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Using Medicaid to Advance Evidence-Based Treatment of Substance Use Disorders:
A Toolkit for State Medicaid Leaders

Patricia Boozang, Senior Managing Director
Jocelyn Guyer, Managing Director
Jessica Nysenbaum, Senior Manager

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Patricia Boozang
Senior Managing Director
Manatt Health
212.790.4523
pboozang@manatt.com

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- Ashley Traube, Manager, Manatt Health Solutions

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Introduction

In 2019, the number of drug overdose deaths in the United States declined, suggesting that the efforts of state and local governments, providers and other stakeholders to stem the crisis of drug-related deaths are beginning to have some effect. But there is much more work to be done: Over 70,000 individuals in this country still die each year from drug overdoses.[1] This document—**Using Medicaid to Advance Evidence-Based Treatment of Substance Use Disorders: A Toolkit for State Medicaid Leaders** (the Toolkit)—reviews promising strategies that state Medicaid programs are adopting to address the substance use disorder (SUD) crisis, and specifically the opioid epidemic. The Toolkit identifies implementation strategies, action steps and examples of implementation tools deployed in leader states.

Highlighted strategies are informed by evidence-based research on what is effective in combating SUD and the opioid epidemic in particular, but it is important to note that the fast-moving nature of the epidemic, the evolving response of state and local governments, and the complexity of teasing out the individual impact of concurrent interventions mean that such research is limited. Recognizing the limits of current research, the Toolkit also addresses how states might monitor and evaluate their selected strategies, both to allow for timely policy adjustment and to amplify the body of evidence-based research. The strategies addressed in the Toolkit are organized into three main focus areas:

- **1.0 Strategies to Increase Access to Medication-Assisted Treatment (MAT).** MAT remains the gold standard for the treatment of most individuals with OUD. With a strong evidence base proving MAT's effectiveness, expanding access to MAT should be a top priority for states to fight the opioid epidemic.
- **2.0 Strategies to Promote Coordinated Team-Based Care for Opioid Use Disorder (OUD).** Given the complexity of comprehensive SUD treatment, team-based care can be effective in meeting the physical, mental health, and psychosocial needs that support recovery. As a result, state Medicaid programs increasingly are promoting use of team-based care for individuals with OUD, including by offering enhanced reimbursement to providers that offer care teams and by covering and paying for peer supports as part of team-based initiatives.
- **3.0 Strategies to Monitor and Evaluate OUD Interventions on an Ongoing Basis.** As states deploy a broad range of interventions and strategies to fight the opioid (and broader SUD) epidemic, monitoring and evaluating the impact of these strategies is critical. States are using monitoring metrics to track implementation of 1115 waivers of the IMD exclusion; building dashboards that publicly display trends on overdose rates, ED visits for OUD and other measures; and collaborating with academic institutions on research and evaluation of key interventions.

Notably, with passage in the fall of 2018 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), some of these strategies are or will become mandatory or incentivized activities for state Medicaid agencies. A discussion of relevant provisions of the SUPPORT Act is integrated into the strategies outlined below.

Finally, the Toolkit **Appendix—The Opioid Epidemic: A National Snapshot** provides a series of tables with state-by-state data on the epidemic, allowing state leaders to compare their state's progress with that of their peers.

Exhibit 1. The Opioid Epidemic: A National Snapshot

The Opioid Epidemic: A National Snapshot provides state-by-state information on the epidemic and on each state Medicaid program's policy response. It provides data on the severity of the epidemic, coverage policies related to Medication Assisted Treatment (MAT), other Medicaid design decisions, and the extent to which providers are providing MAT. While covering a range of topics, the **National Snapshot** focuses heavily on MAT, given the critically important role it plays in the treatment of opioid use disorder (OUD).

Scope of the Epidemic

- Table 1. Number of Opioid Overdose Deaths, and Rates per 100,000, by State CY 2016 and 2017
- Table 2. Ranking of 2017 Opioid Overdose Deaths per 100,000

MAT Coverage Policies

- Table 3. States With Medicaid Prior Authorization Requirements for Medications for Opioid Use Disorders, 2016–2017
- Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017
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- Table 6. Medicaid Enrollment Policies for Criminal Justice Involved Populations, FY 2019
- Table 7. Medicaid Health Home Programs Targeting Individuals With an OUD
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MAT Provider Availability

- Table 9. Number and Percent of SUD Facilities Participating in Medicaid, by State, 2017
- Table 10. Number and Percent of Medicaid Participating Outpatient and Residential SUD Facilities Providing MAT, by State, 2017

1.0 Strategies to Increase Access to Medication-Assisted Treatment

MAT combines behavioral therapy and medications to treat SUDs. It remains the gold standard of biomedical care for OUD[2,3] and has proven effective in reducing death rates and a range of other harms associated with OUDs.[4] By design, it includes both a pharmacological and a behavioral intervention. In the SUPPORT Act, Congress mandated that states cover all drugs and biological products (including methadone) approved by the Food and Drug Administration (FDA) for MAT and related counseling services and behavioral therapy beginning on October 1, 2020, and continuing at least through September 31, 2025.[5] Even so, there is a growing acknowledgment that medication alone is preferable to no treatment at all; the National Academy of Sciences recently recommended treatment of OUD with medications regardless of whether behavioral health interventions are also available.[6]

For a number of years, the states hardest hit by the opioid epidemic have deployed a range of strategies to expand access to MAT. As a result, MAT prescribing in Medicaid has increased in recent years, but there is still wide variation in prescribing rates, especially between states that have expanded Medicaid and those that have not. Between 2013 and 2017, Medicaid spending on prescriptions for the treatment of OUD and overdose tripled or more in states that expanded Medicaid compared to nearly doubling in non-expansion states. The strategies already in use among leading states offer an important roadmap for states seeking to further increase access to MAT.

Implementation Strategy 1.1: Include All Forms of Medication and Biological Products Used for MAT on the State's Preferred Drug List

As of May 2019, three medications were available to treat OUDs as part of MAT—buprenorphine, methadone, and naltrexone.[7] Since individual circumstances and characteristics can influence which drug is likely to work best, it is important that a state review its Medicaid policies with respect to covering all three drugs, including all formulations. Buprenorphine and naltrexone come in several formulations—injectable, extended-release implant and sublingual film—and the use of a particular formulation may be important to any given individual.

Under long-standing federal Medicaid law, all prescription drugs that are approved by the FDA must be covered by Medicaid, regardless of whether a beneficiary is enrolled in a Medicaid managed care plan or in a state fee-for-service program. Congress recently reiterated that all forms of MAT must be covered by requiring in the SUPPORT Act that Medicaid programs cover all medications (including methadone) approved by the FDA for OUDs, beginning on October 1, 2020, and continuing at least through September 31, 2025.[8] Notably, the SUPPORT Act permits states to pursue an exemption from this requirement due to provider shortages. However, the SUPPORT Act also authorizes capacity grants to help states address provider shortages, including shortages of MAT providers. Further discussion of this issue is provided below in **Implementation Strategy 1.2**.

While states are required to cover all forms of MAT, in practice, they can dramatically shape the extent to which a drug is accessible by deciding whether to include it on the state's preferred drug list (PDL) or, in Medicaid managed care states, giving plans discretion to determine which medications are included on their PDLs. Medications that are not included on PDLs are more likely to be subject to prior authorization and other utilization management requirements that can pose barriers to access. For example, a state might require providers to do substantially more paperwork or make more phone calls to secure authorization for a non-preferred medication. Due to unclear documentation of policies, it is sometimes difficult to discern that a state actually covers all forms of MAT, particularly methadone, as required by federal law.[9] Indeed, a 2018 Substance Abuse and Mental Health Services Administration (SAMHSA) analysis based on a review of state documents, policies and regulations reports that nine states are not covering methadone as MAT even though it is required under federal law.[10]

Action Steps

- **Work with the state Pharmacy and Therapeutics (P&T) Committee** to review and update, if necessary, the state's Medicaid PDL to ensure that all forms and formulations of medications and biological products needed for MAT are on the state's preferred list.
- In Medicaid managed care states, **review and update model contract language** to ensure that plans are required to cover and include on any plan PDL all the medications and biological products needed for MAT, including the various formulations.[11]
- **Establish and disseminate a written policy for Medicaid providers** that clearly communicates that all MAT drugs are covered and outlines the procedures used to obtain treatment.

State Example

- **Washington, D.C.** As reflected in the city's PDL, all oral, injectable and implantable forms of buprenorphine and naltrexone are preferred and none require prior authorization.[12]

Implementation Strategy 1.2: Review and Reduce Non-quantitative Utilization Management Restrictions

States may also consider reviewing and reducing utilization management (UM) restrictions applied to medications and biological products used in MAT. These can include prior authorization requirements, blanket limits on the number of prescriptions that can be filled in a month, higher co-payments, step therapy requirements and quantity limits. Medicaid UM restrictions on MAT, as reflected in **The Opioid Epidemic: A National Snapshot**; **Table 3. States With Medicaid Prior Authorization Requirements for Medications for Opioid Use Disorders, 2016–2017**; and **Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017.** Such restrictions typically are imposed due to cost concerns (some medications are more expensive), clinical reasons (enforcing guidelines about which patients should be treated with a particular drug), or, in some instances, concerns about diversion, though these may not be warranted. Reasons to impose restrictions can be weighed against the body of evidence showing that UM restrictions can impact treatment access.[13,14,15,16] One study evaluating the impact of the introduction of a three

prescription cap in a state Medicaid program found large drops in prescription fills for essential medications such as insulin.[17] A different study assessing the impact of a Medicaid prior authorization policy for drugs used to treat bipolar disorder illustrated how prior authorization may reduce overall treatment rates.[18]

Exhibit 2. Diversion: How Big an Issue?

States sometimes impose UM restrictions on access to MAT medications to prevent "diversion" or the sale or donation of a drug such as suboxone (a form of buprenorphine) to a friend, neighbor or other individual for whom it was not prescribed. However, studies show that diverted buprenorphine is most often used by individuals to self-treat an opioid addiction rather than for abuse. They also indicate that barriers to buprenorphine may actually be increasing diversion by making it harder for individuals who need it to obtain it through legal means. In light of this research, states may want to review their access restrictions on buprenorphine, weighing the benefit of simplifying access to MAT against concerns about Medicaid fraud and diversion.

