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Expanding Access to Addiction Treatment Services through Section 1115 Waivers for Substance Use Disorders: Experiences From Virginia and Maryland

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Executive Summary

In response to the nation's opioid epidemic, an increasing number of states are applying for and receiving Medicaid Section 1115 demonstration waivers for substance use disorders. The Centers for Medicare and Medicaid Services (CMS) created this opportunity under the authority of section 1115(a) of the Social Security Act for states to draw down federal Medicaid payments for facilities with greater than 16 beds that provide short-term residential treatment, which are otherwise prohibited through the Institution for Mental Disease (IMD) exclusion. Waiving the IMD exclusion allows states to offer short-term residential treatment, thereby offering the entire continuum of addiction treatment services to their Medicaid members based on widely accepted standards for evidence-based care.

The purpose of this report is to describe the experiences of two early adopters of IMD waivers, Maryland and Virginia, in terms of their implementation and impact on the addiction treatment system for Medicaid members. The two states differed markedly in terms of the availability of residential services for substance use disorders prior to the waiver, as well as the objectives of the waiver. While Maryland had a robust state-funded delivery system in place prior to the waiver, Virginia combined its waiver with a comprehensive reform and expansion of addiction treatment services – the Addiction and Recovery Treatment Services (ARTS) program. Based on interviews with 26 state officials, providers, and health plans in the two states along with analysis of quantitative data from the Medicaid Outcomes Distributed Research Network, the report includes the following major findings:

- **Both states expanded access to residential treatment services.** The waivers have expanded access to residential treatment services to Medicaid members with substance use disorders in both states, especially in Virginia where few Medicaid members had access to such services prior to the waiver. Nevertheless, few new providers have opened since the waiver, and overall capacity has not changed.
- **Maryland reported higher utilization of residential treatment services.** Utilization of residential treatment services is considerably higher in Maryland compared to Virginia. Among members with substance use disorders, 8.6 percent of members in Maryland used residential treatment services in 2018, compared to 2.2 percent of Virginia members. The average number of days in treatment was also higher in Maryland – 21.2 days per person with a stay compared to 18.5 days in Virginia. Length of stay was likely even higher in Maryland as the state often funds stays beyond the waiver limit of 30 days.
- **Maryland's higher utilization of residential treatment services is likely due to the existence of a more robust service delivery system prior to waiver implementation.** Higher utilization of residential treatment services in Maryland likely reflects a number of factors, including greater availability and coverage of such services prior to the waiver, a greater number of treatment facilities, and ongoing state support for residential treatment services beyond the limits specified in the waiver. Almost all Virginia providers interviewed for the study (and many in Maryland) reported that there were shortages of residential treatment providers, including waiting lists and patients having to travel long distances to obtain such services.
- **Virginia experienced greater increases in initiation and engagement in treatment after waiver implementation.** While overall access to addiction treatment services tended to be higher among Medicaid members in Maryland, access has increased to a greater extent in Virginia likely due to the ARTS program in addition to the IMD waiver. For example, the percent of Maryland Medicaid members with opioid use disorder who initiated and engaged with treatment increased from 36.4 percent to 37.4 percent between 2016 and 2018. In Virginia, initiating and engaging in treatment increased from 6.8 percent to 26.4 percent during the same time period.
- **Rates of use of medications for opioid use disorder (MOUD) treatment in Virginia are now comparable to rates in Maryland.** Both states are promoting the use of evidence-based MOUD treatment along the entire continuum of care. Rates of MOUD treatment doubled among Medicaid members in Virginia between 2016 and 2018 (from 32 to 63 percent) and are now comparable to MOUD treatment rates among Medicaid members in Maryland.
- **Acceptance of MOUD treatment has increased, but resistance persists in some sectors.** MOUD treatment remains controversial among some providers, patients, and other sectors of society. Although pockets of resistance remain, respondents report greater acceptance of evidenced-based MOUD treatment and less stigma among providers, law enforcement, the courts, and other community organizations since the waivers were enacted.
- **In both states, the addiction treatment system remains largely fragmented, with little or no coordination across providers and settings of care.** While Medicaid programs in both states now cover the entire continuum of addiction treatment services based on American Society of Addiction Medicine guidelines, respondents in both states report that transitions to community-

based care following discharge from residential treatment remain a problem. Lack of communication and information-sharing between providers, waiting lists for services in some locations, and lack of patient motivation to continue treatment were cited as the major barriers to follow-up. In general, the addiction treatment system remains largely fragmented in many communities, with little or no coordination in service delivery between providers offering different levels of care.

The results highlight that IMD waiver states have different starting points with respect to coverage of addiction treatment services and the delivery system infrastructure, which will affect waiver implementation and ultimate impact. In particular, states with less robust coverage and delivery systems prior to waiver implementation will require more extensive preparations, outreach, and provider trainings on the part of state agencies, as was the case in Virginia. While waivers may expand Medicaid access to existing residential treatment facilities in the short-term, increasing overall system capacity is a longer-term challenge.

Introduction

State Medicaid programs play a leading role in addressing the nation's opioid epidemic, covering nearly four in 10 people with opioid use disorders.^{1,2} Self-reported prevalence of opioid dependence or abuse is more than four times higher among Medicaid members compared to those with private insurance, and similar to prevalence for the uninsured.³ In response, states are taking a number of actions both to prevent addiction and to improve access to and quality of treatment services.⁴

An increasing number of states have applied for and received Medicaid Section 1115 waivers for substance use disorder (SUD) treatment from the Centers for Medicare and Medicaid Services (CMS). A central goal of these waivers is to allow states to receive matching federal Medicaid payments for services at short-term residential treatment facilities that fall under the definition of an Institution for Mental Disease (IMD). Otherwise, states are generally prohibited through the IMD* exclusion from using federal funds to pay for residential or institutional care in such facilities with more than 16 beds.⁵ As of February 2020, CMS had approved IMD SUD waivers for 27 states, while five were pending and more state applications were in process.⁶

State Medicaid programs are seeking IMD waivers because residential treatment and medically managed intensive inpatient services are considered essential components of the continuum of addiction treatment services, as defined by the American Society of Addiction Medicine (ASAM).⁷ ASAM criteria are widely used in determining patient placement and include:

- Medically managed intensive inpatient services (ASAM level 4)
- Residential treatment services (ASAM level 3)
- Intensive outpatient and partial hospitalization services (ASAM level 2)
- Outpatient services (ASAM level 1)
- Early intervention (ASAM level 0.5)

IMD waivers allow federal Medicaid payments for ASAM level 3 services. For some states, these waivers build on prior Medicaid reforms that increased coverage and access to addiction treatment services. For other states, waivers have been combined with—among other reforms—expanded coverage of treatment services, increased provider reimbursement, and quality improvement efforts.⁸

Objectives

The purpose of this report is to describe the experiences of two states—Maryland and Virginia—in implementing IMD waivers for their Medicaid programs. Both Maryland and Virginia were early adopters of IMD waivers, with Virginia implementing their waiver in April 2017, and Maryland in July 2017. However, the two states differ markedly in terms of addiction treatment services available to Medicaid members prior to the waiver. Maryland had a more robust delivery system in place to provide residential services, and had been incrementally expanding coverage and access to treatment services prior to the waiver. By contrast, IMD and other addiction treatment services were much less available to Virginia Medicaid members prior to the waiver. As a consequence, Virginia's IMD waiver was part of a major reform and expansion of addiction treatment services for Medicaid members, while Maryland's waiver essentially completed reforms that had begun much earlier.

