018 for the Opioid STR Grant, which provides support to states for increasing access to treatment, reducing unmet treatment need and reducing opioid-related overdose deaths through the provision of prevention, treatment and recovery activities for OUD. Allotments are determined through a formula based on unmet need for OUD treatment and drug poisoning deaths. FFY 2017 funding totaled $500 million, with $484.5 million in grants awarded to states.[44] For FFY 2018, an Opioid STR Supplement will be awarded to three states for up to $333,000 each. Eligible applicants are Opioid STR grantees with the top 10 highest rates of overdose deaths in 2015 (including Kentucky, Massachusetts, New Hampshire, New Mexico, Ohio, Pennsylvania, Rhode Island, Tennessee, Utah and West Virginia). Up to $12 million per year is also provided for Opioid STR technical assistance to states.[45]
- **Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant**. The MAT-PDOA Grant provides funds for states to expand and enhance access to medication-assisted treatment services for people with an OUD. Eligibility for the program is limited to the states with the highest rates of primary treatment admissions for heroin and opioids per capita and those with the largest increase in rates from 2007 to 2014.[46] FFY 2017 funding totaled $25 million,[47] and 28 states have received grant awards since the program's inception in 2015.[48]
- **First Responders-Comprehensive Addiction and Recovery Act (FR-CARA) Cooperative Agreement Grant and Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths**. In 2016, the Comprehensive Addiction and Recovery Act authorized $181 million in discretionary funding per year from FFY 2017 to FFY 2021 for a number of new and existing OUD-specific grant opportunities administered by SAMHSA, including the MAT-PDOA program (described above). The FR-CARA opportunity provides funds for states, tribes and tribal organizations, and local governmental entities to train and provide resources to first responders and members of other key community sectors on carrying and administering drugs or devices for emergency treatment of known or suspected opioid overdoses. Grantees are also expected to establish processes, protocols and mechanisms for referral to appropriate treatment and recovery communities.[49] FFY 2017 funding totaled $12 million,[50] with entities in 14 states receiving awards.[51] Beginning with FFY 2016, an additional $12 million has been provided for a similar Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths opportunity,[52,53] with 12 state governments receiving awards.[54]

- **CDC Funding**. Since 2015, states have also had access to CDC funding through the Opioid Prevention in States (OPIS) effort, which includes three programs: Prevention for States (PfS), the Data-Driven Prevention Initiative (DDPI), and Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS). PfS currently funds 29 states to advance various efforts to prevent overdoses, such enhanced prescription drug monitoring programs.[55] DDPI funds 14 states to increase data capacity and improve data collection efforts around opioid misuse, abuse and overdose. Combined, these two programs awarded $48.3 million in FFY 2017.[56,57] ESOOS currently funds 33 states, including $7.5 million in FFY 2017, to improve the timeliness and comprehensiveness of fatal and nonfatal opioid overdoses and associated risk factors.[58]

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at *www.shvs.org*.

ABOUT MANATT HEALTH

This brief was prepared by April Grady, Patricia Boozang, Deborah Bachrach, Adam Striar, and Kevin McAvey. Manatt Health is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Manatt Health helps clients develop and implement strategies to address their greatest challenges, improve performance, and position themselves for long-term sustainability and growth. For more information, visit *www.manatt.com/ManattHealth.aspx*.

Endnotes

1. HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis, U.S. Department of Health and Human Services website, https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html Published October 26, 2017. Accessed March 1, 2018.

2. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services website, *HHS FY 2018 Budget in Brief – SAMHSA*, https://www.hhs.gov/about/budget/fy2018/budget-in-brief/samhsa/index.html Accessed March 1, 2018.

3. Bachrach, D., et al., Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis, State Health Reform Assistance Network website, Robert Wood Johnson Foundation, https://www.statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf Published July 2016. Accessed March 1, 2018.

4. While we generally refer to "substance use disorder" or "addiction" in this brief, the terminology used in sources cited throughout may vary. Individuals with an OUD are a subset of those with a SUD. The current Diagnostic and Statistical Manual of Mental Disorders (DSM) used by health care professionals categorizes a variety of substance use disorders separately, with criteria that provide a gradation of severity within each diagnostic category. Previous editions of the DSM identified two separate categories of substance use disorder, referred to as "substance abuse" and "substance dependence."

5. Ahrnsbrak, R., Bose, J., Hedden, S.L., Lipari, R.N., Park-Lee, E., Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services website, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm Published September 2017. Accessed March 1, 2018.

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