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Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis

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Introduction

The United States is in the throes of a rapidly worsening opioid epidemic. The crisis is far-reaching: as of 2014, 1.9 million Americans had an opioid use disorder involving prescription medication, and an additional 19.6 million Americans had a substance use disorder (SUD) outside of addiction to prescription opioids.[1] Since 1999, the number of opioid overdoses resulting in death has increased by more than threefold for men and fivefold for women.[2] None of this is lost on state Medicaid officials. Even before the Affordable Care Act's (ACA) Medicaid expansion, Medicaid was the largest source of coverage for behavioral health services, including those related to SUDs. And Medicaid has taken on an even bigger role since passage of the ACA: in the 31 states that have expanded, 1.2 million individuals with SUDs have gained access to coverage.[3,4]

This paper reviews Medicaid strategies to combat the opioid epidemic. Our primary focus is the important role Medicaid can play and is playing in combatting the opioid epidemic; however, it must be acknowledged that Medicaid is a far more powerful weapon in states that have expanded their Medicaid programs to all adults with incomes up to 138 percent of the federal poverty level (FPL). At least 1.1 million adults with SUDs reside in non-expansion states.[5]

Background

Medicaid covers over 70 million people—nearly 22 percent of the United States population—and is the largest payer in most states, with total annual spending of nearly $500 billion nationwide.[6] Medicaid is also the largest source of funding for behavioral health treatment in the country, paying approximately $60 billion in 2014 for behavioral health services, including those related to SUDs.[7] In short, throughout the nation, Medicaid is the most significant source of coverage and funding for critical substance use prevention and treatment.

Medicaid expansion under the ACA has amplified Medicaid's role in fighting the opioid epidemic. The expansion population—largely single adults not traditionally covered under Medicaid before the ACA—has a higher prevalence of SUDs than populations previously eligible for Medicaid. Now, with expansion, these adults have access to comprehensive insurance coverage, and states can thereby rely on Medicaid funds to cover the cost of prevention and treatment.[8] Without Medicaid expansion, states are forced to rely on limited state general funds to provide SUD services to uninsured adults. In addition, prior to expansion, a number of states limited SUD coverage to pregnant women. By

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contrast, expansion adults receive the alternative benefit plan or ABP which covers the ACA's 10 essential health benefits, including SUD services. And expansion states are tapping into federal Medicaid funds to cover SUD prevention and treatment as well as the full range of comorbid physical and mental health conditions that come with substance use.[11]

> **"The best way to get treatment if you're addicted to drugs in Missouri is to get pregnant."[12]**
>
> -Dr. Joe Parks, Director of MO HealthNet (Missouri Medicaid)
> Note: Missouri has not expanded its Medicaid program.

Uninsured individuals living in non-expansion states are less likely to obtain treatment for mental illness and substance use disorders as compared to insured individuals living in the same states.[9] Up to 1.1 million additional individuals with an SUD would be newly eligible for Medicaid coverage if all states were to participate in Medicaid expansion.[10]

In states that have expanded, justice-involved populations are generally eligible for Medicaid upon their release. This fact is central to the SUD crisis: 68 percent of inmates of jails and 50 percent of inmates in state prisons have an SUD.[13] With the implementation of Medicaid expansion in 2014, the rate of justice-involved populations that were uninsured dropped by 10 percentage points.[14]

As a major source of coverage and payment in all states—especially expansion states—Medicaid programs are answering the charge to fight the opioid epidemic. This report outlines tools that state Medicaid programs can use to prevent and treat opioid use disorders ranging from modest, but meaningful strategies for SUD prevention and treatment, to more innovative and transformative changes to the way that Medicaid pays for and delivers SUD services. Today, under their Medicaid State Plans, Medicaid agencies are enhancing coverage and benefits for those who are at the highest risk of or already grappling with SUDs; implementing Health Homes to provide care management services for individuals with SUDs; and leveraging Medicaid's purchasing power to require Medicaid providers and plans to promote best practices in SUD treatment. To institute broader reforms, Medicaid agencies are applying for and implementing SUD-focused Section 1115 demonstration waivers to transform their entire SUD delivery systems.[15] The Centers for Medicare and Medicaid Services (CMS) has matched and supported state efforts to address the opioid epidemic not only through waiver design and approvals, but also through the technical assistance provided by the Innovator Accelerator Program (IAP).[16] (We provide an overview of recent CMS guidance on strategies to address the opioid epidemic and other SUDs in Appendix A to this report.)