Based on the perspective of state officials, providers, and health plans, this report compares and contrasts the two states' experiences in implementing their IMD waivers, the impact of the waivers on the supply and utilization of IMD and other addiction treatment services, and the impact on the addiction treatment system for Medicaid members overall.

* An Institution for Mental Disease is defined in statute 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, including medical attention, nursing care, and related services.” See: 42 U.S.C. § 1396d (i)

Methodology

This report is based on the results of semi-structured interviews with state officials, addiction treatment providers, and health plans in Maryland and Virginia between February and May of 2019. Addiction treatment providers interviewed include IMD providers – primarily residential treatment providers – as well as intensive outpatient and outpatient providers. A total of 26 interviews were conducted. To assess how the waivers and other Medicaid reforms affected the “system” of treatment services in local communities, interviews with addiction treatment providers were concentrated in three communities: Baltimore, MD; Richmond, VA; and Roanoke, VA.

Major topics included goals of the waiver; processes and challenges encountered in waiver implementation; provider recruiting and training efforts; impact of the waivers on IMD access and utilization; perceptions of the adequacy of IMD supply and utilization; the impact on other addiction treatment providers and utilization of these providers; and changes in the amount of stigma and resistance to medications for opioid use disorder (MOUD) treatment among providers, patients, and others in the community.

Interviews were conducted in-person and by telephone. All interviews were recorded and transcribed, and responses from each interview were summarized and categorized based on the major questions of interest in the study. A synthesis of responses and major themes was initially developed independently for Maryland and Virginia. The findings and conclusions in this report reflect an analysis of similarities and differences between Maryland and Virginia in the major themes and experiences with their IMD waivers.

Changes in the number of specialized addiction treatment facilities in the two states between 2016 and 2018 – and the number of facilities accepting Medicaid payment – was based on the National Survey of Substance Abuse Treatment Services (N-SSATS), a census of treatment facilities conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA).⁹ Differences in utilization of IMD facilities between Maryland and Virginia were assessed based on analysis of Medicaid claims data from Virginia and Maryland.

Changes in access to addiction treatment services after waiver implementation were assessed based on analysis from the Medicaid Outcomes Distributed Research Network (MODRN), a collaborative effort to analyze data across 11 states to facilitate learning

among Medicaid agencies, and to profile the opioid epidemic among the Medicaid population.¹⁰ To facilitate cross-state comparisons, MODRN employs a common data model to standardize estimates of opioid use disorder (OUD) prevalence, treatment, and quality of care derived from state Medicaid claims and enrollment data.

Quantitative analysis of the utilization of addiction treatment services compares Maryland and Virginia between 2016 and 2018 (covering the years before and after IMD implementation). Because Virginia did not expand Medicaid under the Affordable Care Act until 2019, separate estimates for non-expansion members in Maryland are provided in order to enhance comparability with Virginia estimates.

Background on IMD Waivers in Maryland and Virginia

Both states sought IMD waivers to permit federal Medicaid payments for residential and inpatient facilities. The primary purpose of seeking IMD waiver approval in Maryland and Virginia was to permit federal Medicaid payments for residential and inpatient facilities. In general, 1115 waiver applications allow federal Medicaid payments for otherwise non-reimbursable services or allow states to waive program rules. The Secretary of Health and Human Services has broad authority to approve 1115 waiver applications, as long as they further the goals of the Medicaid program.

Both Maryland and Virginia applied for their IMD waivers under 2015 guidance from CMS. Most waivers approved under this guidance included specific day limits, although Virginia had this requirement removed during a renewal process. Waivers approved under subsequent 2017 guidance usually do not have specific day limits. Additionally, states applying under the 2015 guidance were expected to ensure coordination with and support for community-based services.¹¹

In both states, coverage of addiction treatment services was similar prior to the waivers (see Appendix Table 1). Neither state provided coverage for residential treatment services (ASAM level 3) with the exception that pregnant women and adolescents eligible for early and periodic screening, diagnosis, and treatment (EPSDT)* services were eligible for clinically managed high intensity residential services (ASAM level 3.5) in Virginia. Adolescents in Maryland were also covered for certain ASAM level 3 services in an IMD setting prior to the waiver, and all Maryland Medicaid members were covered for level 4 services provided in inpatient hospital settings.**

* EPSDT is a comprehensive benefit for children under age 21 enrolled in Medicaid, which provides medically necessary services “needed to correct and ameliorate health conditions.” See: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

** Prior to the waiver, Maryland covered level 4 services in inpatient settings, so long as the facility was not considered an IMD.

Virginia Medicaid members relied primarily on 40 Community Services Boards (CSBs) for behavioral health services, funded through a combination of state and federal grants. CSBs could refer Medicaid members and uninsured patients for inpatient detoxification and residential treatment services. However, funding for such services was not viewed as adequate to support a robust delivery system for medically indigent people, and many treatment providers were not incentivized to accept such patients unless they were able to pay out-of-pocket.

By contrast, Maryland had a robust system of care in place prior to the waiver. In response to a 2012 budget requirement, the Maryland Department of Health convened several workgroups “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues.”¹² The Department worked with stakeholders to develop a model for integrated behavioral health service delivery and financing reform. On January 1, 2015, SUD services were carved out of the benefit package offered by Medicaid managed care organizations (MCOs) and services were delivered through a behavioral health administrative services organization (ASO). In administering the Public Behavioral Health System (PBHS), the ASO provided Medicaid covered services for Medicaid members, as well as certain behavioral health services for eligible uninsured and underinsured individuals. Non-Medicaid services, such as residential care, were authorized and paid for by local authorities using state and federal grant dollars.

Additionally, Maryland had previously made broader incremental changes to Medicaid as well as to SUD coverage. Using 1115 waiver authority, Maryland provided a limited primary care and pharmacy benefit to childless adults with incomes up to 116 percent of the federal poverty level through the Primary Adult Care (PAC) program beginning in 2006. Beginning January 2010, Maryland expanded the PAC benefit to include outpatient substance use disorder treatment. At the same time, Maryland Medicaid increased reimbursement to SUD providers to improve overall access to care and expanded its self-referral policy to allow Medicaid enrollees to select a SUD provider even if the provider did not have a contract with the enrollee’s MCO.

The Virginia IMD waiver was combined with a comprehensive reform of addiction treatment services covered by Medicaid.

Virginia received approval for its IMD waiver in December 2016, which was implemented in April 2017. Included in the waiver application was the Addiction and Recovery Treatment Services program (ARTS), a comprehensive reform of addiction treatment services for the Medicaid program. ARTS, passed by the Virginia General Assembly and signed into law by Governor Terry McAu-

liffe in 2016, was key to obtaining CMS approval of the waiver. It allowed the state to meet one of the key conditions required by CMS for approval, which is providing a “comprehensive continuum of care based on industry standard patient placement criteria.”¹³

In addition to adding coverage for IMD services, ARTS substantially increased reimbursement rates for these and other addiction treatment services, such as partial hospitalization and intensive outpatient services. To improve quality and reduce fragmentation of addiction treatment services, ARTS created Preferred Office-Based Opioid Treatment providers (OBOTs) with co-located buprenorphine prescribers and behavioral health clinicians. OBOT providers also received enhanced payments for MOUD treatment and care coordination services. Reforms enacted through ARTS included the use of ASAM criteria for determining patient placement along the continuum of care, and an emphasis on evidence-based MOUD treatment.