Sources: Schuman Oliver, Zev, Albanese, Mark, Nelson, Sarah, et al., "Self-Treatment: Illicit Buprenorphine Use by Opioid Dependent Treatment Seekers," Journal of Substance Abuse Treatment, July 2010, https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(10)00075-9/fulltext; Cicero, Theodore J, Ellis, Matthew and Chilcoat, Howard, "Understanding the Use of Diverted Buprenorphine," Drug and Alcohol Dependence, December 2018, https://doi.org/10.1016/j.drugalcdep.2018.09.007; Yokell, Michael, Zaller, Nicholas, Green, Traci, and Rich, Josiah, "Buprenorphine and Buprenorphine/Naloxone Diversion, Misuse, and Illicit Use: An International Review," Current Drug Abuse Reviews, March 2011, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3154701/; Lofall, Michelle and Walsh, Sharon, "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World," Journal of Addiction Medicine, September/October 2014, https://journals.lww.com/journaladdictionmedicine/Abstract/2014/09000/A_Review_of_Buprenorphine_Diversion_and_Misuse__.3.aspx.

In evaluating the cost impact of removing prior authorization requirements on higher-cost medications like injectable suboxone, states will want to consider research that suggests that reducing barriers to MAT can be cost-effective. One study on the cost-effectiveness of implantable versus sublingual buprenorphine showed that while implantable buprenorphine is more expensive than the sublingual form, it is effective in reducing ED and hospital utilization, and therefore more cost-effective.[19] States may also consider that reducing the administrative burden associated with prescribing MAT may encourage more providers to offer MAT and, among those that already do, encourage a higher caseload of MAT patients.

In instances when states adopt UM barriers for clinical reasons, it may be possible to adopt alternative strategies for shaping the appropriate use of MAT medications that do not delay access to care. Some states use "point-of-service edits" to flag a provider whose prescribing decision appears potentially out of sync with clinical guidelines, or they rely on retroactive utilization review (see Exhibit 3 below). In addition, the medical director in the Medicaid agency (or other appropriate Medicaid agency staff) can work directly with the state medical society on disseminating best practices for MAT to providers, including how to determine which MAT drug and formulation is most clinically appropriate for a particular patient. States can also require Medicaid managed care plans to offer education and training on the issues of concern.

Exhibit 3. Using Point-of-Sale Safety Edits and Retrospective Drug Utilization Review

Ohio uses the following point-of-sale safety edits for initial fills of oral short-acting buprenorphine-containing products:

- Individuals who are 15 years of age or younger
- Individuals who are male and receiving short-acting buprenorphine without naloxone
- Individuals who are female and 45 years of age or older and receiving short-acting buprenorphine without naloxone
- Dosages that are greater than 24 mg/day
- Dosages over 16 mg/day beginning 90 days after the initial fill
- Long-acting or injectable buprenorphine

These edits will cause transactions to deny at the pharmacy point of sale and require the prescribing provider to request the product per existing prior authorization processes.

A retrospective drug utilization review (DUR) process identifies prescribers/providers who deliver services inconsistent with clinical standards of care. Providers identified are subject to a communication requirement by the state and managed care plans until the provider demonstrates a consistent pattern of appropriate care.

DUR evaluation criteria are as follows:

- Individuals who receive a dose of buprenorphine that is greater than 16 mg/day for three months or longer (this will be programmed as a point-of-sale safety edit after the three months)
- Females of reproductive age (15 to 44 years old) with claims for short-acting buprenorphine only for longer than nine months
- Individuals with claims for concurrent use of opioids (including MAT) and benzodiazepines
- Individuals without urine drug screen claims in the prior three months
- Individuals with claims for excessive or non-random utilization of urine drug screens
- Individuals without claims for medical professional services (E&M codes) related to Medication-Assisted Treatment (MAT) prescription in the prior three months

Source: Wharton, Donald, and Archibald, Tracy, "Effective Treatment for Opiate Use Disorders: Removing Barriers to Medication Assisted Treatment," The Ohio Department of Medicaid, Policy Effective January 1, 2019, https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/Increasing-access-to-Medication-Assisted-Treatment.pdf.

Action Steps

- **Review state UM policies for MAT**, with an eye to reducing or eliminating, where appropriate, prior authorization, step therapy and other limits on MAT medications.

- To the extent states have clinical concerns about certain forms of MAT for certain populations, **deploy alternative strategies such as point-of-service edits**; retroactive utilization review; and coordinated provider training and education initiatives with the state medical society, Medicaid managed care plans and other stakeholders.
- Establish and disseminate a written policy for Medicaid providers that consolidates and clarifies the Medicaid agency's policies with respect to medication for MAT, including coverage of medications and formulations and any UM guidelines. Manatt's analysis of Montana Medicaid's MAT policies provides an example of the type of information that could be gathered, synthesized and presented in a single document (see Exhibit 4 below).

Exhibit 4. Medicaid Policies for MAT Drugs in Montana

For medication-assisted treatment drugs covered under Montana's Medicaid program, prior authorization and payment policies vary based on whether they are billed by an outpatient pharmacy or by a physician or other provider who administers the drug:

- For buprenorphine-containing products that can only be prescribed to a limited number of patients by a physician with a federal waiver, coverage is typically under the outpatient pharmacy benefit, and prior authorization and a number of other criteria must be met (e.g., compliance with counseling, drug screens, and office visits). Once a prescription is authorized, it may be filled and billed to Medicaid by an outpatient pharmacy.
- In the case of methadone prescribed for opioid use disorders, the drug is always physician-administered because only opioid treatment program facilities that are subject to federal certification and accreditation requirements may dispense it. Physician-administered drugs are typically billed directly to Medicaid by a provider that serves as both the prescriber and dispenser. There is no prior authorization requirement for methadone, or for buprenorphine, when billed as a physician-administered drug.
- For naltrexone, the oral form is covered under the outpatient pharmacy benefit with no prior authorization. The injectable form (Vivitrol) must be administered by a physician regardless of how it is billed. In the case of physician-administered billing, prior authorization is not required. In the case of outpatient pharmacy billing, which allows certain providers to avoid the high cost of stocking the drug, prior authorization is required.

Other services associated with the provision of MAT drugs (e.g., SUD counseling and medical office visits to monitor physical health) are billed separately. As with other SUD providers, MAT providers typically must be State-approved to bill Medicaid for SUD fee schedule services (e.g., individual or group therapy for SUD) and are subject to the rules that apply to other fee schedules as well (e.g., those governing medical office visits under the physician fee schedule). See Exhibits 7 and 8 earlier in this report for information on the circumstances under which various SUD services may be billed to Medicaid.

Source: Grady, April, Bachrach, Deborah, and Boozang, Patti, "Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana," Manatt Health, 2017, https://www.manatt.com/getattachment/5c943485-16d3-48aa-9d20-8a47368b3c88/attachment.aspx.

- **Update clinical practice guidelines** to reflect new information and evidence on clinical indications and cost issues regarding the appropriate use of various MAT medications or formulations of those medications, drawing on resources such as SAMHSA guidelines on the use of MAT for pregnant women.[20]

State Examples

- **New Hampshire.** In its Medicaid managed care contract, New Hampshire requires that "the MCO shall cover without prior authorization or other utilization management restrictions any treatments identified as necessary by a clinician trained in the use and application of the ASAM criteria." The contract also directly precludes prior authorization for urine drug screenings—an important ancillary service needed for MAT—unless screens exceed 30 per month. If a plan is concerned about fraud, it can request an exception from these policies from the state.
- **Washington.** Apple Health's (Washington Medicaid) Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment provide step-by-step information on coverage for each MAT, and include advice to prescribers on when to use a particular treatment (see Exhibit 5 below).[21]

Exhibit 5. Apple Health Clinical Guidelines for MAT

Coverage for IM naltrexone:

Covered without authorization or limitations.

The following information are prescribing guidelines, and do not represent authorization criteria.

Health Care Authority requests that prescribers use sound clinical judgment in determining the best course of treatment for their patients, and reserve the use of IM naltrexone for those patients who meet the suggested guidelines. Oral naltrexone is significantly less costly to the State, and should be considered first unless the patient has a demonstrated need for an intramuscular formulation.

Source: "Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (MAT)," Washington State Health Care Authority, 2018, https://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/coverage-requirements-for-mcos.pdf.

Implementation Strategy 1.3: Ensure Sufficient Networks of MAT Providers

With the growing recognition of the importance of MAT, policymakers are making concerted efforts to increase the supply of providers who offer this treatment, particularly in geographic areas where capacity is limited. The federal government has taken some steps to increase the supply of MAT providers, including by (1) extending the ability to secure a waiver to provide MAT to nurse practitioners and physician assistants; (2) increasing from 30 to 100 the number of patients that certain MAT providers can treat at any given time; and (3) providing federal grant dollars to increase the provider supply. States that obtain SUPPORT Act provider capacity grants (CMS will distribute $50 million in grant funding to at least ten states) can use the additional funding to help expand MAT provider supply, as well as to focus on other SUD provider capacity challenges.[22]

States and localities are best positioned to determine where they lack MAT provider capacity and how best to address those access gaps, and Medicaid can play an important role in those efforts. As a first step, states may want to assess the number of MAT providers available in the state by region, as well as by key subpopulation (e.g., longtime users, individuals with multiple conditions, pregnant women). It is also important to consider the number of waivered providers, the number of waivered providers who are participating in Medicaid, and the extent to which those providers are using their waivers.[23] Research shows that many waivered physicians are not actively providing MAT, or are serving very few patients.[24,25,26] One study of buprenorphine prescribers in seven states found that 22% of prescribers had a monthly census of only one to three patients.[27] While data on MAT providers are not always readily available, a Medicaid agency may find that a sister agency (e.g., a SUD agency or mental health agency) already has such data, or it can purchase access to the Drug Enforcement Administration Controlled Substances Act Registration Information Databases.[28] To the extent data are available, examining the prevalence of OUD within the state and in the Medicaid population specifically at the county or ZIP code level can help in assessing the "right" number of MAT providers to require by geographic region. Leading states note that it is also critical to evaluate the mix of MAT provider types available in the community, including "bridge clinics" that manage MAT initiated in the emergency department until an individual is able to get situated with a long-term MAT provider.[29]

Once they quantify capacity gaps, states are using creative methods for expanding MAT provider supply, extending limited capacity, and ensuring the right mix of providers across all geographies and populations. States can directly incentivize providers to offer MAT by increasing reimbursement rates or by directing their Medicaid managed care plans to do so. States can also directly develop or incentivize their MCOs to build focused networks of providers that initiate and stabilize individuals on MAT, and broader networks of community-based providers for ongoing maintenance treatment. This type of tiered provider network approach is used in hub-and-spoke models, discussed below in **Implementation Strategy 1.5: Provide Training and Expert Support to Primary Care Providers That Offer Outpatient MAT**. States are also leveraging hospital emergency departments to expand capacity for MAT induction, engaging people with OUD at a critical point of care, and bridging waiting lists for ongoing, office-based treatment. Finally, provider outreach and education are essential to increasing MAT capacity and Medicaid participation.