State plan strategies

Through the straightforward mechanism of State Plan Amendments (SPA), state Medicaid agencies can design and pay for a wide range of programs to address the opioid epidemic and other SUDs.

COVERAGE AND BENEFITS

Under Medicaid law, states have the opportunity to tailor their benefit packages to improve SUD prevention and treatment. Specifically, states may:

- **Implement prior authorization requirements, institute quantity limits, and strengthen utilization review criteria for opioid prescriptions.**[17]
- **Expand Medicaid's access to and use of the state's Prescription Drug Monitoring Program (PDMP), a state database containing information about prescriptions for controlled substances, to identify Medicaid enrolled individuals who may be at-risk of opioid abuse and providers with lenient prescribing practices.**[18] Washington state's Medicaid agency is using its PDMP to identify beneficiaries with frequent controlled substance prescriptions, as well as providers that write an above average number of prescriptions. In addition, through its PDMP, Washington can recognize when a pharmacy has dispensed multiple controlled substance prescriptions to one individual in a short period, including when an individual uses Medicaid to pay for one prescription and cash for another.[19]
- **Improve timely access to medications used in medication-assisted treatment (MAT) by eliminating or modifying prior authorization requirements, and reviewing prescription drug policies to ensure that they are evidence-based and do not impose lifetime, duration, or quantity limits for MAT drugs that are not clinically indicated.**[20] To facilitate use of MAT, Medicaid programs in Ohio and Texas have also issued detailed provider guidance on MAT billing procedures.[21]
- **Add all forms of naloxone, a drug that can reverse an opioid overdose, and other evidence-based medications for opioid overdose to their preferred drug lists.**[22] Multiple forms of naloxone are on the preferred drug list in California and New York, among other states.[23]

HEALTH HOMES

Under the ACA, state Medicaid programs can implement Health Homes to provide robust care management services to individuals with chronic conditions, including individuals with SUDs. In the first two years of an individual's enrollment in a Health Home, states are able to access 90 percent federal matching funds. (And of course, for expansion adults, Health Home services will always be eligible for enhanced match.)

States are customizing Health Home SPA design and eligibility criteria to target enrollees with SUDs. Maryland, Rhode Island, and Vermont have implemented Health Home programs specifically for individuals with opioid use disorders and in doing so are providing the following services:

- **Intensive care management and care coordination** for individuals with opioid use disorders. These services include individualized care plans; helping patients navigate care across primary care providers, behavioral health providers, and community-based organizations; conducting outreach to beneficiaries who would benefit from MAT; and enrolling eligible individuals in opioid treatment programs.[24]
- **Provider and workforce education** on evidence-based treatment for opioid use disorders. Training and education activities cover topics including health literacy, motivational interviewing, and care management for beneficiaries with opioid use disorders.[25]

LEVERAGING MEDICAID'S PURCHASING POWER

States can accelerate changes to Medicaid SUD coverage and benefits by leveraging Medicaid's purchasing power to ensure that providers and plans are meeting best practices for SUD prevention and treatment. For example, California requires providers participating in the state's SUD pilot program to incorporate at least two evidence-based SUD treatment practices, such as motivational interviewing or cognitive-behavioral therapy, into care for patients with SUDs.[26]

Given SUD provider capacity and access barriers in most states, Medicaid agencies can also endeavor to expand SUD provider participation in Medicaid (and increase capacity among existing providers) by increasing Medicaid payment rates, as the state of New Jersey has done. In his fiscal year 2017 budget, Governor Christie proposes a $74 million increase in Medicaid rates for SUD services with the stated purpose of increasing access to substance use treatment.[27] States can go further in SUD delivery system reform by enhancing payment rates for providers that meet core SUD prevention and treatment best practices, as many states have done for providers meeting patient-centered medical home (PCMH) standards.[28] Notably, new Medicaid managed care (MMC) regulations provide states with the authority to require health plans to contract with certain providers, pay providers more for high-priority services, and provide incentives to plans that meet certain metrics.[29] States may deploy all of these tools to ensure that their MMC plans provide comprehensive quality care to enrollees with SUDs.