Maryland’s IMD waiver was implemented independent of previous behavioral health reforms. Maryland received approval for its IMD waiver in December 2016, which was implemented in July 2017. At that time, most residential SUD services—ASAM levels 3.7WM, 3.7, 3.5, and 3.3—became covered. Level 3.1 services were covered effective January 1, 2019. This waiver allowed the state to receive federal Medicaid dollars for services that were previously provided through a combination of state and federal grant dollars through the Public Behavioral Health System. Maryland subsequently received approval in March 2019 to add coverage for ASAM level 4.0 services in an IMD setting for individuals with a primary SUD diagnosis and a secondary mental health diagnosis (previously these services were covered only in inpatient hospital settings).

Unlike Virginia, Maryland did not enact other major reforms to Medicaid addiction treatment services along with the waiver. Prior to the waiver, the ASO had been utilizing ASAM medical necessity criteria to determine placement. However, the waiver did introduce ASAM requirements around staffing levels.

Virginia’s behavioral health reforms can be characterized as a “carve-in” model whereas Maryland opted for a “carve-out” model. To improve the integration of physical and behavioral health services, the Virginia ARTS program changed how behavioral health services are delivered and paid for—from a “carve-out” model in which services were carved out from MCOs and covered by Medicaid or a contracted behavioral health services administrator, to a “carve-in” model in which six statewide MCOs receive capitated payments to deliver both

behavioral and physical health services to Medicaid members.* MCOs are responsible for forming networks of addiction treatment providers across the ASAM continuum, approving service authorizations for residential treatment, and receiving and paying for claims for treatment services.

By contrast, Maryland transitioned to a full behavioral health “carve-out” system in 2015 (mental health benefits were previously carved out, but not SUD benefits). A primary purpose of the carve-out was to unify the authorization process, regardless of funding source, as well as to increase access to services. All specialty behavioral health care benefits are administered by an ASO, although provision of behavioral health services provided within the context of primary care are still the responsibility of MCOs. Additionally, MCOs are responsible for the medical component of inpatient stays related to behavioral health conditions.

The ASO in Maryland is also responsible for managing the overall Public Behavioral Health System, which, in addition to Medicaid members, provides services to certain uninsured and underinsured individuals. The ASO applies ASAM standards to determine medical necessity for service authorizations and administers both Medicaid covered services and other state and federally funded services. As a result of this arrangement, the ASO handles authorizations for the Medicaid enrollee’s entire stay, which may extend beyond the 30-day limit covered by Medicaid. Finally, while MCOs in Virginia are paid capitated rates and therefore are at financial risk for the cost of services, the ASO in Maryland does not incur financial risk.

IMD Waiver Implementation

Interagency cooperation was crucial for successful implementation. In Virginia, three state agencies are involved in publicly funded addiction treatment services: the Department of Medical Assistance Services (DMAS, the state Medicaid agency), the Department of Behavioral Health and Developmental Services (DBHDS), and the Virginia Department of Health (VDH). To ensure smooth implementation, DMAS convened a stakeholder group that included DBHDS, VDH, the MCOs, and a number of addiction treatment providers. This group met weekly to determine the national criteria to use in developing services, licensing and credentialing standards, and reimbursement rates. State officials reported that having a dedicated staff working on the ARTS program across state agencies, providers, and MCOs was viewed as crucial for successful implementation.

Virginia also received assistance from the CMS Medicaid Innovation Accelerator Program (IAP), which provides technical support for state Medicaid programs addressing SUD treatment and other services. The IAP connected Virginia agencies to other waiver states to learn about their experiences in SUD implementation, such as measuring length of stay for residential stays. Maryland received technical assistance from CMS, but not through the IAP. They held bi-weekly calls—or more frequently as needed—with subject matter experts, with much of the discussion focused on evaluation design and staffing requirements.

In general, both states reported no major problems with implementation of residential treatment services. Maryland delayed implementation of ASAM level 3.1 services (clinically managed low-intensity residential services) to January 1, 2019 due to concerns about being able to attract enough providers and to ensure that necessary quality oversight and monitoring mechanisms were in place. Although Virginia implemented ASAM level 3.1 services along with other ASAM 3 level services, some facilities experienced longer delays in getting licensed by the state to provide level 3.1 services, as the state needed to change licensing regulations in order to align with ASAM 3.1 services.

Licensing and credentialing of IMD facilities did not pose major barriers to residential treatment providers. In Virginia, facilities must be licensed by the state (through the DBHDS Office of Licensing) and credentialed by the MCOs in order to be part of MCO networks and to receive Medicaid reimbursement. At the time of implementation, state licensing specialists were directed to make substance use providers a priority in assessing applications.

There was also considerable effort in Virginia to get providers pre-certified for MCOs in order to facilitate the building of provider networks, including using private vendors to assist providers with certification for specific ASAM 3 levels. As licensing regulations did not align with ASAM levels of care for residential treatment services, DBHDS constructed a crosswalk between ASAM levels and license type to assist providers with determining the appropriate license for which to apply. In general, the length of time to obtain licenses, ASAM certification, and credentials was about four months. Some providers reported that obtaining a license for ASAM level 3.1 services took longer, although there was disagreement as to whether this reflected delays on the part of DBHDS or incomplete information on applications submitted by some providers.

* A behavioral health carve-out refers to an arrangement whereby Medicaid managed care organizations are generally not responsible or involved in managing or approving behavioral health services. The opposite is true of a carve-in.

Table 1. Reimbursement rates for selected services after IMD waiver implementation.

Selected SUD treatment services ¹	Maryland	Virginia ²
Medically monitored intensive inpatient (3.7)	\$291.65 per day	393.50 per day
Clinically managed high intensity residential (3.5)	\$189.44 per day	\$393.50 per day
Clinically managed population-specific residential (3.3)	\$189.44 per day	\$393.50 per day
Clinically managed low intensity residential (3.1)	\$85 per day	\$175 per day
Room and board (Level 3; state-only dollars)	\$45.84 per day ³	Included with per diem
Partial hospitalization (2.5)	\$139.98 per day	\$500 per day
Intensive outpatient services (2.1)	\$134.60 per day	\$250 per day
Outpatient services (1.0)	Individual: \$21.54 per 15 min Group: \$42.00 per 60-90 min session	\$72 per visit ⁴

1. Any applicable professional fees are separate and not included.

2. Room and board is included in Virginia's rates.

3. Maryland reimburses room and board separately because it is not Medicaid reimbursable; state-only funds must be used.

4. Rate for evaluation and management, which varies by specific code.

In Maryland, facilities are licensed by the Behavioral Health Administration (BHA). As a precondition for the issuance of a license, facilities must be accredited by an organization approved by the Maryland Department of Health, such as the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. As behavioral health services are carved out to a single ASO, there was no further credentialing of facilities. Meeting the licensing requirements for staffing was somewhat challenging for smaller facilities, which required some flexibility on the part of the state in setting these standards. For example, they granted smaller facilities proportionately lower staffing levels than larger facilities.

Both states prioritized efforts to increase provider participation.