Action Steps

- **Explore availability of data from sister agencies on providers waivered to prescribe MAT.** If data are not available, consider purchasing Drug Enforcement Administration data. Calculate the total number of waivered providers in the state, and by sub-state region such as county or ZIP code.
- **Use Medicaid eligibility, claims and encounter data to calculate key metrics and target outreach** aimed at waivered providers who could increase their MAT caseload; reach underserved areas or treat particularly vulnerable populations (e.g., pregnant women):
  - Of the number of Medicaid providers offering MAT to Medicaid enrollees:
    - Number seeing 30 or fewer patients, and number seeing 30–100 patients
    - Number of community providers, opioid treatment programs (OTPs), emergency department-based providers and other provider types

  - Number of providers serving prenatal, pregnant and perinatal women
  - Geographic location of Medicaid MAT providers
- Prevalence of OUD in the Medicaid population, and in subpopulations such as prenatal, pregnant and perinatal women

- **Use quantitative thresholds to set minimum network adequacy** standards for MAT providers in managed care organization (MCO) contracts. Evaluate and implement thresholds using either a set number of providers per county or a percentage of licensed providers approach.
- **Require managed care plans to offer enhanced reimbursement** to providers that secure and use waivers to offer MAT.
- **Require or incentivize hospital emergency departments to facilitate MAT induction** and handoffs to office-based ongoing MAT in the community.

State Examples

- **Ohio.** The Ohio Department of Medicaid developed MAT provider panel requirements for MCOs. The state's Medicaid managed care contract includes a table by county requirements for minimum MAT provider panel size, with panels consisting of both waivered community providers and OTPs. The state-required number of providers varies from zero to 43, depending on population and the MAT provider supply in each region. Plans also must contract with all willing OTP providers that are licensed by Ohio's Department of Mental Health and Addiction Services and SAMHSA.[30]

Exhibit 6. Ohio MAT Provider Panel Requirements

County	MAT
Adams	0
Allen	6
Ashland	0
Ashtabula	2
Athens	3
Auglaize	0
Belmont	1
Brown	0
Butler	8
Carroll	0
Champaign	1
Clark	2
Clermont	4
Clinton	0
Columbiana	3
Coshocton	0
Crawford	1
Cuyahoga	34
Darke	0
Defiance	1
Delaware	1
Erie	2
Fairfield	3

County	MAT
Fayette	1
Franklin	43
Fulton	0
Gallia	2
Geauga	1
Greene	5
Guernsey	1
Hamilton	30
Hancock	1
Hardin	1
Harrison	0
Henry	0
Highland	1
Hocking	3
Holmes	0
Huron	1
Jackson	0
Jefferson	0
Knox	1
Lake	4
Lawrence	1
Licking	4
Logan	2

County	MAT
Lorain	2
Lucas	14
Madison	1
Mahoning	12
Marion	4
Medina	1
Meigs	2
Mercer	0
Miami	2
Monroe	0
Montgomery	18
Morgan	1
Morrow	0
Muskingum	3
Noble	0
Ottawa	0
Paulding	0
Perry	2
Pickaway	2
Pike	1
Portage	2
Preble	0
Putnam	0

County	MAT
Richland	6
Ross	3
Sandusky	1
Scioto	8
Seneca	0
Shelby	1
Stark	6
Summit	14
Trumbull	4
Tuscarawas	1
Union	0
VanWert	0
Vinton	1
Warren	4
Washington	0
Wayne	1
Williams	1
Wood	2
Wyandot	0

- **New Hampshire.** In its Medicaid managed care contract, New Hampshire establishes required participation rates for various SUD providers, including 75% of OTPs and 75% of buprenorphine prescribers and no less than two providers in most other SUD provider categories for each of the state's public health regions (see Exhibit 7 below). If providers will not agree to contract at reasonable rates, plans can request exceptions to this requirement. The New Hampshire Medicaid plan contract also requires managed care plans to pay SUD providers at state-determined rates to support SUD capacity[31] and requires plans to establish two rates for MAT providers, one for those treating up to 30 members and one for those treating up to 100:
  - 4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified providers based on whether providers are certified and providing MAT to up to thirty (30) members per quarter (i.e., tier one (1) providers) or certified and providing MAT to up to one hundred (100) members per quarter (i.e., tier two (2) providers).
  - 4.11.6.5.6 The tier determinations that qualify providers for the MCO's enhanced reimbursement policy shall reflect the number of members to whom the provider is providing MAT treatment services, not the number of patients the provider is certified to provide MAT treatment to.[32]

Exhibit 7. New Hampshire SUD Provider Participation Standards

MLADCs	The MCO's Participating Provider Network shall include seventy percent (70%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Opiod Treatment Programs (OTPs)	The MCO's Participating Provider Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Buprenorphine Prescribers	The Network shall include seventy-five percent (75%) of all such Providers licensed and practicing in NH and no less than two (2) Providers in any public health region unless there are less than two (2) such Providers in the region
Residential Substance Use Disorder Treatment Programs	The Network shall include fifty percent (50%) of all such Providers licensed and practicing in NH and no less than two (2) in any public health region unless there are less than two (2) such Providers in the region
Peer Recovery Programs	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing Programs in NH

- **Massachusetts.** The state passed a law in 2018 that requires all acute care hospitals in the state that provide emergency services to offer MAT and to connect patients to follow-up care.[33] Detailed clinical guidelines produced by the Massachusetts Health and Hospital Association for MAT within EDs present an example of the type of guidance that states can develop in partnership with stakeholders to help hospitals come into compliance with MAT requirements. The clinical guidelines cover issues such as clinical criteria to obtain prior to MAT induction, prescriber guidelines and information on MAT waiver trainings. The guide also provides details on state-specific laws with regard to the circumstances under which patients can be sent home with buprenorphine.

Implementation Strategy 1.4: Require SUD Providers to Provide (or Facilitate) Access to MAT

Despite strong clinical evidence in favor of MAT, many substance use disorder treatment facilities do not offer it, reflecting in part a persistent belief that such medications simply substitute one addictive substance for another. Manatt's analysis of the 2017 National Survey of Substance Abuse Treatment Services (N-SSATS) found that only 41% of facilities participating in Medicaid providing outpatient treatment, and 46% of facilities participating in Medicaid and providing residential nonhospital treatment, offer any type of MAT. See **The Opioid Epidemic: A National Snapshot; Table 10. Number and Percent of Medicaid Participating Outpatient and Residential SUD Facilities Providing MAT, by State, 2017.**[34] In some instances, SUD providers will even refuse to treat individuals who are receiving MAT from a different provider, a practice that is drawing growing legal scrutiny.[35] The federal government is addressing this issue through both guidance and a provision in the SUPPORT Act indicating that it expects residential treatment facilities to provide access to MAT as a condition of receiving Medicaid funding.[36]

State Medicaid agencies also have levers to ensure that SUD providers facilitate MAT access. State Medicaid agencies can work in close partnership with their substance abuse or behavioral health sister agencies that license or certify SUD providers to require the direct provision (or facilitation) of MAT as a condition of licensure and certification and to offer support to providers and plans in meeting such requirements. Missouri has taken this approach as part of a long-term campaign to increase access to MAT through a combination of support, training and new requirements. Alternatively—or in addition—the Medicaid agency could directly require that SUD providers offer MAT (or facilitate access to it) as a condition of receiving Medicaid payment for any services provided to Medicaid enrollees. It is important to pair these increased requirements to offer MAT with provider supports and policies that facilitate offering MAT as discussed in **Implementation Strategy 1.5: Provide Training and Expert Support to Primary Care Providers That Offer Outpatient MAT** and **Implementation Strategy 2.1: Promote Coordinated Team-Based Care for OUD Treatment**. Based on the experiences of states such as Missouri, it is clear that efforts to implement such a change likely will work better if the state adopts a combination of "carrots" (e.g., enhanced payment for offering MAT) and "sticks" (e.g., requiring the provision of MAT as a condition of licensure or payment); the effort is backed by a broad array of stakeholders; and SUD providers are offered a transition period and support in developing the expertise required to meet the requirements. Such steps will make it less likely the state will need to pursue an exemption from the requirement to cover all forms of MAT in the SUPPORT Act, due to provider shortages.

Action Steps

- Work with partner agencies in the state, like the behavioral health or substance abuse agency, to explore the feasibility of **requiring all SUD programs or facilities to provide or facilitate access to MAT as a condition of licensure and certification**.
- **Develop and release Medicaid policy guidance requiring providers to provide or facilitate access to MAT** as a condition of continuing to receive Medicaid payments.
- **Offer SUD providers education, support and training on the use of MAT** to increase the feasibility of implementing requirements to use or facilitate access to MAT.
- **Explore partnerships with local behavioral health provider organizations, the state medical society and others to provide ongoing training and technical assistance to SUD providers.** These efforts can be financed with Medicaid administrative funds[37] or built into the rate-setting process for SUD providers.
- **As appropriate, adjust payment rates to account for administrative costs associated with providing MAT** (following up on labs, outreach to pharmacies, scheduling for nurses and doctors).