In addition, several states including New York, Florida, and Arizona have designed special plans for individuals with serious mental illness (SMI) and SUDs. These plans are required to provide services targeted to the special needs of these complex populations including interventions that address the social determinants of health. It should be noted that depending on the complexity or range of services, some strategies require using waiver authority, not just an SPA.

Demonstration waiver strategies

Section 1115 demonstration waivers provide states with a pathway and funding to undertake more far-reaching transformation of their SUD delivery systems. In July 2015, CMS issued a State Medicaid Director letter encouraging states to apply for new 1115 demonstrations that would "promote both systemic and practice reforms in their efforts to develop a continuum of care that effectively treats the physical, behavioral, and mental dimensions of SUD."[30]

States pursuing these waivers must: develop an evidence-based SUD benefit package; ensure adequate networks for SUD services; provide care coordination services; develop a model for integrating physical health and SUD services; and institute other strategies to prevent and treat opioid use disorders. In conjunction with implementing comprehensive SUD delivery reform, a state may obtain an "IMD exclusion" waiver, which would permit a state to obtain federal matching funds for covering residential treatment services delivered at an institution for mental disease (IMD).[32] States are also incorporating strategies targeting SUDs into 1115 demonstrations aimed at broad-based reforms to the Medicaid payment and delivery system.

New Hampshire is in the early stages of implementing a five-year $150 million Delivery System Reform Incentive Payment program 1115 waiver, under which it will create a series of regional integrated delivery networks with a specific focus on improving behavioral health care. The initiative's goals are to "build greater behavioral health capacity, improve integration of physical and behavioral health, and improve care transitions for Medicaid beneficiaries, inclusive of children, youth, and adults."[31]

States are using 1115 waivers to focus their SUD payment and delivery system reform efforts, draw down additional federal funding to support reform efforts, and hold providers accountable for meeting clinical quality and performance measures related to SUD prevention and treatment. Specific state waiver strategies include:

- **Establishing integrated delivery networks of physical health, behavioral health, and social service providers.** Through its Delivery System Reform Incentive Payment (DSRIP) waiver, New Hampshire is creating new regional integrated delivery networks to improve the continuum of care for Medicaid beneficiaries with SUDs. These networks will include primary care providers, SUD providers, community mental health centers, peer health workers, hospitals, community health centers, and community-based organizations to address the full spectrum of physical health, behavioral health, and unmet social needs.[33] In Massachusetts's draft 1115 waiver application, the state is seeking to create interdisciplinary care teams including physical health, behavioral health, social service, and long-term services and supports providers. In addition, new Medicaid accountable care organizations formed under Massachusetts's waiver will be required to have memoranda of understanding with "Behavioral Health Community Partners," to provide Health Home, SUD, and mental health services to beneficiaries with an SUD and/or SMI.[34]

  Under an 1115 waiver, California is implementing a pilot program called the Drug Medi-Cal Organized Delivery System, which enables counties to provide an enhanced set of evidence-based benefits to Medicaid beneficiaries with SUDs. The pilot aims to "demonstrate how organized substance use disorder care increases the success of [Drug Medi-Cal] beneficiaries while decreasing other system health care costs.."[35]

- **Strengthening behavioral health workforce capacity.** New Hampshire is requiring the establishment of statewide work groups to identify strategies for strengthening behavioral health workforce capacity. At a regional level, integrated delivery networks will leverage the work groups' recommendations to "develop regional approaches to closing the work force and technology gaps that impact the capacity for coordinated care management and information sharing among medical, behavioral, and social service providers." New Hampshire is also implementing workforce training and recruitment programs for providers and community-based organizations and law enforcement entities interacting with individuals with behavioral health conditions.[36] As part of its newly released 1115 waiver, Massachusetts is proposing to use DSRIP funds to train new members of its SUD workforce, including recovery coaches, recovery support navigators, and care managers. Massachusetts is also planning to conduct provider education to ensure that physical and mental health providers are aware of SUD treatment options.[37]