Because of the comprehensive reforms through ARTS, Virginia invested significant effort prior to waiver implementation in building relationships with providers and conducting training sessions on the ASAM standards of care and ARTS billing requirements. State representatives met personally with executives of residential treatment facilities and other providers to discuss Medicaid participation. More than 400 addiction treatment practitioners were trained on ASAM, using “Train for Change”, an ASAM-approved trainer.¹⁴ VDH trained an additional 850 providers in Addiction Disease Management.

In Virginia, recruiting providers to accept Medicaid payment was described as requiring a “cultural shift” because many addiction treatment providers were cash-based prior to the waiver (that is, they did not bill insurance companies), including short-term residential treatment providers. Setting up billing systems and training staff on how to bill or authorize services for addiction treatment was a significant challenge for both providers and the MCOs, who also had little prior experience with behavioral health services.

In Maryland, provider participation required less of a cultural shift. Providers were largely familiar with the billing and authorization processes of the ASO. BHA also held stakeholder meetings which

included technical assistance regarding IMD provider requirements. In addition, a residential quality of care technical assistance workgroup was recently established to provide peer sharing and learning for level 3.1 providers. Coverage of ancillary services for the treatment of pregnant women with children and individuals in court-ordered treatment—such as reimbursement for completing reports and providing transportation of patients to court—were also viewed as important to gaining provider participation.

Providers in both states agreed that the reimbursement rates set for residential treatment were either adequate or had improved substantially over what they were prior to the waiver (see Table 1). Higher rates for IMD services were especially important for Virginia, given the lack of such services prior to the waiver and that many providers were previously “cash-based” and did not accept insurance of any type.

Virginia MCOs who were new to providing behavioral health services experienced challenges. Some providers reported significant problems with submitting claims, denied claims, and delays in obtaining reimbursement for services. Some providers reported delays in receiving authorization for residential treatment services, sometimes resulting in delays in treatment. The high administrative costs for processing billing and prior authorization requests were also cited as a challenge, requiring as many as four hours of administrative staff time per day in the estimate of one provider.

Problems with billing and service authorization have improved over time as MCOs and providers gained greater experience in providing services and standardizing the process. In addition, most providers believed that the care coordination benefits of having MCOs administer both behavioral and physical health services were beneficial to patients despite the complexity of working with six different MCO entities instead of a single “carve-out” organization. Providers in Maryland tend to prefer having a single authorization entity.

Impact of Waiver on Utilization and Supply of Residential Treatment Services

There are substantially more specialty treatment facilities in Maryland than in Virginia, though the number of facilities accepting Medicaid payment grew the most in Virginia. Data from the National Survey of Substance Abuse Treatment Services (N-SSATS) show that Maryland had 402 substance use treatment facilities of all types in 2016 compared to 229 facilities in Virginia (see Figure 1). Moreover, 299 facilities in Maryland accepted Medicaid payment compared to just 94 facilities in Virginia, a three-fold difference. The N-SSATS survey also shows that Maryland had twice as many residential facilities in 2016 (74) than did Virginia (37 facilities).

The difference in the number of facilities is even greater when differences in prevalence of substance use disorders is considered. Although the prevalence rate of substance use disorders was similar in the two states based on self-reported data (7.7 percent in Maryland compared to 7.4 percent in Virginia), the overall prevalence of substance use disorders is higher in Virginia (520,000 individuals) compared to Maryland (388,000), reflecting the larger overall population in Virginia (findings not shown).¹⁵

There was only a small increase in the total number of facilities in both states by 2018, following implementation of the IMD waiver. However, the number of facilities in Virginia accepting Medicaid

payment increased from 94 in 2016 to 166 in 2018 (a 77 percent increase), consistent with the expansion of SUD Medicaid coverage and increases in reimbursement rates. The increase in facilities that accept Medicaid payment was somewhat smaller in Maryland, from 299 facilities in 2016 to 326 facilities in 2018, a 9 percent increase.

State officials in Maryland report that in addition to an increase in the number of residential treatment providers serving Medicaid patients, existing providers are adding capacity. In addition, facilities are now allowed to operate at full capacity, whereas prior to the waiver, there were caps on the number of beds they could operate. Nevertheless, state respondents report that there are still waiting lists for residential treatment services, especially for pregnant women. Expanding residential capacity for pregnant women is currently a priority for the state.

State officials in Virginia also confirmed that the ARTS program increased the number of residential treatment programs serving Medicaid patients (there were 88 such programs as of September 2019), although there has been little or no increase in new capacity for residential treatment services since the waiver. Residential capacity could increase in the future as higher reimbursement rates change perceptions about the financial viability of these services. For example, Pinnacle Treatment Centers—a private provider operating in five states—has opened outpatient and intensive outpatient treatment centers in Virginia following the ARTS program, although they have yet to open a residential treatment facility.

Figure 1. Maryland has more specialty treatment facilities overall, but the number of facilities accepting Medicaid payment increased the most in Virginia.

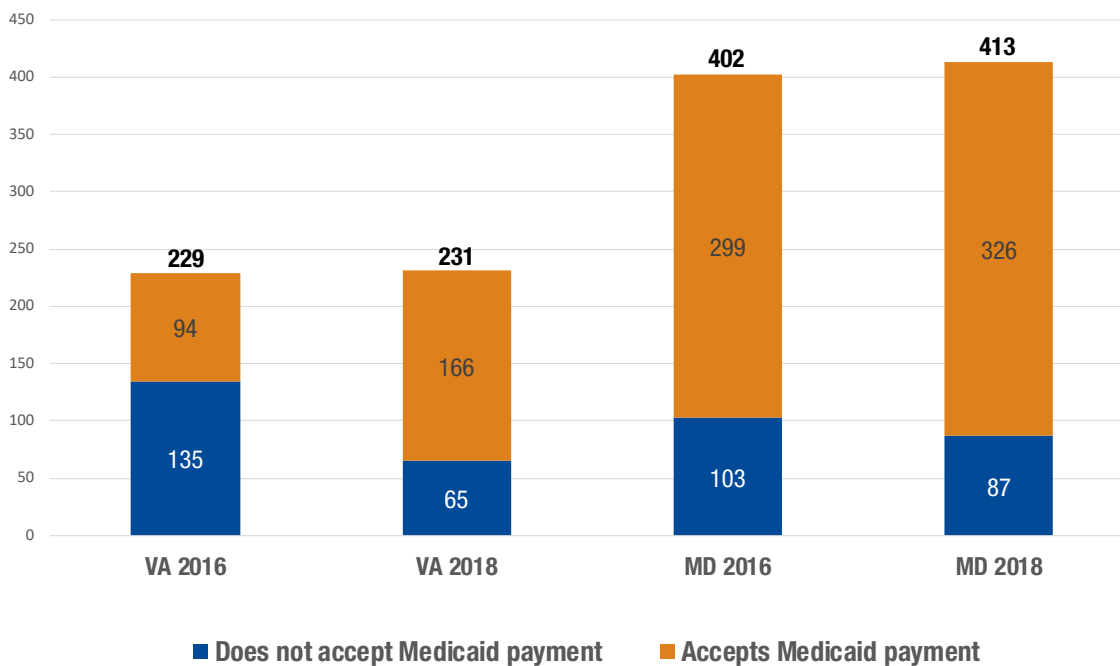


Table 2. Number of Medicaid members with stays in residential treatment centers in 2018.