State Examples

- **Missouri.** Several decades ago Missouri's Department of Mental Health (DMH) implemented a policy that, as a condition of certification in the state, SUD agencies must offer or arrange for MAT. The state increased enforcement of the policy eight years ago, beginning with data analysis to determine which agencies were offering MAT, identify the number of patients they were treating, and assess the extent to which they were treating patients with OUD and alcohol use disorder. The state took an incremental approach, allowing SUD agencies to keep their existing provider network while expanding access to MAT, and working with them over time to come into compliance with the policy. By using a steady but gradual approach, and providing support and training to providers, the state was able to bring all SUD agencies in the state into compliance, and the agencies now are either directly providing or arranging for MAT.[38]

Exhibit 8. Extract From Missouri DMH Memo re: Certification Requirements for Medication-Assisted Treatment

For many years we have been saying that to remain certified and contracted with DMH, an agency must offer to arrange for MAT. This means ensuring the availability of ALL forms of MAT for Opioid Use Disorders and Alcohol use Disorders, including buprenorphine products (e.g., Suboxone), injectable naltrexone (Vivitrol), oral naltrexone, acamprosate, and disulfirum. The one exception is methadone, which can be administered only in certified Opioid Treatment Programs.

Not only must an agency offer or arrange for MAT, but it must be delivered in a way that is supported by evidence. For example, we have recently become aware that in some agencies, buprenorphine products are used only in a defined, time-limited regimen, even though the evidence shows that for some individuals, a longer course of therapy ("maintenance") is clinically appropriate and leads to better outcomes.

The point is that we will be looking not just at whether MAT is offered, but also whether it is delivered in a manner consistent with evidence-based practice.

We are identifying agencies that we believe are not meeting the requirements for MAT and will notify them. In the next 12 months, any of those agencies that do not show progress in advancing MAT will be required, at a minimum, to submit plans of correction. We will also offer on-site training and technical assistance. After that, agencies that do not improve will be placed on CONDITIONAL certification and may ultimately lose certification. **Department Director Mark Stringer and Division Director Rick Gowdy have instructed that, after taking the steps above, we discontinue contracting with agencies that do not adequately offer this evidence based intervention to individuals for whom it is clinically appropriate and potentially lifesaving.**

Source: Bock, Nora, "Certification Requirements for Medication Assisted Treatment," State of Missouri Department of Mental Health, October 25, 2016.

- **California.** In a California Health Care Foundation (CHCF)-funded study, the San Francisco Department of Public Health implemented academic detailing and cut opioid-related emergency department visits by nearly half among patients who were co-prescribed naloxone. Academic detailing relies on conducting intensive, office-based outreach with providers, sharing evidence-based information on opioid safety and naloxone prescribing.[39] Academic detailing resources developed as part of this project include a Provider Guide to prescribing naloxone for patients who use opioids.

Implementation Strategy 1.5: Provide Training and Expert Support to Primary Care Providers That Offer Outpatient MAT

Increasing the number of primary care providers (PCPs) who prescribe MAT is a critical strategy for expanding access to OUD treatment, especially in rural areas where PCPs often are the main source of healthcare. Understandably, providers who are inexperienced in treating SUDs have concerns about their ability to take on this new type of care. Persistent stigma among providers about taking patients with SUDs remains a barrier to treatment access. But leader states note that many providers are unaware that they are

already treating patients with SUD or OUD, and alerting them to the presence of patients with OUD in their practice, and encouraging them to begin providing MAT to these and other patients, can be an effective strategy.

Initiatives and programs that connect PCPs to SUD experts for clinical training, advice and guidance can leverage and expand the limited capacity of SUD-focused providers. States can look to a number of different models to connect PCPs to SUD experts who can back them up and offer support in providing MAT and serving patients with SUD. These include the hub-and-spoke model, Project ECHO and MCO-driven technical assistance. All of these models aim to reduce provider concerns about and improve provider capacity related to taking on new, complex patients. They offer PCPs opportunities to receive direct case consults (including through use of telehealth modalities), which is particularly important for PCPs who are new to providing MAT.[40] Hub-and-spoke and Project ECHO also offer a community of peers with whom providers new to MAT can learn about best practices, challenges and lessons learned. Hub-and-spoke models represent substantial infrastructure investment to select, certify and develop treatment center hubs and ongoing care spokes. California's hub-and-spoke system was funded through a 21st Century Cures Act grant totaling $44.7 million for both hub-and-spoke and a tribal MAT expansion project.[41]

Exhibit 9. Models for Connecting MAT Prescribers to SUD Experts

- **Hub-and-Spoke:** Centralized specialty centers or "hubs" provide both patient care and support to "spokes," which are community-based providers. Hubs typically manage the most complex patients, and may initiate treatment for patients who are then transferred to spokes when they are stable.
- **Project ECHO:** Academic medical centers that provide training for community providers, sometimes through learning collaboratives. Some programs offer direct case consults. These activities are typically done virtually, through webinars, conference calls, and individual calls for case consults. Project ECHO initiatives exist for a wide variety of clinical areas. Project ECHO is also referred to as a hub-and-spoke system.
- **MCO Technical Assistance:** A state with managed care can require MCOs to have SUD experts on call to do individual case consults (see example from Massachusetts below).

Action Steps

- **Conduct data analysis to identify providers whose patient populations have a high or moderate prevalence of OUD**; reach out to these providers to educate them about their patients' needs and encourage them to provide MAT. Provide ongoing support as new providers become waivered and begin offering MAT.

- **Evaluate whether developing a hub-and-spoke system is a viable option.** Developing and launching a hub-and-spoke system will require substantial effort and investment of funds and staff time, but it can offer support to frontline MAT providers and also directly expand the network of SUD specialty providers available to treat particularly complex patients.
- **Work with academic medical centers to expand existing Project ECHO programs to include MAT** support, or to develop new programs specifically on SUD treatment.
- **Consider Medicaid funding options for Project ECHO.** Require MCOs to contract with the Project ECHO site for MAT or identify Project ECHO as an option for MCO in lieu of value-added benefits.[42] States may also be able to use Medicaid administrative funds to cover some ongoing Project ECHO costs by directly contracting with Project ECHO sites to provide training to Medicaid-participating providers.[43]
- **Review and update as necessary state Medicaid coverage and payment policies** to encourage broad adoption of tele-behavioral health services, including linking members with SUDs to outpatient counseling and providers who can prescribe MAT.
- **Revise managed care contract language** to require MCOs to have a licensed physician who is an expert on MAT available for case consults during standard business hours, and conduct widespread dissemination to their provider networks about this available support.

State Examples

- **West Virginia.** West Virginia officials run data analyses to flag provider specialties that have patient populations with a high prevalence of SUDs. They then conduct personalized outreach to providers to encourage them to prescribe suboxone. This process has successfully expanded the number of providers, including obstetrician/gynecologists (a targeted provider type), offering MAT. During the outreach process, state officials learned that some providers they contacted already wanted to prescribe MAT, but had concerns about beginning to provide treatment. The state's proactive outreach and assistance helped them to overcome this barrier.[44]
- **Vermont.** Vermont's hub-and-spoke system pairs regional specialty OUD treatment centers that provide intensive treatment ("hubs") with support teams of community healthcare professionals offering MAT ("spokes"). Spokes are generally outpatient medical and specialty offices. Spokes receive direct staff support through Vermont's Blueprint for Health Community Health Teams. For every 100 Medicaid patients receiving MAT at a spoke practice, the Department of Vermont Health Access pays the cost of one nurse and one licensed mental health/addiction counselor to support the prescribing providers.[45] Hubs offer more intensive treatment and handle more difficult cases, often initiating treatment and then transferring the patient to a spoke when they are stable. Spoke providers have the ability to transfer patients back to the hub, should they become destabilized.[46] Hubs also offer ongoing trainings and consultation to spoke providers. In Vermont, Medicaid health home payments, authorized through a state plan amendment are a critical funding source for the program: Hubs receive a monthly bundled payment rate, and spokes receive a per-member per-month payment. Exhibit 10 below provides additional details on payments under the Hub and Spoke Model. Hubs also receive grant funds in addition to Medicaid dollars to pay for outreach and services not included in the hub bundle.[47]

Exhibit 10. Vermont's Payment Methodology for Hub-and-Spoke

Hub & Spoke Provider	Payment Mechanism	Purpose of Payment
Physician	Fee-for-Service payment, under current Medicaid State Plan.	MAT (buprenorphine & methadone).
Nurse + Clinician Case Manager	**Hub**: % of monthly rate per patient for health home services. **Spoke**: Capacity payment to Blueprint administrative entity, based on numbers of unique patients receiving buprenorphine.	Care management, care coordination, transitions of care, health promotion, individual and family support, and referral to community services.

Source: State of Vermont, "Concept For Medicaid Health Home Program," October 2, 2012, https://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/SupportingDocuments/VT_SPA_Concept_Paper_final_CMS_10_02_12.pdf.

- **Massachusetts.**
  - The Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP) offers PCPs free telephone consultations Monday through Friday on safe prescribing and managing care for patients with chronic pain, SUD or both. The program, developed through legislation, is funded through appropriations and surcharges on commercial insurers, and is run by the Executive Office of Health and Human Services. MCSTAP consultations can provide support around topics such as prescribing buprenorphine or naltrexone, overall management plan for complex and challenging cases, and questions related to caring for pregnant women with SUDs.[48] Exhibit 11 below provides additional details about MCSTAP.

Exhibit 11. Details About Physician Consultation Through Massachusetts' MCSTAP Program

Physician consultation: After being notified by the resource and referral specialist about a request for consultation, the physician consultant will call the provider within 30 minutes, or at a time specified by the provider. The physician consultant will ask the provider about the presenting issue and a summary of the patient's history. The consultation may involve diagnostic support, guidance related to prescribing new medications or adjusting current medications, treatment planning, and community support needs. The physician consultant will collaborate with the provider to identify next steps and will ask if the provider would like a follow-up call in the future.

Source: MCSTAP, "How MCSTAP Works," 2019, https://www.mcstap.com/Providers/HowMCSTAPWorks.aspx.

  - MassHealth, Massachusetts' Medicaid program, recently issued a policy to cover and pay for tele-behavioral health services for its members. Community health centers, community mental health centers and outpatient substance use disorder providers are eligible for Medicaid reimbursement for tele-behavioral health. The goals of the policy include linking members with SUD to outpatient counseling and to providers who offer MAT, and offering services to members who live in rural areas with a dearth of providers.[49] Providers must adhere to best practices set out by the state when delivering tele-behavioral health services (see Exhibit 12 below).