- **Implementing targeted clinical programs for beneficiaries with SUDs.** States including New Hampshire and New York are using waivers to test a wide range of delivery models for fighting the opioid epidemic and other SUDs including: community re-entry for justice-involved populations, peer behavioral health, community-based stabilization, school-based mental health and substance abuse screening and intervention, integrated dual disorder treatment for SUDs and mental health conditions, integration of primary care and behavioral health services, and community-based withdrawal management.[38]

- **Expanding SUD benefits.** States can also use 1115 waivers to offer coverage for services that may not be authorized under their standard Medicaid benefit packages or to populations that would not otherwise be eligible for Medicaid. California is using an 1115 waiver to provide the full range of services for SUDs recommended by the American Society of Addiction Medicine, including partial hospitalization services, residential treatment services (including those offered at an IMD), and recovery services.[39] Similarly, under its pending 1115 waiver, Massachusetts is seeking to increase its coverage of American Society of Addiction Medicine-recommended services and to obtain an IMD exclusion waiver.[40] Through its 1115 waiver, New Jersey is implementing a Medication Assisted Treatment Initiative, which makes MAT services available to adults with incomes up to 150 percent of the FPL who would otherwise have income above Medicaid limits.[41]

- **Increasing access to care management and care coordination services.** Under its DSRIP waiver, California requires that counties, the entities overseeing SUD delivery system reform, "[develop] a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e., withdrawal management, residential, outpatient) without disruptions to services."[42] Massachusetts is also planning to strengthen care management and coordination services across its SUD delivery system as part of its forthcoming 1115 demonstration.[43]

Conclusion

States are grappling day to day with the vast and deadly public health crisis. Medicaid is the most powerful vehicle available to states to fund coverage of prevention and treatment for their residents at risk for or actively battling opioid addiction. Through federal flexibility, states can create strategies that meet their specific needs, designed to augment other efforts underway. The greatest opportunity to address this crisis is in those states that have elected to expand Medicaid, given the greater reach of the program, additional tools available, and the increased availability of federal funds.

End notes

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Appendix A

CMS GUIDANCE ON MEDICAID COVERAGE FOR AND PAYMENT OF SUD SERVICES

In recent years, CMS has issued a significant amount of guidance specifically related to Medicaid coverage and payment of SUD services. The table below provides an overview of this guidance.

Title	Date	Type of Guidance	Topics Addressed in Guidance
Medication Assisted Treatment for Substance Use Disorders	July 11, 2014	Informational Bulletin (CMCS in conjunction with SAMHSA, CDC, NIH National Institute on Drug Abuse, and NIH National Institute on Alcohol Abuse and Alcoholism)	Provides an overview of the components of MAT; discusses options to improve beneficiaries' access to MAT; and reviews strategies that state Medicaid agencies can implement to prevent SUDs.
Coverage of Behavioral Health Services for Youth with Substance Use Disorder	January 26, 2015	Joint CMCS and SAMHSA Informational Bulletin	Describes the types of SUD treatment that state Medicaid agencies can consider including in their benefit package for youth; outlines potential financing mechanisms for covering SUD services to youth; and identifies quality measures assessing SUD treatment.
Coverage of Housing-Related Activities and Services for Individuals with Disabilities	June 26, 2015	CMCS Informational Bulletin	Provides an overview of the types of housing services that state Medicaid programs may be interested in covering and identifies mechanisms for reimbursing these services under Medicaid.
New Service Delivery Opportunities for Individuals with a Substance Use Disorder	July 27, 2015	State Medicaid Director Letter	Provides information on the goals and requirements for SUD transformation 1115 waivers and identifies conditions for states to obtain IMD exclusion waivers.
Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction	January 28, 2016	CMCS Informational Bulletin	Provides an overview of strategies that state Medicaid programs can implement to address the opioid epidemic, including those related to pharmacy benefit management, access to naloxone, and coverage of MAT.

Notes

CMCS = Center for Medicaid and CHIP Services
SAMHSA = Substance Abuse and Mental Health Services Administration
NIH = National Institutes of Health