	Maryland (all Medicaid)	Maryland (non-expansion)	Virginia
Residential stays related to all substance use disorders			
Total number	9,795	2,453	869
As a percentage of all members with SUD	8.6%	5.1%	2.2%
Residential stays related to opioid use disorders			
Total number	8,183	2,108	387
As a percentage of all members with SUD	12.5%	8.2%	2.3%

Source: Medicaid claims data from Department of Medical Assistance Services (VA) and Maryland Department of Health.

Also, Richmond Behavioral Health Authority—the publicly supported behavioral health services provider for Medicaid and medically indigent residents in the Richmond area—purchased one of the few residential treatment facilities in the region and has plans to expand.

Other respondents noted the difficulty of starting a residential program from the ground up, given the time and effort required in finding the right location, financing, and obtaining the necessary licensing and credentialing. Respondents in both Maryland and Virginia noted that attracting and retaining clinical staff is one of the largest barriers to increasing treatment capacity, especially in a tight labor market and in more rural areas.

Utilization of residential treatment is higher in Maryland. In 2018, there were 869 Virginia Medicaid members with substance use disorders who used ASAM 3 residential treatment services, comprising 2.2 percent of all Medicaid members who had a SUD diagnosis during the year (see Table 2). Both the number and percent of Maryland Medicaid members utilizing ASAM 3 services were much higher: nearly 9,800 Medicaid members with a SUD diagnosis used ASAM 3 services in Maryland in 2018, including 2,453 members not enrolled through Medicaid expansion (comprising 5.1 percent of non-expansion members with substance use disorders). While most users of ASAM 3 services in Maryland had opioid use disorder, less than half of ASAM 3 users in Virginia had opioid use disorder.

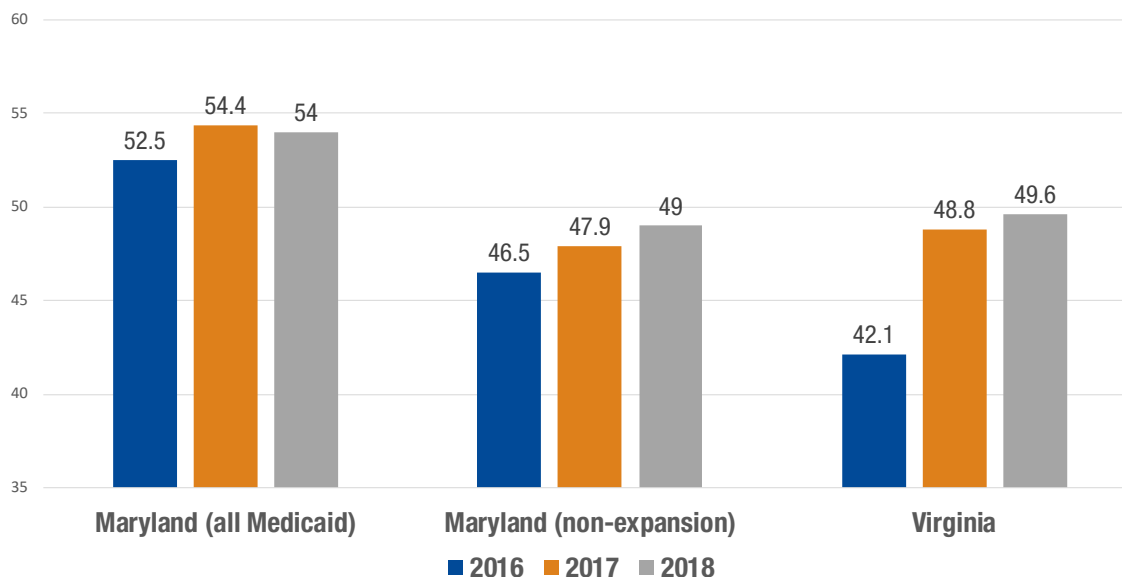
Length of stay restrictions differed significantly between the Maryland and Virginia waivers, which could affect differences in utilization of residential treatment services. Virginia’s waiver did not include a specific limit on the length of any stay for residential treatment, only that the *average* length of stay across all residential stays not exceed 30 days. In contrast, the terms of Maryland’s waiver allow for two non-consecutive 30-day stays—inclusive of all levels of residential care—in a one-year period.

The average number of Medicaid-covered days in residential treatment for members who had any treatment was somewhat lower in Virginia (18.5 days in 2018) than in Maryland (21.2 days), a difference of about 15 percent. The total length of stay is likely even longer in Maryland, as other state or federal funding is often used to extend stays beyond the hard 30-day limit.

Barriers to residential treatment remain in both states. Although respondents in both states confirmed that the waivers had significantly increased access to residential treatment services for Medicaid members, they also described persisting barriers to treatment. In Virginia, virtually all providers interviewed for the study reported that there was an insufficient number of residential treatment facilities or beds, as evidenced by waiting lists of several weeks or longer, which sometimes cause patients to drop out of treatment before a bed becomes available. While Maryland has a greater number of residential treatment providers, respondents in Maryland noted that much of the supply is concentrated in Baltimore City, with less access in rural areas and other regions of the state. Maryland is targeting expansion of residential treatment capacity for pregnant women, as they have experienced especially long waits for treatment.

Providers’ views varied on the need for residential treatment versus lower levels of treatment. Some providers maintain that residential treatment is over-utilized, and that MOUD treatment can be effectively provided in outpatient settings for most patients. Some respondents in Maryland expressed concern that as residential services become more available, individuals will seek it out as their preferred option for recovery—regardless of acuity.

On the other hand, most providers interviewed in Virginia asserted that residential treatment is under-utilized as a result of shortages of these facilities. In addition to more patients benefitting from residential treatment, they believe many patients would also benefit from longer stays. These providers, as well as respondents

Figure 2: Percentage of Medicaid members with OUD who initiated OUD treatment.

Source: Medicaid Outcomes Distributed Research Network (MODRN) Common Data Model

in Maryland, argue that many Medicaid members with addiction problems can benefit from residential treatment because it provides a safe and stable environment from which to treat their addiction, and away from the negative social influences, lack of stable housing, or economic challenges that may inhibit recovery.

