Chapter 4:

Access to Substance Use Disorder Treatment in Medicaid

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Key Points

- Ensuring Medicaid beneficiaries have access to substance use disorder (SUD) treatment requires that services along a continuum of care are covered, affordable to the beneficiary, and designed to meet the unique needs of the population. In addition, providers must be available to provide appropriate care when needed.
- The continuum of care for individuals with an SUD should include outpatient services, intensive outpatient services, partial hospitalization, residential treatment, and medication-assisted treatment (MAT). SUD treatment also should be offered in non-specialty settings such as primary care.
- MACPAC's review of state Medicaid coverage for SUD treatment services shows that only 12 states pay for the full continuum of clinical services, which includes MAT, outpatient treatment and residential treatment at varying degrees of intensity.
- The largest gaps in state clinical service coverage are for partial hospitalization and residential treatment. This creates a barrier to critical treatment for individuals with life-threatening withdrawal potential.
- Although the institutions for mental diseases (IMD) exclusion is often cited as a barrier to paying for residential services, states may currently pay for these services under some conditions through Section 1115 demonstrations and managed care.
- Twenty-three states have sought federal approval for Section 1115 demonstrations to implement comprehensive strategies to improve SUD care. Others have neither taken advantage of this opportunity nor used other Medicaid authorities to reduce gaps in the continuum of care.
- An inadequate supply of SUD treatment facilities and low provider participation rates in Medicaid also affect access to treatment:
  - Roughly 40 percent of counties do not have an outpatient SUD treatment program. Gaps are more pronounced for partial hospitalization and short-term residential treatment, with less than 15 percent of providers offering these services.
  - About 6 in 10 specialty SUD treatment facilities accept Medicaid, but there is wide variation among states, with Medicaid participation as low as 29 percent.
- In some states, Medicaid payment rates are low; paying for certain levels of care may do little to improve access. Rates must be set at a sufficient level to attract a supply of providers.
- Early results from Section 1115 SUD demonstrations in California and Virginia indicate that implementing comprehensive strategies that include covering additional services and undertaking efforts to attract new providers can improve access to SUD treatment.

CHAPTER 4: Access to Substance Use Disorder Treatment in Medicaid

The opioid epidemic continues to ravage families and communities across the country. In 2016, drug overdose deaths in the United States increased by 21.4 percent over the previous year, with nearly two-thirds of these deaths involving opioids obtained by prescription, illicitly, or in some cases both (Vivolo-Kantor et al. 2018).

Medicaid beneficiaries have been disproportionately affected by the opioid epidemic, accounting for roughly half of all opioid-related overdose deaths in some states (McMullen 2016, Sharp and Melnik 2015, Whitmire and Adams 2010, CDC 2009). Compared to privately insured individuals, Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder (OUD) and are prescribed pain relievers more often than individuals with other sources of insurance. The introduction of cheaper, more potent opioid alternatives, such as fentanyl, to the illicit drug supply has also resulted in a higher risk of overdose for Medicaid beneficiaries (MACPAC 2017a).

State Medicaid programs are using a variety of approaches to respond to the opioid crisis, but Medicaid beneficiaries continue to face barriers when trying to access substance use disorder (SUD) treatment. As MACPAC noted in the June 2017 report to Congress, access to care may be impeded by factors ranging from fears about the stigma of having an SUD to a fragmented and poorly funded delivery system. Medicaid-participating providers and practitioners trained in providing medication-assisted treatment (MAT) remain in short supply, and gaps in the continuum of care persist (MACPAC 2017a). Federal regulations meant to protect the privacy of individuals with SUDs have also been cited as a potential impediment to care coordination; further work and recommendations on this topic can be found in Chapter 2 of this report.

An effective SUD treatment system provides access to a continuum of care, but gaps in the continuum often limit access to treatment. Ensuring access to care requires that services are covered, that they are affordable to the beneficiary, and that they are designed to meet the unique needs of the population. Providers must also be available to provide appropriate care when needed (MACPAC 2011). The delivery system must have an adequate supply of providers located where patients are, and these providers must also be willing to participate in the Medicaid program and accept new patients. All of these components are important to beneficiaries' ability to obtain timely access to treatment.

In this chapter, the Commission extends its analysis of the care delivery system for Medicaid beneficiaries with OUDs, using industry standards for evidence-based care to characterize the SUD continuum of care. We note that as of April 2018, only 12 states cover a full continuum of care. While policymakers have focused on the role played by the Medicaid payment exclusion for institutions for mental diseases (IMD) in creating gaps in residential SUD services, the IMD exclusion is not the only reason gaps in coverage exist. Many states do not take advantage of the various legal authorities available to them, such as the state plan rehabilitation option and the health home option, to expand their SUD treatment benefit. These policy choices reflect a variety of factors, including budgetary constraints.

In this chapter, MACPAC also notes that many states have a limited supply of SUD providers, especially in rural areas. This includes both specialty SUD treatment facilities and practitioners certified to prescribe drugs used to treat OUD. While opportunities to seek Section 1115 SUD demonstrations have created momentum in certain states to create a more comprehensive approach to SUD treatment that focuses on both covered services and the availability of providers, to date, only 23 states have sought this authority.

The chapter begins with a discussion of the components of an SUD continuum of care. These components include both clinical and non-clinical services that address short-term needs, including withdrawal services, as well as services that

support long-term recovery for those with an SUD. It then details Medicaid's coverage of these services and describes the availability of SUD treatment providers, including their participation rates in Medicaid. The chapter describes opportunities available to states to develop an SUD delivery system and highlights the early progress two states are making under Section 1115 SUD demonstrations. Although this analysis focuses on the treatment of OUD, the continuum of care, as well as many of the concerns described here, apply to treatment of other SUDs such as those associated with cocaine and methamphetamines, that continue to trouble many communities.

The chapter concludes by identifying areas for further study. The Commission has already begun work to assess state coverage of recovery support services for Medicaid beneficiaries with an SUD. MACPAC is also interested in further exploring the availability of MAT to Medicaid beneficiaries; and analyzing access to SUD services for certain populations such as older adults, parents or prospective parents, individuals involved in the criminal justice system, and adolescents with an SUD.

Components of a Substance Use Disorder Continuum of Care

Providing access to treatment services along a continuum of care is important for effective treatment and an individual's continued recovery. Because the severity of an individual's SUD influences the type and intensity of services needed, a continuum of care that offers progressive clinical treatment, such as outpatient services and MAT, and non-clinical supports, such as recovery services, is needed. These services enable individuals to manage their SUDs over an extended period of time as their treatment needs change (Mee-Lee et al. 2013). For example, an individual with multiple comorbid SUDs, such as alcohol, benzodiazepines, and opioids, is more likely to need inpatient or medically monitored residential levels of care to safely address withdrawal management. For an individual with OUD alone, however, withdrawal management and transition to maintenance medications can often be safely and effectively addressed in an outpatient setting (Olsen 2018). Compared to residential environments, outpatient environments allow sustained connections to support systems, including interactions with family, spouses, children, and others. Receiving treatment in an outpatient environment can also allow individuals to keep their jobs.

Clinical services

For this report, the Commission selected criteria developed by the American Society of Addiction Medicine (ASAM) as a framework to analyze coverage of SUD treatment services. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions, including service planning, placement, continued stay, transfer, and discharge decisions (ASAM 2014).[1] These guidelines are referenced by both private and public payers to determine medical necessity for treatment. In addition, the Centers for Medicare & Medicaid Services (CMS) requires states applying for Section 1115 SUD demonstrations to use either the ASAM criteria or similar nationally recognized guidelines. The majority of states also require Substance Abuse and Mental Health Administration (SAMHSA) block grant-funded providers to use the ASAM criteria when determining a patient's treatment needs (Grogan et al. 2016).

Appropriate SUD treatment can differ depending on the severity of an individual's disorder, co-occurring mental health conditions, treatment goals, and other factors, such as readiness to change and relapse potential. Accordingly, the ASAM criteria identify five broad levels of service across the SUD treatment continuum: early intervention, outpatient treatment, intensive outpatient services or partial hospitalization, residential inpatient services, and medically managed intensive inpatient services.

Within the five broad levels, there are additional gradations, resulting in nine discrete levels of care that each have specific treatment and provider requirements (Table 4-1). Each of these nine levels of care reflects differing degrees of service intensity that correspond to a specific service. For example, within ASAM level 2.0, there are two discrete levels of outpatient care that range from 9 or more hours of service per week in an intensive outpatient program (ASAM level 2.1) to 20 or more hours of service per week in a partial hospitalization program (ASAM level 2.5). At both levels, services may include family therapy, group counseling, medication management, and other strategies to engage patients in their recovery process.

The ASAM criteria also define a multidimensional assessment framework that assists providers in creating a patient's individualized treatment plan and identifying the clinically appropriate level of care for that individual.[2] To ensure appropriate patient placement, states with approved Section 1115 SUD demonstrations must require providers to use a patient placement assessment tool, such as one based on the ASAM criteria framework, to assess an individual's treatment needs.

TABLE 4-1. Summary of the American Society of Addiction Medicine Criteria Levels of Care for Adults T 4-1

ASAM level of care		Functional limitations of individual
0.5 Early intervention		
0.5 Early intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder.	None or minimal.
1.0 Outpatient services		
1.0 Outpatient services	Fewer than nine hours of service per week for recovery or motivational enhancement therapies or strategies.	Needs motivating and monitoring strategies to support recovery.
2.0 Intensive outpatient services/partial hospitalization		
2.1 Intensive outpatient services	Nine or more hours of service per week to treat multidimensional instability.	Minimal risk of severe withdrawal. Mild emotional, behavioral, or cognitive complications. Has variable engagement in treatment.
2.5 Partial hospitalization	Twenty or more hours of service per week for multidimensional instability not requiring 24-hour care.	Moderate risk of severe withdrawal. Mild to moderate emotional, behavioral, or cognitive complications. Has poor engagement in treatment.
3.0 Residential inpatient services		
3.1 Clinically managed low-intensity residential services	Twenty-four-hour structure with available trained personnel; at least five hours of clinical service per week or as step-down from more intensive care.	No withdrawal risk or minimal or stable withdrawal. Problems in the application of recovery skills, self-efficacy, or lack of connection to the community systems of work, education, or family life.