Exhibit 12. MassHealth Requirements for Delivery of Tele-Behavioral Health Services

Requirements for Telehealth Encounters

Providers must adhere to and document the following best practices when delivering services via telehealth.

1. Providers must properly identify the patient using, at a minimum, the patient's name, date of birth, and MassHealth ID.
2. Providers must disclose and validate the provider's identity and credentials, such as the provider's license, title, and, if applicable, specialty and board certifications.
3. For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any available medical records with the patient before initiating the delivery of the service.
4. For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service.
5. Prior to each patient appointment, the provider must ensure that the provider is able to deliver the service to the same standard of care and in compliance with licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access) using telehealth as is applicable to the delivery of the services in person. If the provider cannot meet this standard of care or other requirements, the provider must direct the patient to seek in-person care. The provider must make this determination prior to the delivery of each service.
6. Providers must ensure the same rights to confidentiality and security as provided in face-to-face services.
7. Providers must follow consent and patient information protocol consistent with those followed during in person visits.
8. Providers must inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site).
9. The provider must inform the patient of how the patient can see a clinician in-person in the event of an emergency or as otherwise needed.

Source: Tsai, Daniel, "MassHealth All Provider Bulletin 281: Access to Behavioral Health Services Through Use of Telehealth Options," Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid, January 2019, https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf.

2.0 Strategies to Promote Coordinated Team-Based Care for Opioid Use Disorder (OUD)

Individuals with an OUD often confront an array of physical health, mental health, substance use and related psychosocial challenges. In response, a number of states have used Medicaid to promote coordinated, team-based care for OUD treatment, following the research indicating that effective team-based care can improve outcomes for a range of complex health conditions.[50,51,52,53,54,55] In the context of OUD, team-based care generally consists of the following:[56]

- A physician, nurse practitioner or other physical health provider who is authorized to prescribe the medications used in MAT
- A mental health or substance use professional, such as a licensed substance use counselor
- A care manager who can offer "high touch" support in navigating health and social services, particularly for those with more severe OUDs
- A peer support specialist or community health worker who has some shared experiences with the individuals served by the program

States can modify the configuration of team members to respond to state-specific access gaps or needs, or vary the way that team-based care is implemented (e.g., allow telemedicine in addition to or instead of co-location of mental health and SUD professionals in rural areas). Regardless, the foundation of the approach is a coordinated team that includes professionals with expertise on the physical health, mental health, SUD and psychosocial elements of an individual's experience.[57]

Implementation Strategy 2.1: Promote Coordinated Team-Based Care for OUD Treatment

Team-based care can increase patient satisfaction and contribute to better outcomes, but it is challenging to implement for a host of reasons.[58,59] States pursuing this strategy will need to develop and issue clear policy to providers on the parameters and requirements of OUD team-based care and operationalize a process to certify practices that meet team-based care requirements. States may also consider developing a program to provide capacity-building support and ongoing technical assistance to practices interested in team-based care. As an additional mechanism for capacity building and incentivizing providers to build teams around OUD treatment, states may consider establishing enhanced reimbursement for team-based OUD treatment, including payment for case management services. States can also work with their providers and managed care plans to assess and develop strategies for coordinating team-based care services with other Medicaid case management services (e.g., MCO or health home care management programs) to avoid duplicate

payment and confusion for members. Finally, to facilitate team-based care, states can assess and modify regulations and policies that impede billing team-based care, such as restrictions on billing for a physical health visit and a behavioral health visit on the same day.

Action Steps

- **Establish the state's definition of team-based care** for OUD treatment—including, for example, required and optional team members, team-based care services (e.g., case management), licensure and certification requirements, and panel size standards—and integrate the definition into clinical guidelines and reimbursement policies. Draw on successful models from within the state and the research and evidence available on the key elements of team-based care.[60]
- **Review (or develop) a State Plan Amendment (SPA) authorizing reimbursement for peer support** specialists, as allowed under federal law.[61,62]
- **Create a process for certifying qualified teams** to ensure that they meet state standards (e.g., verify that the team includes a waivered physician) and gather data on the number of individuals that teams can serve.
- **Review Medicaid reimbursement policy and increase payment to those providers meeting state standards** for team-based OUD treatment; require Medicaid managed care plans to conform to the enhanced payment standards; and update any codes as needed to ensure that case management services are covered as part of team-based opioid treatment.
- **Consider leveraging Medicaid funds to provide training and practice support** to providers as they initially become team-based care providers. States can do so by building training costs into their reimbursement rates.[63]
- **Evaluate whether to adopt or expand usage of health homes** as a tool for financing and supporting team-based care.

State Examples

- **Virginia.** As part of a comprehensive review in 2017 of its substance use benefit, Virginia established enhanced reimbursement for team-based care for OUD treatment. Known as preferred office-based opioid treatment (OBOT) providers, the teams deliver addiction treatment services to individuals with moderate to severe OUDs. Preferred OBOT teams must include a buprenorphine-waivered practitioner working in collaboration and co-located with a licensed psychologist, a social worker or another credentialed addiction treatment practitioner. Moreover, the teams must meet state-defined expectations for the way that MAT is delivered including dosage maximums, use of random urine drug screens, use of the state's prescription drug monitoring program at least quarterly, and regular weekly visits during initiation of MAT. Providers with preferred or "gold card" status can bill for certified peer recovery specialists and substance use care coordination, can receive higher reimbursement rates for opioid counseling, and do not have prior authorization requirements for buprenorphine products.[64] In the first ten months of implementing its new approach to SUD treatment, including use of preferred OBOTs, Virginia saw a 64% increase in treatment rates, drops in emergency department visits for SUDs (-14%) and OUDs (-24%), and declines in the number of members with hospitalizations for SUDs (-4%) and OUDs (-6%).[65] Some resources developed by Virginia to implement its policy include:

- **Established standards and registration procedures for OBOT**, which were outlined in a special supplement to the provider manual and disseminated through public presentations
- **Increased reimbursement rates generally for SUD treatment and established enhanced rates for preferred OBOT practices** through an updated fee schedule
- **Clarified and updated MAT codes and prior authorization requirements**, including identification of when MAT can be billed separately when delivered in combination with other services; see Tables 1 and 2 of the state's memo to providers on these issues
- An established process for **measuring and evaluating outcomes** for OBOTs and the broader set of changes adopted as part of the state's 2017 overhaul of its substance use benefit
- **Pennsylvania.** Pennsylvania's 45 Centers of Excellence (COEs) for Opioid Use Disorder use community-based care management teams including diverse providers, such as licensed clinical social workers, counselors, peer navigators, physicians, nurses and care managers. Care management teams work together to ensure client needs are coordinated across OUD care, mental health care, physical health care, and a variety of social needs including job training, housing and transportation support, and education services.[66]

Implementation Strategy 2.2: Establish a Health Home for Individuals With OUDs

Under an option included in the Affordable Care Act (ACA), states can establish a health home that provides coordinated medical care, mental health and substance use services, long-term services and supports, and community-based social services for Medicaid beneficiaries with complex healthcare needs, including those with an opioid use disorder. According to CMS, "health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations. By better coordinating care and linking people to needed services, health homes are designed to improve health care quality and reduce costs."[67] The ACA provides states a 90% federal matching rate for up to eight calendar year quarters for health homes. A provision in the SUPPORT Act allows states that secure approval for a health home for individuals with SUD after October 1, 2018, to receive the enhanced matching rate for up to ten quarters under certain conditions.[68] As of August 15, 2019, five states have implemented a health home for individuals with OUD (see **The Opioid Epidemic: A National Snapshot** and **Table 7. Medicaid Health Home Programs Targeting Individuals With an OUD**).

Action Steps

- Assess whether a health home option is consistent with the state's opioid strategy, taking into account the availability of enhanced matching funds for team-based care, as well as the costs associated with establishing a health home and meeting various reporting and quality requirements.
- To pursue a health home for individuals with substance use disorders, **submit to CMS a new health home state plan amendment that is "SUD focused"** along with a formal request for enhanced funding. CMS already has indicated that one way a state can establish that its health home is "SUD focused" is by including a MAT provider as part of the team structure.

- **Work with providers to establish the health home**, including by developing strategies for identifying individuals who are eligible for the health home and connecting them to the available support.

State Examples

- **Maine.** Using health homes SPA authority, Maine has established the MaineCare Opioid Health Home (OHH), a statewide health home specifically for individuals with opioid use disorders. It offers support through a multidisciplinary team of providers, including a clinical team lead, MAT prescriber, nurse care manager, opioid dependency clinical counselor and peer recovery coach. Beneficiaries have the option to enroll and can opt out at any time.[69]

Exhibit 13: Excerpt from Maine Health Homes SPA

> "The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving MaineCare members with opioid dependency who are receiving Medication Assisted Treatment (MAT) in the form of buprenorphine, buprenorphine derivatives, and/or naltrexone. In addition to expanding access to treatment for an individual's opioid use disorder, the OHH integrates physical, social, and emotional supports to provide holistic care. This model is based on a multidisciplinary team approach consisting of a clinical team lead, MAT prescriber, nurse care manager, clinical counselor, patient navigator, and peer recovery coach. The OHH must be a community based provider in Maine, preferably licensed to provide substance use disorder services. It is expected that the OHH program will not only result in more individuals receiving opioid use disorder treatment but will also lead to improvements in the quality of care they are receiving."

Source: MaineCare, "Health Homes State Plan Amendment: ME-17-006," Submitted June 6, 2017, Effective October 1, 2017.

3.0 Strategies to Monitor and Evaluate OUD Interventions on an Ongoing Basis

As states deploy a broad range of strategies to fight the opioid and broader SUD epidemics, monitoring and evaluating the impact of these strategies are critical. Regular monitoring and evaluation can help determine which strategies are most impactful, allowing state officials to allocate limited resources (funding and staff time) wisely, and providing a critical input into future planning and investment. Close examination of impacts may also reveal unintended consequences that inform modifications to or even discontinuance of strategies for which harm outweighs the benefits. For example, limits to the number of days or the dosage of opioid prescriptions, widely implemented nationwide, have had well-documented consequences of negatively impacting chronic pain patients and even being blamed for suicides by chronic pain patients unable to get adequate pain relief.[70,71]

Publishing state monitoring, evaluation and other assessment results informs the national evidence base on OUD and SUD interventions which state and federal officials can use when setting new policy and budget priorities. States with SUD 1115 waivers are required as a condition of their waivers to conduct ongoing monitoring, and do summative evaluations, following detailed CMS requirements. The framework that states put into place to meet demonstration monitoring and evaluation requirements can in many cases be leveraged to measure the impacts of non-waiver SUD policies.