Impact of the Waiver on the Addiction Treatment System

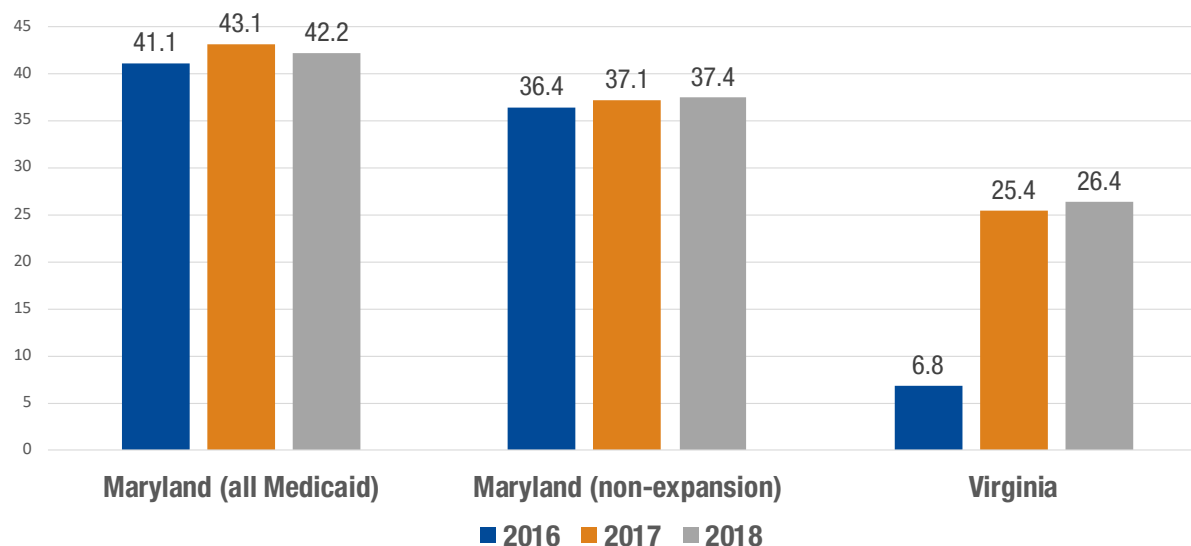
After Virginia implemented ARTS and the waiver, disparities in access to addiction treatment services in Virginia and Maryland narrowed significantly. Figures 2-5 show results from MODRN on changes in access to and utilization of addiction treatment services among Medicaid members ages 21-64 between 2016 and 2018 (see Appendix for more detailed discussion of analysis and measures). Because Virginia did not expand Medicaid until 2019, the results focus on comparisons for the non-expansion populations in both states.

The results show that overall access to addiction treatment services was higher in Maryland prior to the waivers. However, the differences in access between the two states have narrowed significantly following implementation of the waivers and the Virginia ARTS program. Prior to the waivers (in 2016), the percentage of

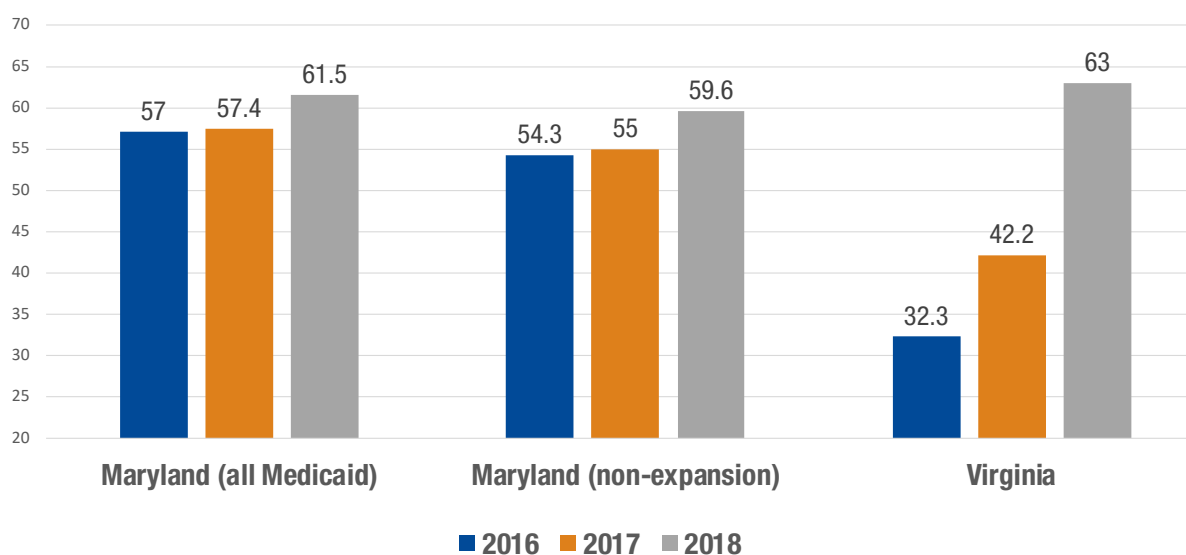
non-expansion Medicaid members with opioid use disorder who initiated treatment within 14 days of a diagnosis was 46.5 percent in Maryland, compared to 42.1 percent in Virginia (see Figure 2). By 2018, rates of initiation for OUD treatment had increased to around 49 percent in both states.

The differences between the two states are more striking in terms of the percent who initiated *and* engaged with treatment (that is, they had two or more additional treatment services or MOUD within 34 days of the initiation visit). In 2016, rates of initiation and engagement with treatment for opioid use disorder were 36.4 percent for non-expansion members in Maryland, compared to only 6.8 percent in Virginia (see Figure 3). Rates of initiation and engagement with treatment for opioid use disorder increased to 26.4 percent in Virginia by 2018, although still substantially below the rate for Maryland (37.4 percent).

MOUD treatment rates have also increased in both states, although the change is much larger for Virginia. In 2016, MOUD treatment rates per 1000 member months were 54.3 percent in Maryland for non-expansion members, compared to 32.3 percent in Virginia (see Figure 4). By 2018, MOUD treatment rates had increased to around 60 percent or higher in both states.

Figure 3. Percentage of Medicaid members with OUD who initiated and engaged with OUD treatment.

Source: Medicaid Outcomes Distributed Research Network (MODRN) Common Data Model

Figure 4. Rate of MOUD treatment for opioid use disorder per 1000 member months.

Source: Medicaid Outcomes Distributed Research Network (MODRN) Common Data Model

Providers in Virginia reported major changes in attitudes toward addiction treatment services after implementation of ARTS.

Providers in Virginia described ARTS as having a profound change in attitude by the state in their approach to covering addiction treatment services through Medicaid. Another provider described the impact as having professionalized addiction treatment services in the state, especially through the emphasis on evidenced-based MOUD treatment. Because ARTS affected virtually all aspects of the addiction treatment system, the changes affected outpatient and other treatment providers to a much greater extent than in Maryland, where providers already had greater familiarity with Medicaid and the PBHS.

Nevertheless, both states have experienced an increase in other addiction treatment services. Opioid Treatment Programs (OTPs)—the main source of care for methadone treatment—have increased in both Virginia and Maryland, especially the Baltimore area. In Virginia, while OTPs were primarily cash-based and few accepted any insurance, the number of OTPs accepting Medicaid payment increased from six facilities before the waiver to 38 currently. Higher reimbursement rates have attracted new outpatient and intensive outpatient providers, including over 100 new Office-Based Opioid Treatment programs, which receive enhanced reimbursement rates to provide MOUD treatment and care coordination activities. Both states report increases in patient volumes in outpatient and inten-

sive outpatient treatment services since the waiver, which has led to strained capacity and longer waiting times for services in some areas. One respondent in the Baltimore area described the supply of treatment providers as having become “saturated,” resulting in a decrease in referrals to their outpatient and intensive outpatient treatment programs.

Stigma and resistance to MOUD persists in both states among some providers and in some sectors. The evidence-based use of opioid-based pharmacotherapies to treat opioid addiction, including buprenorphine, methadone, and naltrexone (Vivitrol), remains controversial among some providers, patients, law enforcement officials, and others in the community. However, respondents in both states report that perceptions towards MOUD have grown more favorable since the waivers, although there are still pockets of resistance, especially in rural areas and among some law enforcement agencies. In Virginia, the ARTS program was cited by several respondents as having convinced many who were previously skeptical that MOUD was scientifically legitimate. In Maryland, attitudes towards MOUD have improved for buprenorphine treatment, but methadone clinics still often face neighborhood resistance.