TABLE 4-1. (continued)

ASAM level of care		Functional limitations of individual
3.3 Clinically managed population-specific high-intensity residential services	Twenty-four-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.	At minimal risk of severe withdrawal. Limitations are primarily related to cognitive impairment, which can be either temporary or permanent. Limitations may result in problems in interpersonal relationships, emotional coping skills, or comprehension.
3.5 Clinically managed high-intensity residential services	Twenty-four-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.	At minimal risk of severe withdrawal. Multiple limitations, which may include criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.
3.7 Medically monitored intensive inpatient services	Twenty-four-hour nursing care with physician availability for significant problems in acute intoxication, withdrawal potential, or both; biomedical conditions and complications; above symptoms may or may not be accompanied by emotional, behavioral, or cognitive conditions and complications. Counselor availability 16 hours per day.	At high risk of withdrawal. Subacute biomedical and emotional, behavioral, or cognitive problems.
4.0 Medically managed intensive inpatient services		
4.0 Medically managed intensive inpatient services	Twenty-four-hour nursing care and daily physician care for severe, unstable problems in acute intoxication, withdrawal potential, or both; biomedical conditions and complications; above symptoms may or may not be accompanied by emotional, behavioral, or cognitive conditions and complications. Counseling available to engage patient in treatment.	At high risk of withdrawal. Acute biomedical and emotional, behavioral, or cognitive problems.

Note: ASAM is American Society of Addiction Medicine. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. For a full description of the levels of care, see *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (https://www.asam.org/resources/the-asam-criteria/text).

Source: Mee-Lee et al. 2013.

Application to individuals eligible for Medicaid. The ASAM criteria can be used to determine the level of care needed by adults and adolescents regardless of insurance status. They also take into account the unique needs of subpopulations that are often covered by Medicaid, including adults age 65 and older who are dually eligible for Medicaid and Medicare; parents or prospective parents, including pregnant women; and individuals in the criminal justice system, a traditionally uninsured population that now may be eligible for Medicaid coverage upon release in states that adopted the Medicaid expansion to the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (Box 4-1).

BOX 4-1. Application of the American Society of Addiction Medicine Criteria: Select Adult Populations

Older adults. The American Society of Addiction Medicine (ASAM) criteria note that older adults are more likely to struggle with social isolation, which can hinder their recovery process, and describe additional services older adults may need for recovery support. For example, twelve-step programs may alleviate their isolation issues. Older adults are also more likely than the general population to have chronic health conditions that require multiple medications. Often those drugs can interact with medications used to treat opioid use disorder. Finally, extra attention to discharge planning may be needed to link individuals to aging services or other community supports, particularly if they are caring for an aging partner.

Parents or prospective parents. The ASAM criteria identify additional considerations for this subpopulation. In many instances, parents or prospective parents with a substance use disorder (SUD) may need therapy that includes family members. For example, additional counseling may need to be arranged for a parenting couple or for extended family members, including a non-custodial parent. Sometimes concurrent treatment with the parent and child is necessary.

According to the ASAM criteria, the accepted standard of care is to provide opioid-addicted pregnant women access to medication-assisted treatment (MAT). Such treatment can stabilize the pregnant woman and protect the fetus from episodes of withdrawal. When initiating MAT, providers must counsel the woman regarding neonatal abstinence syndrome and ensure connections to prenatal care.

The ASAM criteria also recommend helping connect patients to supportive relationships and services early in treatment, including supportive family members and public programs like Temporary Assistance for Needy Families (TANF). Navigating these services can be overwhelming for parents or prospective parents and, for individuals leaving inpatient treatment, connections to these services before discharge are critical to continued recovery.

Individuals involved in the criminal justice system. The ASAM criteria acknowledge that the objectives of public safety and desirable clinical outcomes may not always align with an individual's treatment needs. The court system often mandates specific levels of care, such as residential treatment. This typically occurs due to a misconception that residential treatment is superior to other levels of SUD care. The court system may also mandate specific lengths of stay for populations involved in the criminal justice system. However, fixed lengths of stay are not person-centric and do not account for the individual's specific treatment needs.

BOX 4-1. (continued)

Therapy may need to be further personalized for this population to address the behaviors that are related to their criminal offenses. If an individual relapses while participating in community-based, court-ordered treatment, conducting a multidimensional assessment and intensifying the level of clinical services needed for an individual may be warranted in lieu of incarceration. Additional support may be needed to reintegrate the individual in the community during the transition from a prison or jail setting. Support might include referrals to safe housing resources, job readiness training, and employment services.

Notes: ASAM is American Society of Addiction Medicine. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. For a full description of the criteria, see *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (https://www.asam.org/resources/the-asam-criteria/text). For individuals involved in the criminal justice system, mandated treatment times required by the court system may conflict with medical necessity standards for payers, including state Medicaid programs and managed care organizations. In some instances, court-mandated treatment may also prohibit certain treatment modalities, specifically medication-assisted treatment.

Source: Mee-Lee et al. 2013.

Although the ASAM criteria mention additional factors that providers may need to consider when initiating treatment for an individual from one of these special populations, other variables may also inform treatment needs. The ASAM criteria recommend that a multidimensional assessment be conducted to account for the distinct needs of the individual. For example, parents may need to receive outpatient rather than residential treatment to remain connected to their community so they can maintain employment or remain in contact with children, extended family, or other individuals or organizations in their support system.

Treatment progression. As individuals move through the continuum, appropriate transitions between levels of treatment are important for ensuring continuity of care. In general, a patient with a severe SUD should stay engaged for at least one year in the treatment process; this may involve participation in three to four different programs or services with varying intensities. A typical progression for an individual with a severe SUD, where withdrawal potential is life-threatening, might start with three to seven days in a medically managed withdrawal program followed by a period of intensive 24-hour care in a residential treatment program. Care could continue after discharge from residential treatment, first in an intensive outpatient program that meets two to five days a week for a few months and then in a traditional outpatient program that meets less frequently. Such an approach would be responsive to patients' changing needs as they gradually develop the ability to self-manage their SUDs. For patients whose living situations are not conducive to recovery, outpatient services may need to be provided in conjunction with non-clinical services such as housing (OSG 2016). It is important to note that recovery is not always linear and individuals often move from less intensive to more intensive settings during their recovery.

Variation in Medicaid SUD Coverage by State

Medicaid's role in the coverage and financing of SUD treatment varies considerably across states. Nearly all state Medicaid programs offer some form of SUD services; however, most do not cover all of

the levels of care described in the ASAM criteria for adults age 21–64. The largest gaps in coverage exist for residential SUD treatment (Appendix 4A-1). In part, this may be attributable to the IMD exclusion, especially in states where the majority of residential treatment facilities are considered IMDs. (A detailed discussion of the IMD exclusion occurs later in this chapter.)

Coverage gaps also exist at other levels of care, even where there are no federal Medicaid policy barriers that affect a state's ability to pay for a given service (Appendix 4A-1). Many SUD services are optional under the Medicaid statute, and states may opt not to cover these for a variety of reasons. For example, gaps in coverage of partial hospitalization may reflect state policies designed to mirror those of Medicare. In other cases, state Medicaid programs may deliberately choose not to cover services available to beneficiaries through the use of non-Medicaid funding sources. State Medicaid programs often work with other agencies, such as the single state substance use authority that receives block grants for prevention, treatment, and recovery support from SAMHSA to ensure that block grant funding complements Medicaid-financed care.

In addition, the services that are provided to Medicaid beneficiaries vary among Medicaid eligibility groups. In states that expanded Medicaid to the new adult group, these beneficiaries are entitled to coverage of 10 essential health benefits, including SUD treatment services (CMS 2017a).[3] For children enrolled in Medicaid, states must pay for SUD treatment when it is medically necessary, as required by the early and periodic screening, diagnostic, and treatment (EPSDT) benefit.[4] Although coverage for behavioral health services such as SUD treatment is not mandatory in separate CHIP, as of 2013, nearly all states covered some form of outpatient and inpatient SUD treatment (MACPAC 2015, Cardwell et al. 2014).

To determine whether states offer a full SUD continuum of care, the Commission used the ASAM criteria and the levels of care it describes as a framework. Specifically, the Commission reviewed state documentation including Medicaid state plans, provider manuals, enrollee handbooks, fee schedules, Section 1115 SUD demonstrations, and other publicly available materials to independently align service descriptions with the ASAM levels of care. In instances where publicly available information was insufficient to determine coverage, MACPAC contacted states directly. MACPAC's categorization of state-level coverage approximates the closest level of care described by the ASAM criteria.[5]

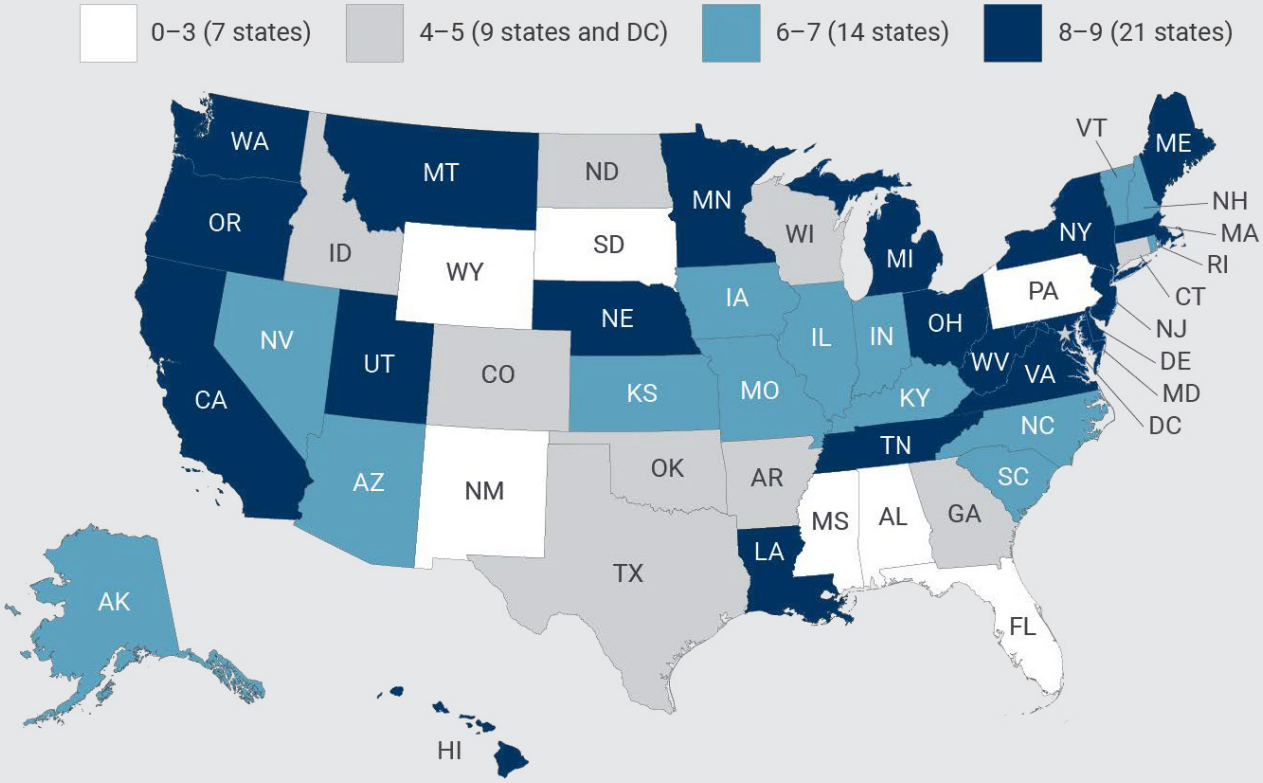
Our analysis found that most states have gaps in SUD coverage, covering on average just six of the nine levels of care described by the ASAM criteria (Figure 4-1). Nearly half of states (24) provide four to seven levels of care. Seven states cover up to three levels of care. Only 12 states offer the full continuum of care, that is, each of the nine ASAM levels of care (Appendix 4A-1).