Exhibit 14. Monitoring Versus Evaluation

Monitoring entails review of information on an immediate and ongoing basis. It is used to determine how an intervention is unfolding, and whether policies should be tweaked to address unintended consequences or facilitate smoother implementation. Monitoring usually looks at descriptive statistics, and is typically done by program staff.

Evaluation is done at set intervals, often the midpoint and end of a demonstration program, or yearly for other types of interventions. It is used to determine whether hypotheses about impacts have occurred, and to assess whether impacts can be attributed to the intervention after controlling for other factors. It is often done by independent outside entities, but may also be done by program staff, and uses more rigorous methodologies such as regression modeling.

Source: Boozang, Patricia, Bachrach, Debra, and Grady, April, "Monitoring and Evaluation Work and Community Engagement Requirements in Medicaid: Data Assets, Infrastructure and Other Considerations for States," Manatt Health, February 2019, https://www.manatt.com/getattachment/bde310d2-c679-4991-a1bd-11e726368d55/attachment.aspx.

Implementation Strategy 3.1: Develop, and Implement, a Monitoring Plan

State Medicaid agencies can implement monitoring, using descriptive statistics to review trends over time, to assess the overall performance of the Medicaid program in relation to OUDs. Monitoring can also be used to gain early insights into the impact of Medicaid strategies to address SUD, such as if ED visit rates for SUDs decrease after an ED diversion program is implemented.

CMS guidance on SUD 1115 demonstration monitoring includes a robust set of required and recommended monitoring metrics developed by CMS in collaboration with states and SUD subject matter experts. The metrics use many standard measures, such as those endorsed by the National Quality Forum and the Medicaid Child and Adult Core Set, and can all be calculated using Medicaid administrative data. These measures are an appropriate list from which state officials can choose to monitor a wide variety of SUD and OUD policies.[72] Examples of SUD 1115 waiver monitoring metrics include:[73]

- Number of beneficiaries receiving MAT
- Initiation and engagement of alcohol and other drug abuse or dependence treatment, for all individuals with SUD, and for people with OUD (CMS Adult Core Set Measure)
- Concurrent use of opioids and benzodiazepines (CMS Adult Core Set Measure)

- Continuity of pharmacotherapy for opioid use disorder
- ED visits for SUD per 1,000 beneficiaries
- Overdose death rate

Once states define key metrics, they can set up standard reports run at regular intervals (such as quarterly) to measure and compare results over time. States should also consider specific reports for special populations (pregnant women, adolescents, people with an IDD), as well as regional metric reports. These reports can be reviewed to assess impacts of policies and potential issues with their implementation. For example, if there is a sudden decline in the number of Medicaid enrolled beneficiaries receiving MAT, officials may investigate potential causes such as a drop in the number of providers offering MAT, closure of a key SUD provider, or changes to MCO policies that create barriers MAT.

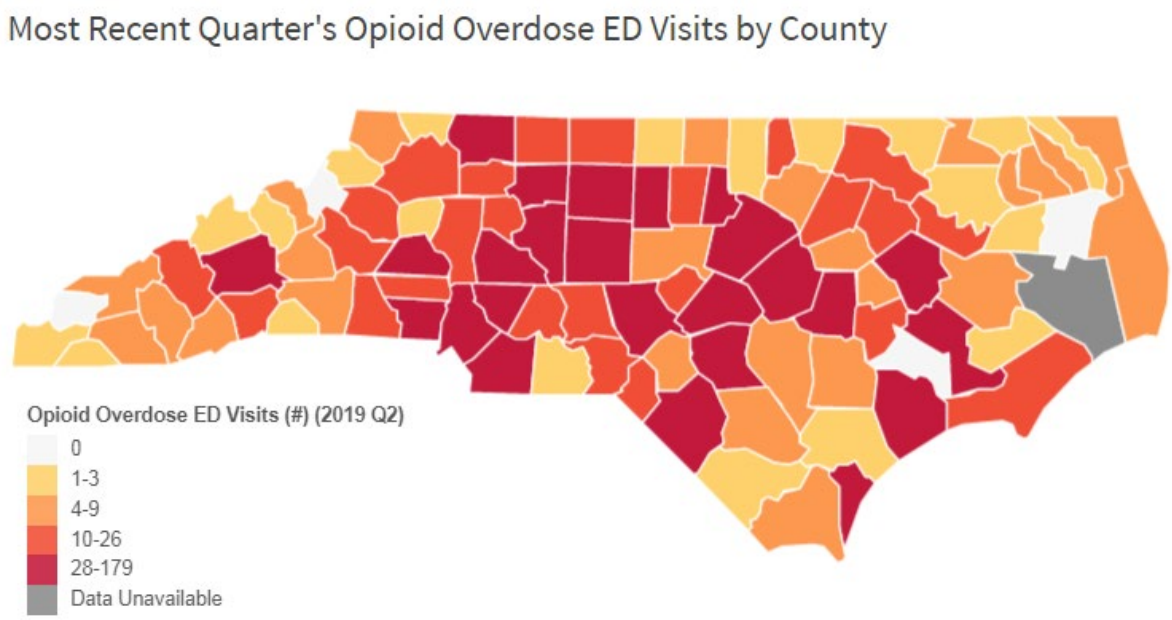
Action Steps

- **Develop a monitoring plan** by selecting metrics for monitoring Medicaid's overall performance fighting the SUD and OUD epidemics, leveraging Monitoring Metrics for 1115 SUD Waivers. Create and run quarterly reports or create a dashboard, looking at trends over time and with break-outs for key subpopulations and regions.
- **Use lessons learned from monitoring metrics and evaluations to modify current policies and programs, and to inform future planning.**

State Examples

- **North Carolina.** The state's Opioid Action Plan Data Dashboard is used for ongoing monitoring of goals outlined in the state's Opioid Action Plan. The dashboard provides visualizations of each metric, displaying rates at the county level, on 13 measures including opioid overdose deaths, ED visits for opioid overdoses, concurrent benzodiazepine and opioid prescriptions, and the number of buprenorphine prescriptions (see Exhibit 15 below). The dashboard is very timely; as of August 2019, 2019 Q1 data were available for many of the measures. The dashboard's detailed technical notes on the methodology behind the measures, along with contextual text displayed alongside the visualizations, make the dashboard easy to use and understand.[74]

Exhibit 15. Visualization From North Carolina's Opioid Action Plan Data Dashboard



Source: "NC Opioid Action Plan Data Dashboard," North Carolina Department of Health and Human Services, https://injuryfreenc.shinyapps.io/OpioidActionPlan/.

Implementation Strategy 3.2: Partner With Foundations and Academic Researchers to Fund and Conduct Evaluations of SUD Program Interventions

States can seek partnerships with foundations and academic researchers to evaluate their non-waiver SUD interventions. Evaluation will provide states with more in-depth analysis, and make it possible to draw conclusions about causes and effects. Evaluations aim to determine if specific, desired or hypothesized outcomes related to a particular policy have been achieved. By using rigorous, science-based methodologies, evaluation aims to determine if a given policy or program had a particular impact. For example, when considering the number of ED visits per 1,000 members for monitoring purposes, state officials may look to see if this measure trends downward. In considering the same measure in an evaluation, researchers would seek to determine whether a particular intervention led to a reduction in ED visits by using either a control group or other statistical methods that control for other factors impacting the number of ED visits. By partnering with academic researchers to conduct robust evaluations of selected state policy changes to fight SUD and OUD, and sharing these results, state officials will have stronger evidence of which policies are working than can be determined by monitoring alone.

States that partner with universities on evaluation or research can participate in learning and research networks that help support state-university partnerships. The State University Partnership Learning Network (SUPLN), managed by AcademyHealth with support from the Patient-Centered Outcomes Research Institute, facilitates peer-to-peer learning and dialogue among state-university partnerships through meetings and

bimonthly web conferences with the goal of improving the cost and quality of care of the Medicaid program. Twenty-seven partnerships across 23 states currently participate.[75] Participating partnerships must draft or have a contract/interagency agreement that spans at least one year between a state or state-related university research center and a state Medicaid agency and/or any state governmental entity that works on the Triple Aim with Medicaid as a principal partner.[76] The Medicaid Outcomes Distributed Research Network (MODRN) is a new initiative developed by members of SUPLN and the Medicaid Medical Director Network. Under MODRN, each state-university partnership adopts a common data model, contributes to a common analytic plan, and conducts analyses locally on their own Medicaid data using standardized code developed by the data coordinating center. Finally, the state-university partners provide aggregate results, not data, to the data coordinating center, which synthesizes the aggregate findings from multiple states for reporting. MODRN's first project assessed OUD treatment quality and outcomes in Medicaid, working with nine states (KY, MD, MI, NC, OH, PA, VA, WV and WI) to inform policy decisions on coverage of OUD treatments in Medicaid. MODRN analyzed 20 access, quality and outcomes measures, and found there is significant variation in access and quality of treatment for OUD across Medicaid programs.[77]

Action Steps

- **Explore partnerships with foundations and academic researchers** to fund and conduct evaluations of SUD and OUD program interventions to build the evidence related to efficacy of various strategies.
- **Consider joining cross-state learning and research networks** to engage in peer-to-peer learning with other state officials, and contribute to the evidence base on the Medicaid program.