Although stigma and resistance to MOUD has decreased, providers vary considerably in terms of their approaches to using MOUD with patients who have opioid use disorder. In some clinics, the vast majority of patients with opioid use disorder are started on MOUD, while other clinics may have fewer than half of their patients with opioid use disorder on MOUD. There is also no agreement as to the length of time that patients should be on MOUD. In some cases, providers encounter resistance to MOUD from patients and family members, who either are not comfortable with pharmacotherapy or expect withdrawal from narcotic medications to be more immediate.

In both states, use of MOUD among residential treatment providers has not been consistent or universal. In December 2018, Virginia began requiring ASAM level 2 and 3 providers to provide access to MOUD services to members with opioid use disorder (consistent with new CMS guidelines), as there was concern that some providers were not offering such services to patients.¹⁶ Even when MOUD is available, some residential treatment providers in both states are either hesitant or not proactive in starting patients on this treatment. In Maryland, it was reported that some facilities were accepting patients receiving methadone treatment, but began tapering down their medication even when not medically appropriate.

Conversely, some providers who have traditionally opposed MOUD in favor of abstinence-only treatment approaches have loosened their resistance. In Richmond, one abstinence-based provider recently began offering Vivitrol through their program. The change was motivated primarily because they understood the life-saving potential of MOUD for patients with opioid use disorder, although the expansion of MOUD treatment options in the community was also a factor.

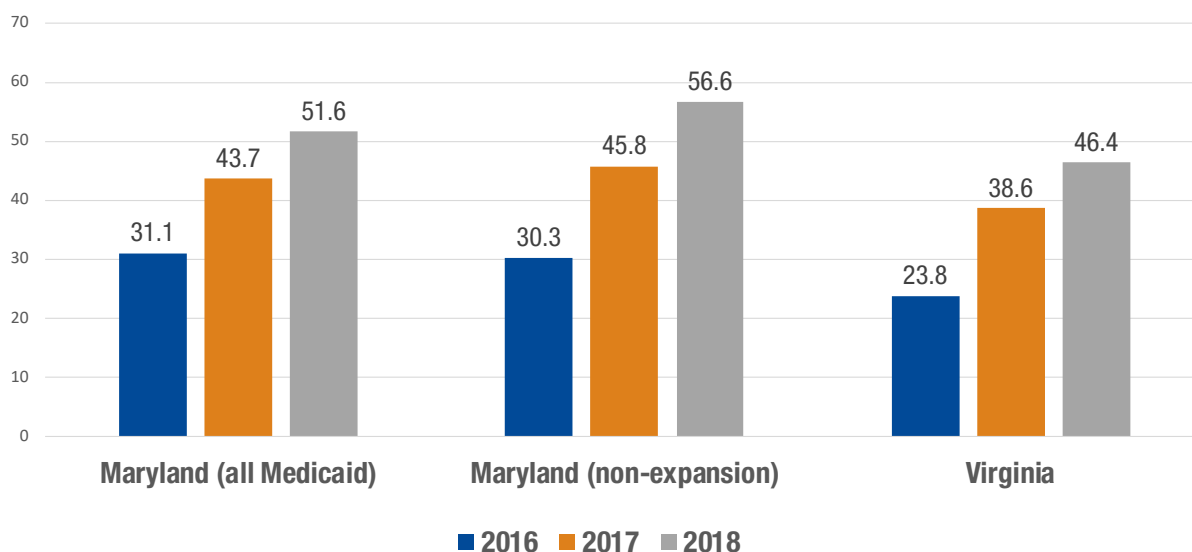
Improvements Needed in Care Transitions and System Integration

Transitions following discharge from residential treatment to outpatient care require improvement. Providers expressed concern that lack of a “smooth hand-off” between residential and outpatient providers leads to disruptions or discontinuation of treatment services, which could result in relapse or readmission to higher intensity care. In Virginia, members using ASAM 2 through 4 services are assigned specialized ARTS care coordinators by the MCOs. These care coordinators work with both providers and patients in facilitating entry into the next level of care, and to ensure that members are directed to network providers who meet the MCO’s quality of care standards. Otherwise, arrangements for transitioning patients between levels of care are largely made by individual providers.

Although providers routinely perform discharge planning, the communication and coordination required for smooth handoffs of patients are frequently lacking, especially when residential and outpatient providers are in different systems. One MCO in Virginia reported that some providers were initially reluctant to provide the plan with detailed clinical information on patients due to the federal 42 CFR Part 2 regulations that seek to protect patient records relating to substance use disorders. This appears to be less of a barrier in Maryland, where officials noted that they have received authorizations from around 90 percent of patients to share their behavioral health treatment data with MCOs and primary care providers.*

Another major barrier to smooth handoffs cited by respondents is a lack of patient motivation to follow through with outpatient or intensive outpatient services. Despite efforts to follow up with patients on the part of MCOs and some providers, they have limited ability to ensure that patients continue with their treatment. Other barriers include lack of staffing capacity on the part of residential providers to follow up with patients post-discharge, lack of available outpatient capacity in the community, lack of housing for patients being discharged to the community, and lack of transportation between providers.

* Under 42 CFR Part 2, disclosure of patient records related to substance abuse treatment generally requires patient consent.

Figure 5. Percent of ED visits for opioid use disorders in which member had follow-up care within seven days.

Source: Medicaid Outcomes Distributed Research Network (MODRN) Common Data Model

Transitions to care following emergency department visits require improvement. Many people with opioid use disorder come to the emergency department for overdoses, symptoms of withdrawal, or other co-occurring health problems. Therefore, hospital emergency departments (EDs) are potentially key points of entry into the addiction treatment system, either by referring patients to residential treatment or other providers, or by starting patients on MOUD while they are at the ED. One study showed that MOUD treatment initiated in the ED increased engagement in addiction treatment services and reduced self-reported illicit drug use.¹⁷ The ED-Bridge program in California is promoting the initiation of MOUD treatment in EDs along with referrals to outpatient care.¹⁸

Such efforts are increasing in both Maryland and Virginia. Findings from the MODRN show an increase in the rate of follow-up care within seven days of an emergency department visit related to opioid use disorders (Figure 5). In Maryland, the percent of non-expansion members with follow-up care within seven days of an OUD-related ED visit increased from 30.3 percent in 2016 to 56.6 percent in 2018. In Virginia, the seven-day follow-up increased from 23.8 percent in 2016 to 46.4 percent in 2018.

These increases are consistent with observations from interviews with providers. For example, Carillion Memorial Hospital in Roanoke, VA—the largest health system in the region—has initiated an ED Bridge program that connects directly with the outpatient and intensive outpatient services offered through the Carilion Clinic.

Hospitals in Baltimore are promoting the use of SBIRT (Screening, Brief Intervention, and Referral to Treatment) in their EDs, with the option to start patients on MOUD and fast-track them into treatment—although MOUD initiation is fairly rare. However, such efforts are uneven and not widespread in the two states. Moreover, when outpatient and residential treatment providers are in a different system than the ED, transitions between the ED and treatment providers may encounter some of the same barriers as transitions from residential treatment.