Gaps in care can be categorized by the number of services covered in a given state. Of the seven states that offer zero to three services, none pay for residential SUD treatment. Most also do not pay for early intervention (ASAM level 0.5), intensive outpatient services (ASAM level 2.1), or partial hospitalization services (ASAM level 2.5). In many instances, these states only pay for outpatient services (ASAM level 1.0) and medically managed intensive inpatient treatment (ASAM level 4.0), creating substantial gaps in the continuum.

Nine states and the District of Columbia pay for four to five services. All of them pay for outpatient services (ASAM level 1.0), and all but one state pays for early intervention (ASAM level 0.5). Only two states do not pay for intensive outpatient treatment (ASAM level 2.1). Most of these states do not pay for partial hospitalization (ASAM level 2.5) and five pay for only one of the levels of care for residential SUD treatment identified by the ASAM criteria.

Fourteen states cover six to seven services and all of them pay for outpatient services (ASAM level 1.0). Only one state does not pay for early intervention (ASAM level 0.5) and intensive

FIGURE 4-1. State Medicaid Program Coverage of American Society of Addiction Medicine Criteria Levels of Care, 2018



Notes: ASAM is American Society of Addiction Medicine. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. For a full description of the levels of care, see *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (https://www.asam.org/resources/the-asam-criteria/text). Estimate of the number of states covering services in the ASAM criteria levels of care is based on MACPAC's analysis of coverage under state plan authority and approved Section 1115 substance use disorder (SUD) demonstrations. Many state Medicaid agencies do not use the ASAM criteria to determine SUD treatment coverage or require providers to use them for patient assessment purposes. For residential treatment services, states use a variety of terms to describe coverage. For the purposes of this analysis, states providing low-intensity or long-term residential treatment were classified as covering ASAM level 3.1; those providing medium-intensity residential SUD treatment were classified as covering ASAM level 3.5; and states covering high-intensity or short-term residential treatment were classified as providing ASAM level 3.7.

Sources: MACPAC, 2018, analysis of Medicaid state plan and Section 1115 demonstration coverage. Mee-Lee et al. 2013.

outpatient services (ASAM level 2.1). The majority of these states pay for partial hospitalization (ASAM level 2.5). Most of these states also pay for at least two of the levels of care defined by ASAM that are considered residential SUD treatment (ASAM level 3.0).

Coverage of residential treatment and the IMD exclusion

The largest coverage gaps in the continuum of care are for intensive outpatient or partial hospitalization (ASAM level 2.0) and residential treatment (ASAM level 3.0). Most states (43 states and the District of Columbia) pay for intensive outpatient services (ASAM level 2.1); however, partial hospitalization

(ASAM level 2.5) is covered in only 33 states. Thirty-eight states and the District of Columbia cover at least one level of residential SUD care described by the ASAM criteria. Seventeen states cover all four residential levels of care. Sixteen states and the District of Columbia pay for two or three services. Five states pay for just one level of residential SUD care.

Identifying gaps in coverage for residential treatment is of particular interest given that Medicaid programs are not allowed to receive federal payment for inpatient care provided to individuals age 21–64 who are patients in an IMD. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The Medicaid IMD exclusion is one of the few instances in the Medicaid program in which federal financial participation (FFP) is not available for medically necessary and otherwise covered services for certain Medicaid beneficiaries receiving treatment in a specific setting.

Although the IMD exclusion applies to residential SUD treatment facilities of more than 16 beds, states can still pay for residential SUD treatment for this population in facilities with 16 beds or fewer. In fact, many states that pay for residential SUD services do so in facilities of this size. Nevertheless, in 2015, CMS recognized that the IMD exclusion was acting as a barrier to accessing SUD treatment in these settings and offered states two pathways to pay for IMD stays under certain circumstances: as an in-lieu-of service in managed care settings and through Section 1115 demonstrations.[6]

Managed care. Under current managed care regulations, states may receive FFP for capitation payments made on behalf of an enrollee age 21–64 who is receiving inpatient treatment in an IMD for a short-term stay of no more than 15 days during the period of the monthly capitation payment, so long as the facility is a hospital providing SUD inpatient care or a subacute care facility providing SUD crisis residential services. The 15-day limit was selected based on multiple data sources and to ensure that during the month in which a capitation payment is made, beneficiaries are eligible to receive services in the community (CMS 2016). This regulation does not extend to states that provide SUD services in a fee-for-service delivery system or non-risk-based managed care arrangements.

Although some states have welcomed the opportunity to provide crisis residential SUD services in IMDs for the limited time period allowed, other states view the 15-day limit as too rigid.[7] Prior to the issuance of the current managed care regulations in 2016, managed care organizations (MCOs) had historically used in-lieu-of services to pay Medicaid benefits in alternate settings without day limits. CMS estimates that in 2010, approximately 17 states were using the in-lieu-of provision to pay for services in IMDs and another 9 states were potentially using this provision (GAO 2017). Thus, when the 15-day limit was imposed, some states viewed this action as more restrictive. Some stakeholders have further criticized the 15-day limit as being arbitrary and not meeting the needs of individuals with an SUD.

CMS has advised that Medicaid managed care plans should not be used to pay for services for which coverage and payment are prohibited by Medicaid statute (CMS 2016). Absent a change in statute, it is unclear if federal regulations could be further revised to pay for IMD services for longer periods of time. In an ideal environment, Medicaid MCOs would implement day limits for residential SUD services that reflect what is medically necessary. CMS advised that Section 1115 demonstrations are available to states seeking to provide services beyond the 15-day limit.

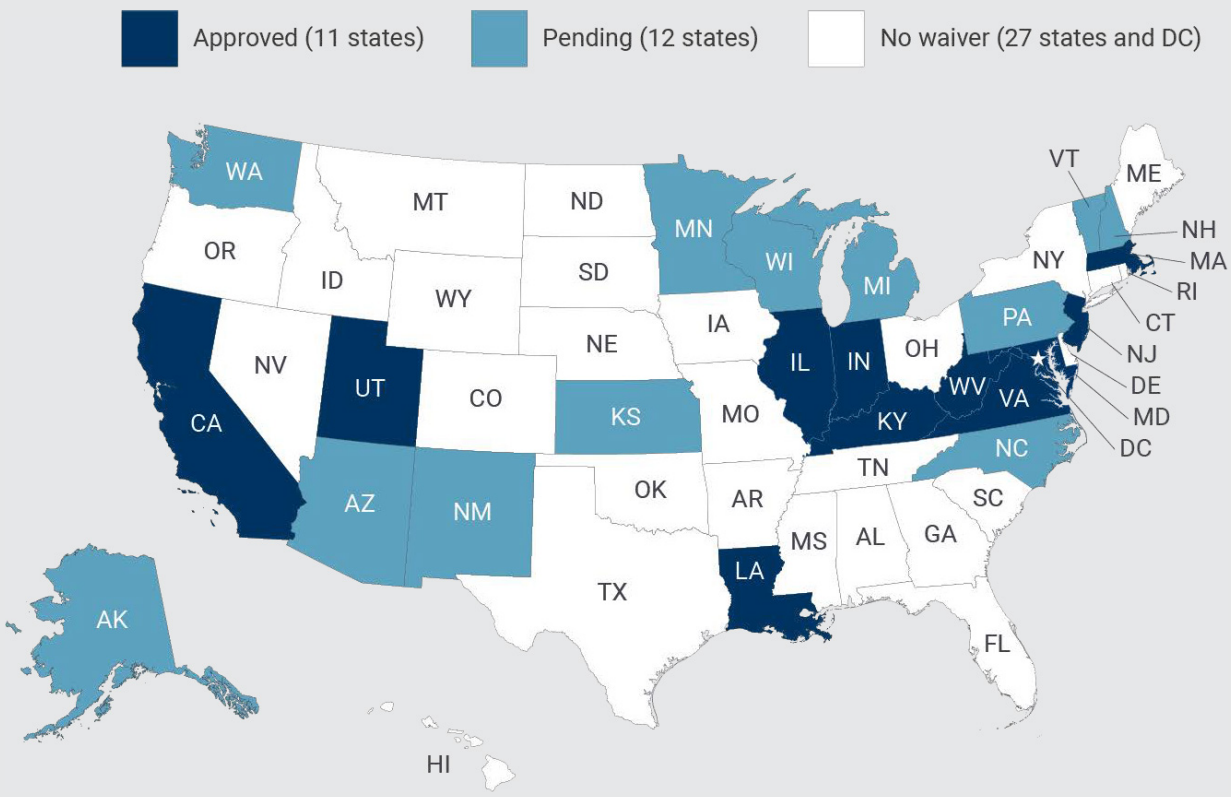
Section 1115 demonstrations. In July 2015, CMS issued guidance allowing states to receive FFP for SUD care in IMDs under a Section 1115 demonstration, if they could demonstrate that residential service providers meet the ASAM criteria (CMS 2015). On November 1, 2017, CMS sent a letter to state Medicaid directors outlining a number

of changes to the policy (discussed later in this chapter) (CMS 2017c).

To date, 23 states have sought authority via Section 1115 to provide residential SUD treatment in IMDs (Figure 4-2). In addition to paying for services in IMDs, some states are undertaking broader delivery system reforms. California, Maryland, Virginia, and West Virginia have approved demonstrations under the 2015 guidance. Massachusetts also has an approved demonstration under that guidance and an additional amendment to further expand their authority is pending approval. Illinois, Indiana, Kentucky, Louisiana, New Jersey, and Utah have received approval under the 2017 guidance, and West Virginia agreed to meet the reporting and evaluation requirements under the new guidance. Several states—Alaska, Arizona, Kansas, Michigan, New Hampshire, New Mexico, North Carolina, Pennsylvania, Vermont, Washington, and Wisconsin—have pending Section 1115 applications or amendments seeking similar demonstration authority (CMS 2018).

Demonstration design components vary, with some states instituting day limits for IMD stays under approved and pending Section 1115 demonstrations. Generally, states have to maintain an average length of stay of 30 days. Of the 23 approved or pending demonstrations, more than half do not have explicit day limits in their special terms and conditions or demonstration

FIGURE 4-2. States with Approved or Pending Section 1115 Substance Use Disorder Medicaid Demonstrations, 2018



Note: This map reflects states with approved or pending Section 1115 substance use disorder demonstrations as of May 23, 2018.