State Example

- **Vermont.** The Vermont Center on Behavior and Health, at the University of Vermont conducted an evaluation of Vermont's Hub and Spoke System. The evaluation was funded through CDC and SAMHSA grants, and used a mix of qualitative and quantitative methods. Evaluation findings included that the Hub-and-Spoke system has expanded access to MAT, and participation in MAT was associated with a large reduction in ED visits and overdoses. The evaluation also provided recommendations on areas for improvement, including increasing access to MAT in spokes, increasing access to mental health services, and developing an addiction workforce plan for Vermont to address high turnover among counselors at hubs.[78]

Appendix

The Opioid Epidemic: A National Snapshot

Table 1. Number of Opioid Overdose Deaths, and Rates per 100,000, by State CY 2016 and 2017

State	2016		2017		
	Number	Rate	Number	Rate	
AK	–	12.5	–	13.9	*
AL	–	7.5	–	9.0	*
AR	769	11.4	928	13.5	
AZ	94	12.5	102	13.9	
CA	2,012	4.9	2,199	5.3	
CO	536	9.5	578	10.0	
CT	855	24.5	955	27.7	
DC	209	30.0	244	34.7	
DE	–	16.9	–	27.8	
FL	–	14.4	–	16.3	*
GA	918	8.8	1,014	9.7	
HI	77	5.2	53	3.4	
IA	183	6.2	206	6.9	
ID	–	7.4	–	6.2	*
IL	1,947	15.3	2,202	17.2	
IN	–	12.6	–	18.8	*
KS	–	5.1	–	5.1	*
KY	989	23.6	1,160	27.9	
LA		7.7		9.3	*
MA	1,990	29.7	1,913	28.2	
MD	1,821	29.7	1,985	32.2	
ME	301	25.2	360	29.9	
MI	1,762	18.5	2,033	21.2	
MN	396	7.4	422	7.8	
MO	914	15.9	952	16.5	
MS	–	6.2	–	6.4	*
MT	–	4.2	–	3.6	*
NC	1,506	15.4	1,953	19.8	
ND		7.6		4.8	*
NE		2.4		3.1	*
NH	437	35.8	424	34.0	
NJ	–	16.0	–	22.0	*
NM	349	17.5	332	16.7	
NV	408	13.3	412	13.3	
NY	3,009	15.1	3,224	16.1	
OH	3,613	32.9	4,293	39.2	
OK	444	11.6	388	10.2	
OR	312	7.6	344	8.1	
PA		18.5		21.2	*
RI	279	26.7	277	26.9	
SC	628	13.1	749	15.5	
SD	–	5.0	–	4.0	
TN	1,186	18.1	1,269	19.3	
TX	1,375	4.9	1,458	5.1	
UT	466	16.4	456	15.5	
VA	1,130	13.5	1,241	14.8	
VT	101	18.4	114	20.0	
WA	709	9.4	742	9.6	
WI	866	15.8	926	16.9	
WV	733	43.4	833	49.6	
WY	–	8.7	–	8.7	*

Primary Source: CDC, "Drug and Opioid-Involved Overdose Deaths - United States 2013-2017, Morbidity and Mortality Weekly Report," January 4, 2019, https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w#T1_down.

* Data were not available in the primary source. Statistic is based on Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released 2018. Data are from the Multiple Cause of Death Files, 1999–2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Table 2. Ranking of 2017 Opioid Overdose Deaths per 100,000

Rank	State	Rate
1	WV	49.6
2	OH	39.2
3	DC	34.7
4	NH	34.0
5	MD	32.2
6	ME	29.9
7	MA	28.2
8	KY	27.9
9	DE	27.8
10	CT	27.7
11	RI	26.9
12	NJ	22.0*
13	MI	21.2
14	PA	21.2*
15	VT	20.0
16	NC	19.8
17	TN	19.3
18	IN	18.8*
19	IL	17.2
20	WI	16.9
21	NM	16.7
22	MO	16.5
23	FL	16.3*
24	NY	16.1
25	SC	15.5
26	UT	15.5
27	VA	14.8
28	AK	13.9*
29	AZ	13.9
30	AR	13.5
31	NV	13.3
32	OK	10.2
33	CO	10.0
34	GA	9.7
35	WA	9.6
36	LA	9.3*
37	AL	9.0*
38	WY	8.7*
39	OR	8.1
40	MN	7.8
41	IA	6.9
42	MS	6.4*
43	ID	6.2*
44	CA	5.3
45	KS	5.1*
46	TX	5.1
47	ND	4.8*
48	SD	4.0
49	MT	3.6*
50	HI	3.4
51	NE	3.1*

Primary Source: CDC, "Drug and Opioid-Involved Overdose Deaths - United States 2013-2017, Morbidity and Mortality Weekly Report," January 4, 2019, https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm?s_cid=mm675152e1_w#T1_down.

* Data were not available in the primary source. Statistic is based on Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released 2018. Data are from the Multiple Cause of Death Files, 1999–2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Table 3. States With Medicaid Prior Authorization Requirements for Medications for Opioid Use Disorders, 2016–2017

State	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Buprenorphine	Buprenorphine-Naloxone	Methadone
Total States With Prior Authorization Requirements	**7**	**18**	**39**	**26**	**25**	**30**	**3**
Total States Without Prior Authorization Requirements	**40**	**26**	**12**	**3**	**7**	**21**	**3**
Total Unknown	**4**	**7**	**0**	**22**	**19**	**0**	**45**
AK			X	X	–	X	–
AL			X	X		X	–
AR	X	–	X	–	–	X	–
AZ				–	–		–
CA							–
CO		X	X	–	X	X	–
CT				–	–		X
DC		X	X	X	X		–
DE		X		–			–
FL		X	X	–	–	X	–
GA				–	–		–
HI		–		–	–		–
IA		–	X	–	–	X	–
ID	X	X	X	X	X	X	–
IL							–
IN			X	–	X	X	–
KS			X	X	–		–
KY		X	X	X	X	X	–
LA		X	X	X	–		–
MA			X	X	X	X	–
MD		X		–	X		–
ME			X	X	X	X	X
MI			X	X	X	X	–
MN		X	X	X	X	X	–
MO	X	X	X	X	X	X	–
MS		X		X	X		–
MT	–	X	X	–	–	X	–
NC			X	X			X
ND	X		X	X	X	X	–
NE		–	X	–	–		–
NH	X		X	X	X		–
NJ		–		X		X	
NM			X	X		X	–
NV	X	X	X	–	–	X	–
NY			X	X	X	X	–
OH		X	X	X	X	X	–
OK	–	–	X	X	–	X	–
OR			X	–	–		–
PA			X	X	X	X	–
RI		X		X	X		
SC				X	X		–
SD	–	–	X	–	–	X	–
TN	X	X	X	–	–	X	–
TX		X	X	–	–	X	–
UT		X	X	–	X		–
VA			X		X	X	–
VT			X	X	X		–
WA			X	X	X		–
WI			X	–	X	X	–
WV	–		X	–	X	X	
WY			X	–	–	X	–

Source: SAMHSA, "Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose," 2018, https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093.

Notes: Entries that are blank mean policies could clearly be determined, and prior authorization is not required. Entries with a dash indicate unknown; these are cases where policies were unclear in available documentation. In states with MCOs, the table is based on review of one MCO formulary in each state. In states without a unified formulary (where all MCOs and FFS follow a state-specified formulary), prior authorization policies may vary across MCOs, and this information is not captured.

Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017

State	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Buprenorphine	Buprenorphine-Naloxone	Methadone
AK			Quantity Limits or Maximum Daily Doses	Step Therapy		Quantity Limits or Maximum Daily Doses	
AL			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
AR	Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
AZ							
CA							
CO			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
CT			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
DC		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
DE		Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
FL						Quantity Limits or Maximum Daily Doses Step Therapy	
GA		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
HI							
IA			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
ID			Quantity Limits or Maximum Daily Doses Step Therapy	Step Therapy	Step Therapy	Quantity Limits or Maximum Daily Doses	
IL			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	

Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017

State	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Buprenorphine	Buprenorphine-Naloxone	Methadone
IN			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
KS			Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Step Therapy		Quantity Limits or Maximum Daily Doses	
KY		Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
LA		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
MA				Step Therapy		Quantity Limits or Maximum Daily Doses Step Therapy	
MD		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
ME			Quantity Limits or Maximum Daily Doses Step Therapy	Step Therapy	Step Therapy	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Lifetime Limit
MI			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses		
MN			Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
MO	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Step Therapy		Quantity Limits or Maximum Daily Doses	
MS		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
MT			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	

Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017

State	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Buprenorphine	Buprenorphine-Naloxone	Methadone
NC		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
ND	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
NE			Quantity Limits or Maximum Daily Doses Step Therapy			Quantity Limits or Maximum Daily Doses	
NH			Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses	
NJ			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
NM		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
NV		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
NY		Step Therapy	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Lifetime Limit	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
OH			Quantity Limits or Maximum Daily Doses Step Therapy		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
OK			Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses Step Therapy		Quantity Limits or Maximum Daily Doses	
OR			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
PA		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
RI							

Table 4. Other State Medicaid Restrictions on Medications for Opioid Use Disorders, 2016–2017

State	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine	Implantable Buprenorphine	Extended-Release Buprenorphine	Buprenorphine-Naloxone	Methadone
SC			Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	
SD			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
TN			Quantity Limits or Maximum Daily Doses Step Therapy			Quantity Limits or Maximum Daily Doses	
TX			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
UT	Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
VA			Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
VT		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses		Quantity Limits or Maximum Daily Doses	
WA			Quantity Limits or Maximum Daily Doses			Quantity Limits or Maximum Daily Doses	
WI							
WV		Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses Step Therapy	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	Quantity Limits or Maximum Daily Doses	
WY			Quantity Limits or Maximum Daily Doses Step Therapy			Quantity Limits or Maximum Daily Doses	

Source: SAMHSA, "Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose," 2018, https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093.

Note: In states with MCOs, the table is based on review of one MCO formulary in each state. In states without a unified formulary (where all MCOs and FFS follow a state-specified formulary), prior authorization policies may vary across MCOs, and this information is not captured.

Table 5. States With Medicaid Prior Authorization Requirements for Naloxone, 2016–2017

State	Naloxone	Narcan
Total With Prior Authorization Requirements	**3**	**6**
Total Without Prior Authorization Requirements	**43**	**40**
Total Unknown	**5**	**5**
AK	–	–
AL		
AR		
AZ		
CA		
CO		
CT		
DC		
DE		
FL		
GA		X
HI		–
IA		
ID	X	X
IL		
IN		
KS		
KY	X	X
LA		
MA		
MD		
ME	X	
MI		
MN		
MO		
MS		
MT		

Table 5. States With Medicaid Prior Authorization Requirements for Naloxone, 2016–2017

State	Naloxone	Narcan
NC		
ND		
NE		
NH		
NJ		
NM		X
NV		
NY		
OH		
OK	–	–
OR		X
PA		
RI		
SC		
SD		
TN	–	X
TX		
UT	–	–
VA		
VT		
WA		
WI		
WV		
WY	–	–

Source: SAMHSA, "Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose," 2018, https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093.