Source: MACPAC, 2018, analysis of Section 1115 substance use disorder Medicaid demonstrations (CMS 2018).

applications. Day limits in states that do have explicit day limits in their approved demonstrations range from 30- to 90-day stays. In Massachusetts, the average length of stay in SUD treatment for individuals admitted to residential programs (ASAM levels 3.1, 3.5, and 3.7) during state fiscal year 2015 was 16.1 days (CMS 2017b). In comparison, California has reported the majority (56.2 percent) of residential treatment admissions resulted in lengths of stay of 30 days or longer (Urada et al. 2017). It may be difficult for states to determine an appropriate length of stay for residential SUD treatment because there is limited information on the association between specific lengths of stay and therapeutic gains, and about whether individuals with OUD have better treatment results in residential settings than in outpatient settings. The ASAM criteria acknowledge that further research is needed to predict typical lengths of stay for residential SUD treatment.

Medicaid coverage of medication-assisted treatment

For individuals who have an OUD, current evidence-based guidelines recommend the use of MAT, which combines medication with counseling, behavioral therapies, and recovery support services (VA/DoD 2015, ASAM 2015).[8] The use of MAT was described in detail in MACPAC's June 2017 report (MACPAC 2017a).

Much of the policy discussion about MAT has focused on state policies for drug coverage, specifically, the coverage of the three medications approved to treat OUD: buprenorphine, methadone, and naltrexone. However, drug coverage must be evaluated in combination with the treatment settings paid for by state Medicaid programs. In many instances, the setting MAT is delivered in, such as an opioid treatment program (OTP) or primary care office, is as important as the medication selected to treat an individual.

Payment for OUD medications. Although prescription drug coverage is not a federally mandated Medicaid benefit, all states and the District of Columbia offer this benefit, which includes some coverage of medications used to treat SUD. Currently, all states and the District of Columbia pay for buprenorphine and 48 states and the District of Columbia pay for naltrexone. States are not required to pay for methadone in the treatment of OUD; however, 37 states and the District of Columbia cover methadone treatment services in Medicaid (Appendix 4A, Table 4A-1) (KFF 2018).

MAT treatment settings. Depending on a patient's individual needs, MAT can be used at many levels of care defined by the ASAM criteria. Each of the levels of care corresponds to treatment services that include counseling and therapy, and the intensity of those treatment services varies at each level of care. A partial hospitalization or residential SUD program could have a physician on-site to prescribe buprenorphine or naltrexone as a complement to the intensity of therapy the individual is receiving. In some instances, a program could also obtain certification to function as an OTP.[9]

OTPs provide an appropriate setting for individuals who require a structured environment and daily interaction with their treatment providers. In accordance with federal law, OTPs are the only setting in which methadone can be dispensed for the treatment of OUD, and they must be certified and regulated by SAMHSA (Bagalman 2015). OTPs, in addition to offering daily, supervised dosing of methadone, are increasingly offering buprenorphine. OTP services must also include clinically appropriate counseling and therapy. If states choose not to pay for OTP services, Medicaid beneficiaries with OUD will not have access to methadone. (The limited availability of OTPs is discussed later in this chapter.)

MAT can also be provided in a general medical office. Office-based treatment provides medication on a prescribed weekly or monthly basis and is limited to buprenorphine and naltrexone. Federal law requires practitioners prescribing buprenorphine to offer psychosocial counseling, and if that counseling is not available on-site, they must demonstrate that they have the existing referral

relationships to refer patients to counseling (MACPAC 2017a). Practitioners prescribing buprenorphine in general medical settings are also limited in the number of patients to whom they may prescribe.[10]

Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe medication. For practitioners offering naltrexone, there is no federally mandated counseling requirement. However, the ASAM criteria indicate that psychosocial treatment is recommended in conjunction with naltrexone. Office-based treatment with buprenorphine or naltrexone may not be suitable for individuals requiring daily dosing and supervision or for individuals with active alcohol use disorders or those who use sedatives due to potentially deadly drug interactions.

Non-clinical services

Due to the chronic nature of SUDs, individuals may need additional non-clinical services to support their recovery. For instance, an individual's living environment, school, or work situation affects their ability to engage in treatment. Similarly, the support of friendships and social institutions can increase the likelihood of successful recovery. Availability of transportation, child care, and housing also contribute to an individual's recovery environment (Mee-Lee et al. 2013).

Recovery supports are non-clinical services that are used to address an individual's environment and provide emotional and practical support to maintain remission. Individuals who both participate in treatment and take advantage of support services typically have better long-term outcomes than individuals who do only one of these things. Recovery supports are offered through both treatment programs and community organizations and are conducted by trained case managers, recovery coaches, and peers. Supports include peer support, supported employment, mutual aid groups such as 12-step groups, recovery housing, recovery checkups, telephonic case monitoring, and recovery community centers (OSG 2016). Recovery support services may be needed even after clinical services, such as outpatient treatment, end.

In 2015, 14 states covered some form of peer support for SUDs and 9 states and the District of Columbia covered some form of supported employment under state plan authority (MACPAC 2017a). MACPAC is conducting additional research to examine state policies for covering recovery support services, including which populations are eligible for such services, and how coverage of these services complements coverage for the levels of care described by ASAM.

Access to SUD Services in Medicaid

In addition to covering services, a robust delivery system must also ensure that treatment is readily available in an individual's community. Below we describe the availability of treatment in various settings and states, including outpatient, intensive outpatient, partial hospitalization, and residential treatment. The extent to which existing SUD treatment facilities participate in Medicaid is also examined. In general, the supply of these providers is limited, especially in rural areas, and the number of SUD treatment providers accepting Medicaid is low.

Two key factors influence the availability of providers: provider supply and provider participation in Medicaid. Overall, the availability of SUD providers is influenced by the distribution of providers, including the types of services offered by an SUD treatment facility, as well as state policies and providers' responses to those policies (e.g., provider payment, willingness to accept Medicaid, and workforce issues such as scope of practice). Each of these factors is explained in more detail below, including commonly used measures to describe access. Key factors related to provider availability include:

- the number and type of SUD providers in areas where Medicaid beneficiaries reside;

- the number and type of these providers participating in Medicaid;
- the settings used by Medicaid beneficiaries receiving SUD care; and
- policies enacted at the federal and state levels that influence provider participation, such as payment methodologies and how well they work.

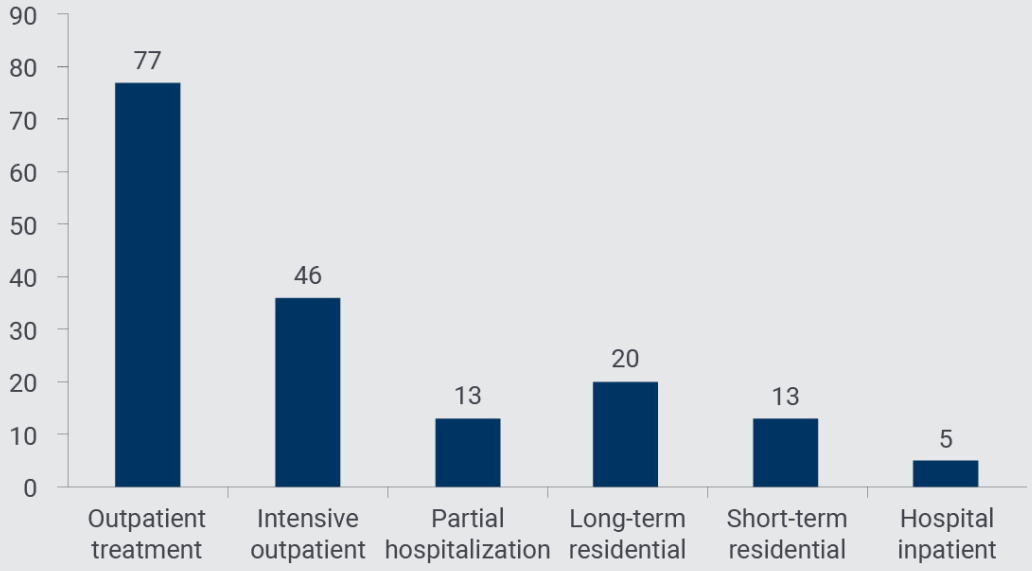
Most individuals receive SUD treatment in outpatient settings and most commonly from specialty SUD treatment providers. However, the supply of these providers, especially for services such as partial hospitalization and residential SUD treatment, is low.

Provider supply

Although no comprehensive source of data on the supply of professionals available to treat individuals with an SUD is available, multiple sources point to a shortage of trained providers (Cummings et al. 2014, OSG 2016, Rosenblatt et al. 2015). In 2016, nearly three-quarters of U.S. counties had severe shortages of psychiatrists and other types of health professionals needed to treat mental health and SUD services (OSG 2016). SUD treatment facilities provide more intense services—such as intensive outpatient services, partial hospitalization, and short-term residential treatment—less often than outpatient services (Figure 4-3). Although the degree to which SUD treatment facilities offer services varies, the majority of SUD treatment facilities provide outpatient services. Partial hospitalization and residential services, which are necessary for people with high withdrawal potential, are offered less frequently than outpatient services.

Little information is available regarding the settings in which Medicaid beneficiaries receive SUD treatment. Data sources not specific to Medicaid suggest that of individuals currently seeking SUD treatment on a given day, the overwhelming majority (91 percent) are receiving services in an outpatient setting; 8 percent receive non-hospital based

FIGURE 4-3. Percentage of Substance Use Disorder Treatment Facilities Offering Certain Services, 2016

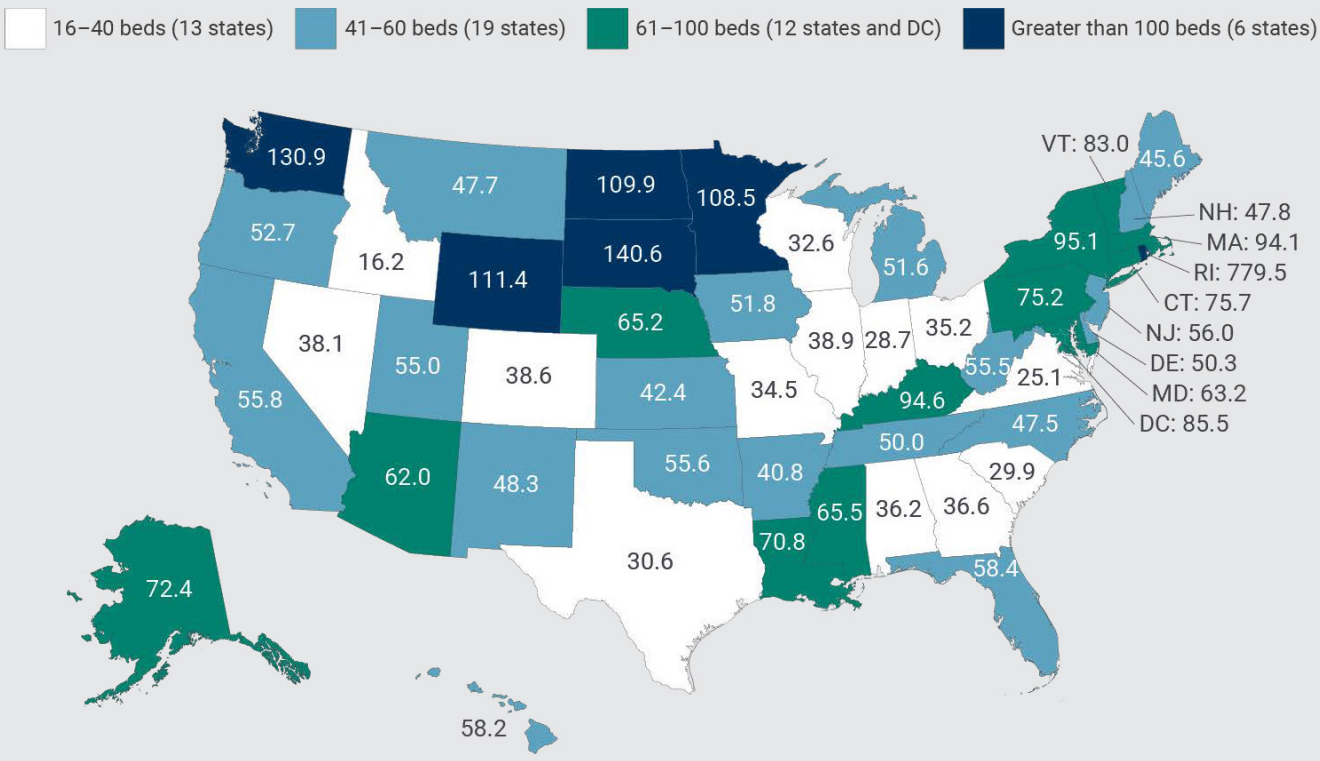


Source: MACPAC, 2018, analysis of SAMHSA 2017.

residential SUD treatment; and 1 percent receive inpatient hospital treatment (SAMHSA 2017).

An August 2017 study by the U.S. Government Accountability Office (GAO) found wide variation in SUD treatment capacity across states, with the number of beds per 100,000 adults ranging from 16.2 in Idaho to 779.5 in Rhode Island in 2015 (Figure 4-4). GAO found that some small facilities maintained waiting lists or turned individuals away when beds were unavailable (GAO 2017).

FIGURE 4-4. Number of Inpatient and Residential Substance Use Disorder Beds per 100,000 Adults by State, 2015



Source: GAO 2017.

For the general population, access to providers offering MAT for OUD is also limited. Only 2.7 percent of specialty SUD facilities report that they offer all three forms of MAT. Eight states do not have any SUD facilities offering all three forms of MAT regardless of payer and 14 states do not have a facility offering all three forms of MAT that also accepts Medicaid (Jones et al. 2018). OTPs are mostly located in urban areas and often require patients to visit daily for on-site administration of methadone, limiting the ability of rural patients to access such treatment (Dick et al. 2015).

In addition, few practitioners are authorized to prescribe buprenorphine. As of 2012, only 18,225 (2.2 percent) of U.S. physicians had obtained the federal waiver necessary to prescribe this medication. Generally, these physicians were concentrated on the East and West Coasts, with limited access in the middle of the country (Rosenblatt et al. 2015). However, the number of

practitioners capable of prescribing buprenorphine has been steadily increasing. As of March 2018, 47,446 practitioners, including physicians, nurse practitioners, and physician assistants, had obtained a waiver to prescribe buprenorphine. Presently, 72 percent of these providers are certified to prescribe buprenorphine to up to 30 patients, 19.3 percent are certified to prescribe to up to 100 patients, and 8.4 percent are certified to prescribe to up to 275 patients (SAMHSA 2018). Although practitioners are certified to prescribe up to a certain number of patients, studies have shown that practitioners generally prescribe well under their current patient limit (Thomas et al. 2017).

Despite limited access to MAT providers in some areas, spending data suggest that MAT is increasingly being used to treat Medicaid beneficiaries for OUD. Between 2011 and 2017 the number of buprenorphine units paid for by Medicaid increased 180 percent, from 51.7 million to 144.9 million units. Between 2011 and 2016, the number of naltrexone units paid for by Medicaid increased 244 percent, from 2.4 million to 8.3 million units. However, it is difficult to attribute increased naltrexone use to the treatment of OUD alone because it is also approved to treat alcohol use disorder (Clemans-Cope and Epstein 2018). Ultimately, additional research is needed to determine if Medicaid beneficiaries are using OTP services, whether there is variation in MAT utilization among state Medicaid programs, and whether Medicaid beneficiaries are accessing the counseling component of MAT.

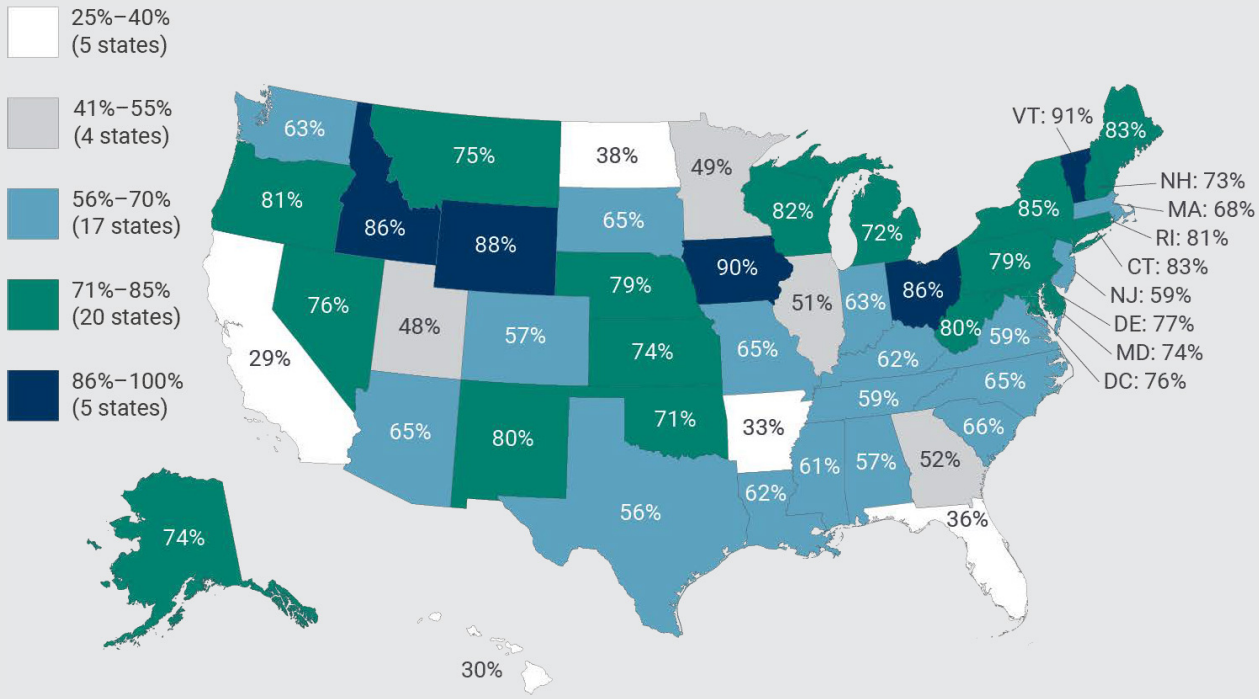
Provider participation

Low SUD provider participation in Medicaid also affects beneficiaries' access to SUD treatment. The SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS) survey data indicate that in 2016, 62 percent of specialty SUD facilities reported accepting Medicaid, which was lower than the acceptance rate for private insurance (68 percent) (SAMHSA 2017).[11] SUD provider participation in Medicaid also varies greatly by state (Figure 4-5). At the state level, specialty SUD provider participation in Medicaid ranges from 29 percent in California to 91 percent in Vermont. One study noted that 60 percent of U.S. counties have at least one outpatient SUD facility that accepts Medicaid, although this rate is lower in many southern and midwestern states. Counties with a higher percentage of black, rural, or uninsured residents are less likely to have one of these facilities (Cummings et al. 2014).

About half of the specialty SUD treatment facilities that offer outpatient treatment participate in Medicaid, but providers of more intensive services are much less likely to be available to Medicaid beneficiaries (Figure 4-6). Facilities may offer services across multiple ASAM levels of care; therefore, the percentage of facilities accepting Medicaid is not necessarily indicative of the percentage of facilities that accept Medicaid payment for a specific level of service. For example, a provider offering two services, partial hospitalization (ASAM level 2.5) and outpatient treatment (ASAM level 1.0), may report accepting Medicaid, but the state Medicaid program may only cover one of the services. Facilities offering partial hospitalization and different intensities of residential services (ASAM level 3.0) accept Medicaid at a lower rate overall.[12]

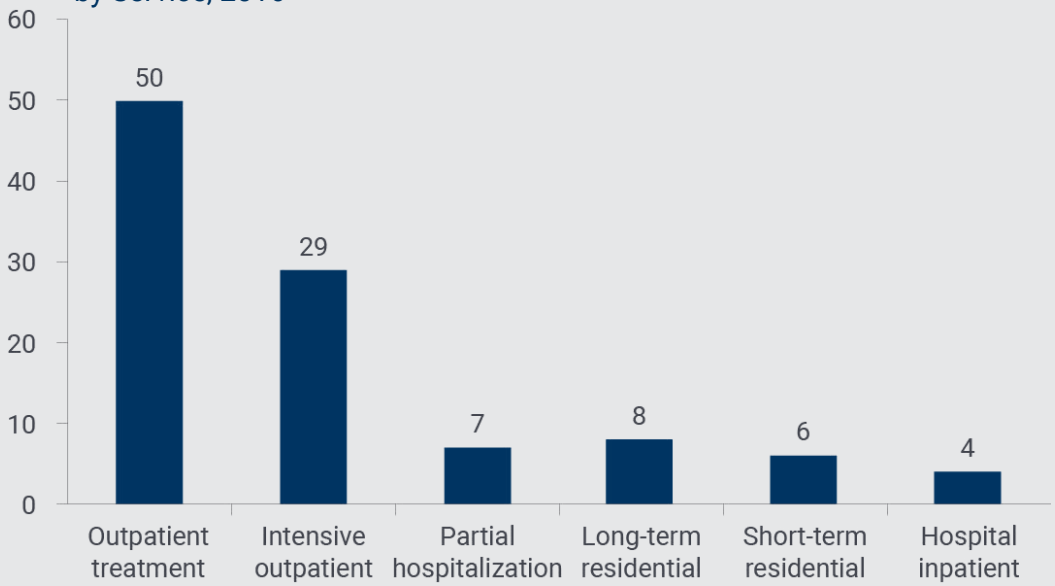
Lower Medicaid participation rates among specialty SUD treatment providers may reflect additional barriers. Different credentialing requirements for Medicaid MCOs may be burdensome for certain providers, who then choose not to participate in Medicaid. In an effort to address these concerns, some states, such as Virginia, have instituted uniform credentialing requirements across all MCOs. Similarly, many SUD treatment providers do not hold the medical licenses required by some payers and traditionally, many of these providers have not contracted with insurers (ASPE 2015, SAMHSA 2012). A 2012 survey also found that many specialty SUD treatment providers did not have adequate information technology systems needed to bill insurers, which posed a challenge to providing care to individuals newly covered under the ACA (Andrews et al. 2015).