Notes: Entries with a dash indicate unknown. These are cases where policies were unclear in available documentation. In states with MCOs, the table is based on review of one MCO formulary in each state. In states without a unified formulary (where all MCOs and FFS follow a state-specified formulary), prior authorization policies may vary across MCOs, and this information is not captured.

Table 6. Medicaid Enrollment Policies for Criminal Justice Involved Populations, FY 2019

	Outreach Prior to Release		Eligibility Suspension Instead of Termination	
State	Jail	Prison	Jail	Prison
Total	**34**	**39**	**36**	**38**
AK	X	X	X	X
AL	X	X	X	X
AR	X	X	X	X
AZ	X	X	X	X
CA	X	X	X	X
CO	X	X	X	X
CT	X	X	X	X
DC	X	X	X	N/A
DE	X	X	X	X
FL			X	X
GA				
HI		X		X
IA		X	X	X
ID				
IL		X		X
IN	X	X	X	X
KS	X	X		
KY	X	X	X	X
LA	X	X	X	X
MA	X	X	X	X
MD	X	X	X	X
ME			X	X
MI	X	X	X	X
MN				
MO	X	X		
MS		X		X

Table 6. Medicaid Enrollment Policies for Criminal Justice Involved Populations, FY 2019

	Outreach Prior to Release		Eligibility Suspension Instead of Termination	
State	Jail	Prison	Jail	Prison
MT	X	X	X	X
NC				X
ND		X		
NE			X	X
NH	X	X	X	X
NJ	X	X	X	X
NM	X	X	X	X
NV	X	X	X	X
NY	X	X	X	X
OH		X	X	X
OK				
OR	X	X	X	X
PA	X	X	X	X
RI	X	X	X	X
SC	X	X	X	X
SD			X	X
TN			X	X
TX	X		X	
UT	X	X		
VA	X	X	X	X
VT	X	X		
WA	X	X	X	X
WI	X	X		
WV	X	X	X	X
WY				

Source: Kaiser Family Foundation, "States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019, Table 3: Corrections-Related Enrollment Policies In All 50 States And DC, In Place In FY 2018 And Actions Taken In FY 2019," October 25, 2018, https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-eligibility-and-premiums/.

Table 7. Medicaid Health Home Programs Targeting Individuals With an OUD

State	OUD-Related Target Population	Providers	Opt-in/ Opt-out?	Payment Methodology	Target Area
MD	Individuals with opioid SUD and the risk of developing another chronic condition	Psychiatric rehabilitation programs, mobile treatment service providers and opioid treatment programs	Opt-in enrollment	PMPM Plus, one-time initial intake assessment payment	Statewide
ME	Individuals with **opioid SUD** and the risk of developing another chronic condition including a mental health condition, substance use disorder, tobacco use, diabetes, heart disease, BMI >25, COPD, hypertension, hyperlipidemia, developmental and intellectual disorders, circulatory congenital abnormalities, asthma, acquired brain injury, or seizure disorders	Multidisciplinary team of providers, including a clinical team lead, medication-assisted treatment prescriber, nurse care manager, opioid dependency clinical counselor and peer recovery coach	Opt-in	PMPM	Statewide
MI	Individuals with **opioid use disorder** at risk for any of the following chronic conditions: depression, anxiety, diabetes, heart disease, COPD, hypertension, asthma, HIV/AIDS, hepatitis, PTSD, schizophrenia, bipolar disorder, ADHD, alcohol use disorder, tobacco use disorder, **other drug use disorders**	Opioid treatment program (OTP) and office-based opioid treatment (OBOT) providers	Opt-out	FFS	Targeted to 21 counties
RI	Individuals with **opioid dependence** currently receiving or who meet criteria for medication-assisted treatment	Opioid treatment programs licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals as Behavioral Healthcare Organizations	Opt-out	Weekly FFS per member payment	Statewide
VT	Individuals with **opioid dependency** as defined by the DSM-IV-TR criteria and at risk for developing other drug or alcohol dependency or co-occurring mental health conditions, especially depression and anxiety, affective disorders, or PTSD		Opt-out	Hub Health Homes: Monthly bundled rate per member Spoke Health Homes: PMPM	Statewide

Sources: Centers for Medicare and Medicaid Services, "Medicaid Health Homes: An Overview," March 2019, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf; Centers for Medicare and Medicaid Services, "Medicaid Health Homes SPA Overview," March 2019, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-spa-overview.pdf; Centers for Medicare and Medicaid Services, "State by State Health Home State Plan Amendment Matrix," March 2019, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa-at-a-glance-matrix.pdf.

Table 8. Medicaid IMD Waivers for SUD and MH

State	Waiver Status	Waiver of IMD Exclusion	
		SUD	MH
AK	Approved	X	
AZ	Under CMS review	X	X
CA	Approved	X	
DC	Under CMS review	X	X
DE	Approved	X	
FL	Approved		
HI	Approved		
IL	Approved	X	
IN	Approved	X	
KS	Approved	X	
KY	Approved	X	
LA	Approved	X	
MA	Approved	X	X
MD	Approved	X	
MI	Approved	X	
MN	Approved	X	
MO	Approved		
NC	Approved	X	
NE	Approved	X	
NH	Approved	X	
NJ	Approved	X	
NM	Approved	X	
NY	Approved		
OH	Under CMS review	X	
PA	Approved	X	
RI	Approved	X	
TN	Under CMS review	X	
UT	Approved	X	
VA	Approved; extension request under CMS review	X	
VT	Approved	X	X
WA	Approved	X	
WI	Approved	X	
WV	Approved; amendment under CMS review	X	

Sources: Manatt Research Using 1115 Waiver Fact Sheets and Demonstration Approval Letters (Updated 8/13/2019).

Table 9. Number and Percent of SUD Facilities Participating in Medicaid, by State, 2017

State	Total	Participate in Medicaid	
		Number	Percent
Total	**13,481**	**8,668**	**64%**
AK	89	71	80%
AL	129	78	60%
AR	118	47	40%
AZ	341	220	65%
CA	1,311	461	35%
CO	381	216	57%
CT	210	180	86%
DC	27	22	81%
DE	34	31	91%
FL	668	254	38%
GA	292	145	50%
HI	168	47	28%
IA	163	145	89%
ID	124	106	85%
IL	633	330	52%
IN	305	184	60%
KS	182	131	72%
KY	359	232	65%
LA	136	85	63%
MA	351	263	75%
MD	387	292	75%
ME	199	163	82%
MI	456	321	70%
MN	356	187	53%
MO	257	174	68%
MS	89	59	66%
MT	70	57	81%
NC	472	317	67%
ND	71	30	42%
NE	125	103	82%
NH	67	53	79%
NJ	344	209	61%
NM	136	114	84%
NV	77	59	77%
NY	842	737	88%
OH	409	358	88%
OK	191	137	72%
OR	226	191	85%
PA	502	410	82%
RI	48	42	88%
SC	108	69	64%
SD	58	34	59%
TN	217	137	63%
TX	431	246	57%
UT	239	110	46%
VA	223	144	65%
VT	42	40	95%
WA	396	267	67%
WI	273	235	86%
WV	102	84	82%
WY	47	41	87%

Source: Manatt analysis of National Survey of Substance Abuse Treatment Services 2017 data.

Table 10. Number and Percent of Medicaid Participating Outpatient and Residential SUD Facilities Providing MAT, by State, 2017

	Provide Outpatient Treatment			Provide Residential (Non-hospital)		
		Provide Any MAT			Provide Any MAT	
State	Total	Number	Percent	Total	Number	Percent
Total	**7,440**	**3,070**	**41%**	**1,554**	**722**	**46%**
AK	59	18	31%	22	5	23%
AL	64	22	34%	10	0	0%
AR	41	2	5%	6	2	33%
AZ	176	62	35%	48	15	31%
CA	387	168	43%	90	25	28%
CO	201	81	40%	23	14	61%
CT	146	87	60%	33	20	61%
DC	18	9	50%	7	3	43%
DE	29	18	62%	3	3	100%
FL	219	84	38%	55	35	64%
GA	125	20	16%	23	6	26%
HI	40	10	25%	10	2	20%
IA	131	23	18%	31	14	45%
ID	105	14	13%	4	0	0%
IL	303	108	36%	60	30	50%
IN	170	77	45%	11	9	82%
KS	123	30	24%	21	4	19%
KY	209	64	31%	34	14	41%
LA	59	20	34%	27	10	37%
MA	206	128	62%	45	24	53%
MD	271	152	56%	38	20	53%
ME	145	40	28%	16	6	38%
MI	285	80	28%	60	22	37%
MN	144	35	24%	67	27	40%
MO	161	76	47%	44	26	59%
MS	44	6	14%	14	4	29%

Table 10. Number and Percent of Medicaid Participating Outpatient and Residential SUD Facilities Providing MAT, by State, 2017

	Provide Outpatient Treatment			Provide Residential (Non-hospital)		
		Provide Any MAT			Provide Any MAT	
State	Total	Number	Percent	Total	Number	Percent
MT	51	13	25%	10	3	30%
NC	273	108	40%	40	13	33%
ND	27	13	48%	14	6	43%
NE	84	14	17%	29	9	31%
NH	46	27	59%	13	5	38%
NJ	193	97	50%	17	10	59%
NM	108	39	36%	12	3	25%
NV	56	20	36%	16	4	25%
NY	556	447	80%	129	91	71%
OH	321	167	52%	72	38	53%
OK	125	30	24%	19	4	21%
OR	173	34	20%	30	14	47%
PA	302	165	55%	115	82	71%
RI	35	28	80%	11	9	82%
SC	59	11	19%	9	4	44%
SD	30	6	20%	5	0	0%
TN	133	45	34%	27	9	33%
TX	207	47	23%	52	17	33%
UT	97	40	41%	18	7	39%
VA	129	61	47%	17	12	71%
VT	35	24	69%	5	4	80%
WA	226	59	26%	51	19	37%
WI	216	88	41%	14	6	43%
WV	62	38	61%	19	6	32%
WY	35	15	43%	8	7	88%

Source: Manatt analysis of National Survey of Substance Abuse Treatment Services 2017 data.

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