FIGURE 4-5. Percentage of Substance Use Disorder Treatment Facilities Accepting Medicaid, by State, 2016



Source: MACPAC, 2018, analysis of SAMHSA 2017.

FIGURE 4-6. Percentage of Substance Use Disorder Treatment Facilities Accepting Medicaid, by Service, 2016



Source: MACPAC, 2018, analysis of SAMHSA 2017.

Although we know that approximately 69 percent of physicians in the United States reported accepting new Medicaid-enrolled patients in 2016, it remains unclear how many physicians, physician assistants, and nurse practitioners who are authorized to prescribe buprenorphine are participating in the Medicaid program (Hing et al. 2015). Additional research is needed to determine the actual availability of buprenorphine-prescribing clinicians to Medicaid beneficiaries.

Opportunities to Improve the SUD Delivery System

MACPAC has previously documented that federal law offers state Medicaid programs several avenues to build or expand their SUD continuum of care (MACPAC 2017a). States can cover all of the levels of care described in the ASAM criteria through their state plan. However, many states do not do so, resulting in gaps in coverage for partial hospitalization and residential treatment in particular. Barriers to care often extend beyond the IMD exclusion.

Section 1115 SUD demonstrations are another option available to states to address gaps. The experience to date of states that are in the early phases of implementing Section 1115 SUD demonstrations indicates that a multipronged strategy can promote the full continuum of care, provide access to specialty SUD providers, and incentivize provider participation in Medicaid (Urada et al. 2017, VDMAS 2018).

Below we discuss recent Section 1115 SUD demonstration guidance and how states are using demonstrations to improve their SUD continuum of care.

Section 1115 SUD demonstration development

Much attention has been paid to the Section 1115 SUD demonstration opportunity because it allows states to pay for treatment in IMD settings. But relief from the IMD exclusion is only one component of such demonstrations. To receive approval and FFP for IMD services, states must develop a comprehensive strategy to improve their SUD delivery system that goes beyond payment for residential treatment. Guidance issued by CMS in November 2017 requires states seeking a demonstration to cover critical levels of care including outpatient, intensive outpatient, MAT, residential, inpatient, and medically supervised withdrawal management. Inpatient and residential SUD care must supplement and coordinate with community-based care that is part of a broader continuum. States must also implement provider requirements and meet stringent reporting requirements (Box 4-2).

As such, many of the Section 1115 demonstrations that have been approved thus far include broad strategies to improve access to and quality of SUD treatment services. California's demonstration requires a strategy to coordinate and integrate across systems of care, and Maryland's demonstration includes a strategy to integrate physical and behavioral health outcomes over the course of the demonstration. Other states, including West Virginia and Kentucky, have Section 1115 demonstrations that expand the use of methadone treatment. Some states, including West Virginia and Massachusetts, are also providing recovery support services such as peer support through their demonstrations.

Section 1115 demonstration findings

Although several demonstrations have been approved by CMS, few have been implemented long enough to be evaluated. Two states—California and Virginia—were early adopters of Section 1115 SUD demonstrations. In addition to offering insight on the provision of residential treatment in IMD settings, these states are taking additional steps, such as capacity building and raising provider rates, to increase the availability of SUD treatment providers.

BOX 4-2. Section 1115 Substance Use Disorder Medicaid Demonstration Requirements, 2017

In November 2017, CMS issued revised guidance outlining parameters for states to obtain a Section 1115 demonstration to pay for short-term inpatient and residential substance use disorder (SUD) treatment services in institutions of mental diseases (IMDs). The 2017 guidance replaced guidance that was issued in July 2015 and requires states to meet the following criteria:

- **Provider capacity.** Within 12 months of approval, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients at the following levels of care: medication-assisted treatment (MAT), outpatient, intensive outpatient, residential, inpatient, and medically supervised withdrawal management.
- **Phased-in provider requirements.** Between 12 and 24 months following demonstration approval, states must ensure that residential providers meet the ASAM criteria or other nationally recognized, evidence-based SUD-specific program standards, and that residential providers offer their patients access to MAT. During the initial implementation period, interim provider qualifications included in the demonstration's special terms and conditions will be used so that states can receive federal financial participation (FFP) as they work toward implementing the national standard.
- **Patient placement criteria.** Between 12 and 24 months following demonstration approval, states must require providers to use an evidenced-based, SUD-specific patient assessment tool. Within 24 months of demonstration approval, states must also ensure that there is an independent utilization management approach that ensures beneficiaries have access to services at the appropriate level of care, that interventions are appropriate for the diagnosis and level of care, and that there is an independent process for reviewing placement in residential settings.
- **Opioid prescribing, naloxone, and prescription drug monitoring.** Throughout the course of the demonstration, states must implement opioid prescribing guidelines and other strategies to prevent opioid abuse. They must also expand coverage of and access to naloxone for overdose reversal. Strategies to increase the use of prescription drug monitoring programs and to improve their functionality are also required.
- **Care coordination strategies.** Between 12 and 24 months following demonstration approval, states must implement policies to ensure that residential and inpatient facilities link beneficiaries, especially those with an OUD, with community-based services and supports following stays in these facilities.
- **Evaluation and reporting.** Through their regular Section 1115 demonstration reports, states are required to include information on performance measures and milestones. CMS is developing a standardized set of reporting requirements and performance measures for these SUD demonstrations, but has not said when they will be finalized and is still determining which measures will be required and which will be optional. However, the agency is expected to draw from existing measures, such as the Medicaid adult core set. Performance measures are tied to demonstration goals, including improved adherence to treatment, and reduced use of emergency department and inpatient hospital settings.

BOX 4-2. (continued)

States must report on progress toward meeting six standardized milestones, some of which must be met within 12 and 24 months of demonstration approval, and some that may be met over the course of the demonstration.[13] States are also required to conduct independent interim and final evaluations that address the milestones, performance measures, and other data. States are subject to a deferral of payment of $5 million per item if they fail to submit an acceptable and timely evaluation design or file required reports in a timely manner.

- **Demonstration approval and FFP.** FFP for services in IMDs is contingent upon CMS approval of each participating state's implementation plan detailing how the state will meet the six milestones; it may be withheld if states do not make adequate progress toward meeting the milestones and goals agreed upon by the state and CMS. States also must be in full compliance with budget neutrality requirements at the end of the demonstration period or CMS will recover the difference from the state. CMS will take achievement of milestones and performance measure targets into consideration if a state requests an extension of its demonstration.

Source: CMS 2017c.

California. CMS approved California's Drug Medi-Cal Organized Delivery System Section 1115 demonstration in August 2015.[14] Through the demonstration, California is restructuring SUD services to operate an organized delivery system that provides a continuum of SUD care that the state has modeled after the ASAM levels of care, facilitates the use of evidence-based practices in SUD treatment, and increases the coordination of SUD treatment with other systems of care.

Prior to approval of California's demonstration, each of the state's 58 counties was responsible for providing Medi-Cal beneficiaries a limited set of SUD treatment services. The services could be offered by the local county health department or, if a county chose not to administer services, by providers who contracted directly with the California Department of Health Care Services. The waiver represents a major change for counties choosing to participate; it requires local jurisdictions to move away from administering services or contracting the administration of block grants and become specialty managed care plans (Hunt and Hamblin 2017). As of March 2018, 40 counties in the state have opted to participate in the demonstration, and 10 of them have already executed contracts.

In addition to offering Medi-Cal beneficiaries coverage for additional SUD services, select counties have undertaken substantial capacity building efforts to set up new providers for certain levels of care (Box 4-3).

Virginia. Elements of Virginia's Section 1115 SUD demonstration were first described by MACPAC in Chapter 2 of the June 2017 report to Congress (MACPAC 2017a). The demonstration included the expansion of SUD treatment benefits to cover the entire continuum of care, which was modeled after the ASAM criteria. In addition, the Commonwealth quadrupled payment for partial hospitalization, intensive outpatient services, and the counseling component of MAT. Virginia also moved SUD services into managed care to promote integration of physical and behavioral health services.

Virginia implemented these benefit expansions on April 1, 2017, and has released evaluation results from the first five months of the demonstration (Box 4-4). It is important to note that expanding

BOX 4-3. Early Results: California's Section 1115 Substance Use Disorder Demonstration, 2017

California's substance use disorder demonstration is being implemented in phases and three counties had fully approved contracts with the state at the end of June 2017. Early evaluation findings were based on stakeholder surveys and interviews that took place between July 1, 2016, and June 30, 2017. The evaluation did not include claims data analysis; however, some data was available from the state's outcomes measurement system. Future analyses will include claims data, which should provide additional insight into the effects of the state's Section 1115 demonstration. Highlights of the existing evaluation include the following:

- **Access to a continuum of care.** Stakeholders reported concerns about the ability to expand the availability of medical detoxification and withdrawal management and residential treatment. They cited provider certification and upfront costs as examples of challenges to capacity expansion, but also noted that barriers to facility certification had been reduced over the previous year.
- **Care transitions.** After release from residential treatment, patients did not typically move along the continuum of care to receive additional treatment. Of all beneficiaries initially admitted to residential treatment in 2016, only 13.4 percent were moving along the continuum of care in a timely manner (e.g., a transfer to another level of care within 14 days).
- **Evidence-based practices.** The majority of counties reported using two of five evidence-based practices listed in the state's Section 1115 demonstration special terms and conditions; however, stakeholders reported that implementing the use of evidence-based practices was challenging.
- **Coordination with other systems of care.** Coordination of services with Medi-Cal managed care plans is a required component for participation in the demonstration. This requires counties to contract with managed care plans. Counties with early participation under the waiver had greater coordination of services than the rest of the state

Source: Urada et al. 2017.

coverage to additional levels of care, including IMD settings, was necessary; Virginia also had to increase payment rates to ensure adequate provider participation. The Commonwealth is still working to attract additional providers in certain parts of Virginia.

Broader implications. After reviewing Section 1115 SUD waiver applications, the Commission notes a number of elements common to states that have obtained demonstration approval to date. In general, these states:

- already pay for the majority of the levels of care modeled after the ASAM criteria;
- pay for certain ASAM levels of care using non-Medicaid funding streams; or
- use the ASAM criteria or another standard within their health care system.

BOX 4-4. Early Results: Virginia's Section 1115 Substance Use Disorder Demonstration, 2017

Virginia's early Section 1115 substance use disorder (SUD) results are derived from the first five months of the demonstration, April–August 2017. The evaluation compares SUD service utilization to the previous calendar year (April–August 2016) and shows a 63 percent increase in the number of Medicaid beneficiaries with an SUD diagnosis receiving any SUD treatment service. The number of beneficiaries with an opioid use disorder (OUD) receiving any OUD service increased by 51 percent. This increased utilization resulted in a $10 million (32 percent) increase in SUD treatment service spending. Emergency department visits related to SUDs declined by 31 percent during the evaluation period; however, total emergency department visits for all Medicaid members decreased over the same time period.

For beneficiaries accessing residential SUD treatment (ASAM levels 3.1, 3.5, and 3.7), including those in IMD settings, the average length of stay was 11.5 days across all residential treatment settings. Additional measures will be included in future reports to CMS, including claims and encounter-based measures that capture whether individuals are continuing in treatment.

Since its Section 1115 SUD demonstration was approved, Virginia has seen a dramatic increase in the number of providers participating in the Medicaid program. For example, the number of residential SUD providers participating in Medicaid increased from 4 to 77. The number of OTPs participating in Medicaid also increased from 6 to 29. However, there are still areas of the state where access to residential SUD treatment remains limited. For an area to be considered accessible there must be at least two providers within 30 miles for urban areas, or within a driving distance of 60 miles for rural areas. Southwest Virginia, an area that has been particularly affected by the opioid epidemic, generally lacks access to residential levels of care.

Source: VDMAS 2018.

Medicaid programs that currently pay for six or more levels of care already pay for at least one level of residential care described by the ASAM criteria. Therefore, they may be better positioned than states paying for fewer levels of care to use a demonstration to pay for SUD treatment in an IMD. Because these states currently pay for at least one level of residential SUD treatment under their state plan, residential SUD providers may already be enrolled with the Medicaid program in their states and participating in managed care networks. This can reduce administrative burdens to expand service capacity, such as those described by California.

Even if states are covering fewer than six levels of care, other factors may enhance their ability to expand coverage of SUD treatment, such as whether they are using state-only funding or federal block grants to offer services along the ASAM continuum of care that are not otherwise paid for by Medicaid. States that already pay for certain levels of care through non-Medicaid funds may be uniquely poised to create a new Medicaid service under a Section 1115 demonstration because there is an existing infrastructure of providers. For example, both Massachusetts and Maryland have expanded treatment under such demonstrations to pay for levels of care that were previously funded by another state agency.

States that currently use the ASAM criteria may also be better positioned to expand services and may be more capable of meeting the provider requirements under CMS Section 1115 demonstration guidance because they will not have to spend additional time and resources on provider education. Many clinicians and programs still struggle to understand the ASAM criteria, as evidenced by providers that advertise as 30-day programs (Mee-Lee et al. 2013). Although the majority of states already require SAMHSA-funded providers to use the ASAM criteria when determining a patient's treatment needs, it appears that additional work is needed to familiarize providers with the criteria. For example, California has sponsored provider training on the ASAM criteria as a part of its Section 1115 SUD demonstration (Urada et al. 2017). CMS also acknowledged this in issuing revised Section 1115 demonstration criteria by allowing for phased-in provider requirements over a two-year period.

Section 1115 SUD demonstrations may also allow an incremental approach to offering the ASAM continuum of care. For example, prior to its demonstration approval, Maryland did not pay for residential SUD treatment for adults. Effective July 1, 2017, the state began paying for residential care modeled after ASAM levels 3.3, 3.5, and 3.7. In January 2019, the state will begin to pay for a level of care meant to meet ASAM level 3.1. West Virginia is also taking an incremental approach: on January 1, 2018, the state began to pay for methadone treatment services, and on July 1, 2018, it will fully implement the demonstration by paying for residential treatment services.

Finally, some states may not seek a Section 1115 SUD demonstration because they can offer a full continuum of care through their state plan. However, even when using state plan authority, states may need to take additional steps to ensure there is access to a continuum of care. For instance, a state may offer coverage, but there may not be an adequate number of specialty SUD facilities to provide care, and low payment rates may deter providers from participating. For these states, increasing Medicaid provider participation might require increasing rates or changing their rate setting methodology to interest existing providers to participate in the Medicaid program. If providers do not exist for a certain level of care, states will have to develop strategies to convince existing providers to expand their service offerings or to attract new providers to the state.

Conclusions

Medicaid plays a critical role in responding to the opioid epidemic. Although much effort has been expended to make federal grant dollars available to states and communities to address different aspects of the opioid epidemic, it is important to note that Medicaid spending on health care services for individuals with OUD is much larger than other federal grants available for states to address the opioid epidemic and has the potential to make a greater impact on the availability of services (Grady et al. 2018).[15]

An effective Medicaid response to the opioid epidemic requires a robust care delivery system. States must pay for the full continuum of care, access to specialty SUD providers must be available, and these providers must participate in Medicaid. Section 1115 SUD demonstrations provide an opportunity for states to comprehensively improve access to clinically appropriate SUD care, but many states have not taken advantage of this opportunity or other Medicaid authorities to reduce gaps in the continuum of care. As evaluation results from Section 1115 SUD demonstrations are made available, lessons learned from states may provide additional insight to states that have yet to expand their SUD Medicaid benefit.

Medicaid's response to the opioid epidemic is limited in several states, in part, due to narrow coverage or payment policies. As noted earlier in the chapter, gaps in coverage are present at several levels of care, not just those that could be explained by the IMD exclusion. These include lack of coverage for partial hospitalization, which offers critical support to individuals who are

ready to receive care in the community, and lack of coverage for methadone treatment in OTPs, a treatment setting necessary for individuals who need the structure of daily dosing to support their recovery. Moreover, while repealing the IMD exclusion could help eliminate barriers to residential treatment, the availability of such resources could also inadvertently divert attention from addressing gaps at outpatient levels of care or result in individuals being placed in institutional settings when they could be more appropriately served in the community.

For many levels of care, especially those that require residential treatment and partial hospitalization, which are covered by fewer state Medicaid programs, there is also a shortage of SUD treatment facilities. This creates additional challenges for beneficiaries when they are trying to access services. Few specialty SUD treatment facilities offer levels of care that support individuals who have higher relapse potential, including intensive outpatient, partial hospitalization, and residential treatment. Even fewer specialty SUD providers accept Medicaid. In some states, Medicaid rates of payment are low, and paying for certain levels of care may do little to improve clinically appropriate access to treatment. Rates must be set at a level to attract a sufficient supply of providers.

Next Steps

In the course of the Commission's work in this area, several key areas for future inquiry have emerged. First, the Commission is interested in better understanding the extent to which states are providing non-clinical SUD treatment services to Medicaid beneficiaries. We expect future work and contracted research projects to focus on identifying coverage of recovery support services at the state level. Next, the Commission is interested in gaining insight into the availability of MAT to Medicaid beneficiaries and the variations in coverage by state, including the coverage of methadone. The degree to which MAT utilization among Medicaid beneficiaries is influenced by preferred drug status and policies that require counseling in combination with office-based therapy is also unknown. A more nuanced understanding of MAT utilization at the state level will help us further assess gaps in treatment. In addition, the Commission is interested in analyzing access to SUD services for special populations identified by ASAM, such as older adults, parents or prospective parents, and individuals involved in the justice system, as well as adolescents with an SUD.

While this report offers numerous findings related to access to levels of care described by the ASAM criteria and medications used to treat OUD, additional work is needed to determine whether these benefits are delivered in systems where behavioral and physical health are integrated. Even when the full continuum of care is paid for, many states deliver SUD treatment services in systems that are not integrated with the rest of the health care system. The Commission is interested in how Medicaid delivery systems, including managed care and fee-for-service programs, affect the identification of the need for SUD treatment and the access to such treatment by Medicaid beneficiaries.

Finally, MACPAC will continue to monitor state efforts to expand their SUD continuum of care through Section 1115 demonstrations and other relevant Medicaid authorities. As approved demonstrations mature, access to demonstration evaluations will help the Commission understand the successes and challenges faced by CMS and states in addressing the opioid epidemic.

Endnotes

[1] ASAM is a non-profit professional medical society dedicated to improving the quality of and access to addiction care. The society represents more than 5,100 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM publishes its clinical guidelines in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* (Mee-Lee et al. 2013). The guidelines were first published in 1991 and have been updated three times, most recently in 2013

(ASAM 2014).

[2] ASAM considers several patient factors when determining placement: intoxication or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use, or continued problem potential; and recovery or living environment (Mee-Lee et al. 2013).

[3] Medicaid beneficiaries in the new adult group are entitled to coverage of SUD treatment services as an essential health benefit; however, coverage of SUD treatment has traditionally been an optional benefit. MACPAC found in its analysis that states that expanded Medicaid generally offered the same SUD benefit not only to the new adult group but to all enrollees regardless of eligibility category.

[4] Under EPSDT, states must provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan (CMS 2013). Children eligible for Medicaid must be provided periodic screenings, known as well-child exams. One required element of this screening is a comprehensive health and developmental history including assessment of physical and mental health development. This includes an age-appropriate mental health and substance use health screening. If, during a routine screening, a provider determines that there may be a need for further assessment, a child should be furnished additional diagnostic and treatment services. The screening may also trigger the need for a further assessment to diagnose or treat a substance use condition.

[5] During this review, MACPAC found that many states use the ASAM criteria within their state plan or other materials as a way to self-describe services. MACPAC also found that some Medicaid agencies do not reference the ASAM criteria, or another standard, to describe SUD treatment coverage. As a result, additional research is needed to determine whether states are consistently applying the ASAM criteria. ASAM is in the process of creating a program that will certify the delivery of addiction care and offer a way to verify that delivery is consistent with the guidelines described in the ASAM criteria.

[6] An in-lieu-of service is one that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service. In August 2017, CMS issued subregulatory guidance on this in-lieu-of provision, noting that states do not need to submit a state plan amendment to provide in-lieu-of IMD services to managed care beneficiaries. CMS also clarified the circumstances under which capitation payments can be made. Specifically, when an IMD stay is more than 15 days but spans across two consecutive months, payments may be made as long as the stay is no more than 15 days in each month. If a beneficiary is a patient in an IMD beyond the allowed 15-day stay in a single month, states may make prorated capitation payments to managed care organizations (MCOs) to cover only the days within the month when the enrollee is not a patient in an IMD (CMS 2016).

[7] Of 39 states that currently operate managed care programs, 26 states reported on the Kaiser Family Foundation's annual budget survey that they planned to use the in-lieu-of provision in fiscal year 2017, 2018, or both years; 5 states said that they would not use this provision; and the response for 8 states could not be categorized clearly. States were also asked whether they believed that the managed care rules allowed them to meet the needs of individuals with SUD and 12 states said they were unsure and 8 states said that it did. The majority of states (19) expressed concern that federal rules do not meet the needs of Medicaid beneficiaries with SUDs and many states said that the 15-day limit was too restrictive (Gifford et al. 2017).

[8] Three medications are approved by the U.S. Food and Drug Administration (FDA) for MAT of alcohol use disorder—acamprosate, disulfiram, and naltrexone (CMS 2014). There are currently no FDA-approved medications to treat addiction to cannabis, cocaine, or methamphetamine (CMS 2014).

[9] Methadone use for treatment of OUD can be provided only in specially designated OTPs certified and regulated by SAMHSA's Center for Substance Abuse Treatment.

[10] Qualifying practitioners must obtain a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver to prescribe buprenorphine in an office-based setting. Qualifying practitioners include physicians, nurse practitioners, and physician assistants. Practitioners who receive a DATA 2000 waiver may treat 30 patients in their first year under the waiver and may increase to 100 patients after one year upon submission of a notice to the Secretary of Health and Human Services. Physicians who have prescribed buprenorphine to

100 patients for at least one year can now apply to increase their patient limits to 275 under new federal regulations.

[11] SAMHSA administers N-SSATS, which, among other things, captures a one-day census across all SUD facilities. N-SSATS is limited to treatment facilities that (1) are licensed, certified, or otherwise approved for inclusion in the Directory by their State Substance Abuse Agencies, and (2) responded to the 2016 N-SSATS. The N-SSATS collects data from institutional providers, not individual providers (SAMHSA 2017).

[12] N-SSATS does not fully align with the levels of care described by the ASAM criteria and sometimes a level of care is used to describe more than one service setting. For example, residential short-term treatment is described by N-SSATS as being similar to ASAM level 3.5; however N-SSATS also uses ASAM level 3.5 to describe hospital inpatient treatment (MACPAC classified it as level 3.7 for its analysis). Residential long-term treatment is described by N-SSATS as being similar to ASAM levels 3.1 or 3.3 (MACPAC classified it as level 3.1).

[13] The six demonstration milestones are: (1) access to critical levels of care for OUD and other SUDs; (2) widespread use of evidence-based, SUD-specific patient placement criteria; (3) use of nationally recognized, evidenced-based SUD program standards to set residential treatment provider qualifications; (4) sufficient provider capacity at each level of care; (5) implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and (6) improved care coordination and transitions between levels of care (CMS 2017c).

[14] California's Medicaid program is called Medi-Cal.

[15] The federal government declared the opioid epidemic a public health emergency and made over $500 million of OUD-targeted funding available to states in 2017. The Bipartisan Budget Act of 2018 (P.L. 15-123) added $3 billion per year in opioid funding to the federal budget for 2018 and 2019; and the President's budget calls for $10 billion to be allotted across multiple agencies to address the opioid crisis. Although this is a substantial amount of funding, program spending for Medicaid beneficiaries with an OUD in 2013 was more than $9 billion. The 2013 spending level does not reflect increased enrollment under the ACA when Medicaid was expanded in many states to cover adults under age 65 with incomes less than or equal to 138 percent of the federal poverty level (Grady et al. 2018).

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APPENDIX 4A: State Coverage of Substance Use Disorder Services

TABLE 4A-1. Medicaid State Plan and Section 1115 Waiver Coverage of Substance Use Disorder Services, April 2018 **T 4A-1**

State	Early intervention (ASAM level 0.5)	Outpatient services (ASAM level 1.0)	Intensive outpatient services (ASAM level 2.1)	Partial hospitalization (ASAM level 2.5)	Clinically managed low-intensity residential services (ASAM Level 3.1)	Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Clinically managed high-intensity residential services (ASAM level 3.5)	Medically monitored intensive inpatient services (ASAM level 3.7)	Medically managed intensive inpatient services (ASAM level 4.0)	Selected medication-assisted treatment therapies		
										Buprenorphine	Methadone	Naltrexone
Total	**44**	**50**	**44**	**33**	**27**	**22**	**34**	**29**	**44**	**51**	**38**	**49**
Alabama	✓	✓	–	–	–	–	–	–	✓	✓	–	✓
Alaska	✓	✓	✓	–	–	✓	–	✓	✓	✓	✓	✓
Arizona	✓	✓	✓	✓	–	–	✓	–	✓	✓	✓	✓
Arkansas	–	✓	✓	–	–	–	✓	–	✓	✓	–	–
California[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	–	–	✓	–	✓	–	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓	–	–	–	–	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
District of Columbia	✓	✓	✓	–	✓	–	✓	–	–	✓	✓	✓
Florida	✓	✓	–	–	–	–	–	–	–	✓	✓	✓
Georgia	✓	✓	✓	–	–	–	–	✓	✓	✓	✓	✓
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho	✓	✓	✓	–	–	–	–	–	✓	✓	–	✓
Illinois[2]	–	✓	✓	✓	–	–	✓	✓	✓	✓	–	–
Indiana	✓	✓	✓	✓	✓	–	✓	–	✓	✓	✓	✓
Iowa	✓	✓	–	–	✓	✓	✓	✓	✓	✓	–	✓
Kansas	✓	✓	✓	–	✓	–	✓	–	✓	✓	✓	✓

TABLE 4A-1. (continued)

State	Early intervention (ASAM level 0.5)	Outpatient services (ASAM level 1.0)	Intensive outpatient services (ASAM level 2.1)	Partial hospitalization (ASAM level 2.5)	Clinically managed low-intensity residential services (ASAM Level 3.1)	Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Clinically managed high-intensity residential services (ASAM level 3.5)	Medically monitored intensive inpatient services (ASAM level 3.7)	Medically managed intensive inpatient services (ASAM level 4.0)	Selected medication-assisted treatment therapies		
										Buprenorphine	Methadone	Naltrexone
Kentucky	✓	✓	✓	✓	✓	–	✓	–	✓	✓	–	✓
Louisiana	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓
Maine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maryland[3]	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Mississippi	–	✓	–	✓	–	–	–	–	✓	✓	✓	✓
Missouri	✓	✓	✓	✓	–	–	–	✓	✓	✓	✓	✓
Montana	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓
Nevada	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓
New Hampshire	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	–	✓	✓	–	–	–	–	–	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina	✓	✓	✓	✓	–	–	✓	✓	✓	✓	✓	✓
North Dakota	✓	✓	✓	✓	–	–	–	–	✓	✓	–	✓
Ohio	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓
Oklahoma	✓	✓	✓	✓	–	–	–	–	✓	✓	✓	✓
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

TABLE 4A-1. (continued)

State	Early intervention (ASAM level 0.5)	Outpatient services (ASAM level 1.0)	Intensive outpatient services (ASAM level 2.1)	Partial hospitalization (ASAM level 2.5)	Clinically managed low-intensity residential services (ASAM Level 3.1)	Clinically managed population-specific high-intensity residential services (ASAM level 3.3)	Clinically managed high-intensity residential services (ASAM level 3.5)	Medically monitored intensive inpatient services (ASAM level 3.7)	Medically managed intensive inpatient services (ASAM level 4.0)	Selected medication-assisted treatment therapies		
										Buprenorphine	Methadone	Naltrexone
Pennsylvania	–	✓	✓	–	–	–	–	–	✓	✓	✓	✓
Rhode Island	✓	✓	✓	✓	✓	–	–	✓	✓	✓	✓	✓
South Carolina	✓	✓	✓	✓	–	–	✓	✓	✓	✓	–	✓
South Dakota	–	–	–	–	–	–	–	–	–	✓	✓	✓
Tennessee	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓
Texas	✓	✓	–	–	–	–	✓	–	✓	✓	–	✓
Utah	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vermont	✓	✓	✓	✓	✓	–	–	✓	–	✓	✓	✓
Virginia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
West Virginia	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wisconsin	✓	✓	✓	–	–	–	–	–	✓	✓	✓	✓
Wyoming	✓	✓	✓	–	–	–	–	–	–	✓	–	✓

Notes: ASAM is American Society of Addiction Medicine. The ASAM criteria comprise a set of guidelines for assessing and making treatment decisions for individuals with addiction and co-occurring conditions. The criteria describe nine discrete levels of care, each with specific treatment and provider requirements. (For a full description of the levels of care, see Mee-Lee et al. 2013.) Estimates of the number of states covering services in the ASAM levels of care are based on MACPAC's analysis of coverage under state plan authority and approved Section 1115 substance use disorder (SUD) demonstrations. In instances where publicly available information was insufficient to determine coverage, MACPAC contacted states directly. The Commission's analysis does not account for additional states that may be utilizing the in-lieu-of provision to provide access to IMD levels of care. Many state Medicaid agencies do not use the ASAM Criteria to determine SUD treatment coverage or require provider use for patient assessment purposes. For residential treatment services, states use a variety of terms to describe coverage. For the purposes of MACPAC's analysis, states that indicate that they provide low-intensity or long-term residential treatment were classified as covering ASAM level 3.1; those providing medium-intensity residential SUD treatment were classified as covering ASAM level 3.5; and states covering high-intensity or short-term residential treatment were classified as providing ASAM level 3.7.

TABLE 4A-1. (continued)

✓ Indicates that a state provides services in this category.

– Indicates that a state does not provide services in this category.

[1] California's Medicaid program operates on a county-by-county basis. Services listed here are those approved in its Section 1115 Drug Medi-Cal waiver. Services may vary at the county or plan level.

[2] Illinois has approval to pay for short-term residential treatment in IMDs through its Section 1115 Behavioral Health Transformation demonstration; however the special terms and conditions of the waiver do not identify levels of care used by ASAM. Therefore, information on coverage is drawn from the state's Section 1115 demonstration application.

[3] Maryland has approval to pay for ASAM level 3.1 through its Section 1115 HealthChoice waiver; however it does not have the authority to pay for such services until July 1, 2019.

Sources: For levels of care: MACPAC, 2018, analysis of Medicaid state plan and Section 1115 coverage; Mee-Lee et al. 2013, *The ASAM Criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions*, third edition, Carson City, NV: The Change Companies. For medication-assisted treatment coverage: MACPAC, 2018, analysis of Section 1115 waivers and materials from Kaiser Family Foundation (KFF). 2018. Medicaid's role in addressing the opioid epidemic. Infographic, February 27, 2018. Washington, DC: KFF. https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.