Lack of coordination between providers reflects a more systemic problem with the fragmentation of addiction treatment services in communities. Some respondents report tendencies among providers within communities to be siloed or territorial about the patients they serve and the services they provide, with little or no coordination between providers. To address this fragmentation, the Roanoke (VA) Valley Collective Response formed in 2018 and is comprised of nearly 200 people representing about 100 providers, law enforcement agencies, schools, churches, and other community leaders. Goals of the group include increasing the quality and capacity of substance use treatment services in the region, identifying gaps in services, and strengthening collaborations between providers and other community organizations. Roanoke also benefits from strong leadership in the community—especially Carilion Hospital and Clinic—in promoting community-wide initiatives and coordination. Among the respondents interviewed for this study, no comparable initiative was identified in Richmond or Baltimore.

Conclusions: Lessons Learned From IMD Waivers in Virginia and Maryland

The findings in this report are limited to Maryland and Virginia, and therefore caution should be used in generalizing to all states that have or are planning to implement IMD waivers. Nevertheless, the similarities and differences between the two states in their experiences with the waivers likely have implications for other states.

The findings highlight that states have different starting points when implementing IMD waivers. That is, they differ in terms of the breadth of coverage of addiction treatment services in their Medicaid programs, the delivery system infrastructure, provider participation in Medicaid, and whether the waivers were combined with other reforms to expand coverage along the continuum of care. These differences have implications both for the likely impact of the waivers and the preparation needed in order to ensure successful implementation.

In particular, Virginia's relative paucity of coverage and services prior to the waiver required extensive preparations on the part of state officials leading up to the waiver as well as the major reforms enacted through the ARTS program. Close coordination and cooperation across state agencies, engaging with and educating providers and MCOs prior to implementation, ensuring that reimbursement rates were sufficient to attract existing providers to accept Medicaid payment, and aligning state licensing and credentialing processes for residential treatment providers were essential for a change of this magnitude.

While adequate reimbursement rates are necessary to attract existing IMD providers to accept Medicaid payment, the experiences of both states suggest that adding new capacity for residential treatment will likely take longer. This may constrain access to such services initially, especially in states that had relatively few providers prior to the waiver. By the same token, low supply of such facilities should alleviate concerns that IMD waivers will dramatically shift the locus of treatment to more institutional forms of treatment in the short term, especially when states are simultaneously expanding access to community-based and outpatient services.

Also, there is much that states can do to influence the amount of utilization of IMD facilities, regardless of length of stay and other restrictions included in the waivers. The use of state-only funds can extend stays beyond that approved for federal funding – as in Maryland. Perhaps the larger challenge is obtaining consensus among providers, state officials, and other stakeholders on what constitutes appropriate levels of residential treatment use.

Finally, it is easier for state Medicaid programs to expand access to the entire continuum of treatment services than it is to ensure smooth transitions between different levels of care, especially for Medicaid patients discharged from IMD facilities. Lack of follow-up care after discharge reflects both the difficulties of motivating patients to continue with treatment as well as the fragmentation of the delivery system, both for addiction treatment services and overall. Lack of housing, transportation, gainful employment, and a supportive home environment are also barriers to successful transitions to community-based treatment. As states implement IMD waivers and implement the full continuum of addiction treatment services available to Medicaid members, improving the coordination of such services should be a key goal.

Appendix. Measures of Access and Utilization From the Medicaid Outcomes Distributed Research Network (MODRN)

Quantitative measures of addiction treatment access and utilization are from the Medicaid Outcomes Distributed Research Network (MODRN), an initiative of AcademyHealth.¹⁹ MODRN is a collaborative effort to analyze data across multiple states to facilitate learning among Medicaid agencies. Participants from AcademyHealth's State-University Partnership Learning Network (SUPLN) and the Medicaid Medical Directors Network (MMDN) developed MODRN to allow states to participate in multi-state data analyses while retaining their own data and analytic capacity.

MODRN is composed of multiple organizations using a common data model to support centralized development, but local execution, of analytic programs. Under MODRN, each state-university partnership adopts the Medicaid Common Data Model, contributes to a common analytic plan, and conducts analyses locally on their own Medicaid data using standardized code developed by the data coordinating center. Finally, the state-university partners provide aggregate results, not data, to the data coordinating center, which synthesizes the aggregate findings from multiple states for reporting. The Medicaid Common Data Model will be continually updated and expanded for future Medicaid research projects.

Eleven university-state partnerships now participate in an effort to provide a comprehensive assessment of opioid use disorder treatment quality in Medicaid. The findings presented in this report reflect estimates from the Common Data Model for two states – Maryland and Virginia -- implemented by the University of Maryland Baltimore County and Virginia Commonwealth University, respectively.

For this analysis, we use data for the years 2016 through 2018. The Common Data Model includes non-dual, full-benefit Medicaid enrollees ages 12-64 with at least one month of Medicaid eligibility in the calendar year. The analysis in this report is restricted to ages 21-64. For Maryland, two sets of results are presented: (1) All Medicaid members based on the above definition, and (2) members not enrolled or eligible through Affordable Care Act Medicaid expansions. As Virginia did not expand Medicaid until 2019, all results for Virginia include non-expansion members only.

IDENTIFYING PEOPLE WITH OPIOID USE DISORDER (OUD)

We identify people with OUD based on diagnosis codes in claims. Specifically, we identify those who had at least one encounter with any diagnosis (counting all diagnosis fields) of OUD in inpatient, outpatient, or professional claims at any time during the measurement period. We used National Quality Forum code sets to identify diagnosis codes for measuring OUD.

MEASURES USED IN THIS ANALYSIS

1. Initiation of treatment for opioid use disorder

Reflects the percentage of Medicaid beneficiaries with a new episode of opioid dependence who initiated treatment through an inpatient admission, intensive outpatient encounter, or partial hospitalization for OUD within 14 days of the diagnosis.

2. Initiation and engagement with treatment for opioid use disorder

Reflects the percentage of Medicaid beneficiaries with a new episode of opioid dependence who initiated treatment (as defined above), and who had two or more additional services with a diagnosis of opioid use disorder within 30 days of the initiation visit.

3. Rates of Medications For Opioid Use Disorder (MOUD) Treatment Among Enrollees With Opioid Use Disorder

Includes Medicaid beneficiaries with OUD who have at least one claim for MOUD treatment. Specifically, we include those who have at least one claim with a National Drug Code (NDC) or a Healthcare Common Procedure Coding System (HCPCS) code for any of the following OUD medications during the measurement period:

- Buprenorphine
- Naltrexone (oral or injectable)
- Buprenorphine/Naloxone
- Methadone administration

We excluded claims for oral medications with negative, missing, or zero days' supply.

4. Follow-up Care Within Seven Days Of An Emergency Department Visit For Opioid Use Disorder

Reflects the percentage of emergency department (ED) visits for Medicaid beneficiaries with a principal diagnosis of opioid use disorder who had a follow-up visit related to OUD within seven days of the ED visit. Excludes ED visits if followed by an inpatient admission within 30 days of the ED visit. Includes only the first ED visit in a 31-day period if more than one eligible visit within that time period.

Appendix Table 1. Comparison of substance use disorder-related services covered by Maryland and Virginia Medicaid programs, before and after implementation of Section 1115 waiver.

	Maryland		Virginia	
	Before waiver (2016)	After waiver (2018)	Before waiver (2016)	After waiver (2018)
Coverage of SUD treatment services				
Medically managed intensive inpatient (4.0)	Yes (hospital-based only)	Yes (hospital-based only) ¹	No	Yes
Medically monitored intensive inpatient (3.7)	No ²	Yes	No	Yes
Clinically managed high intensity residential (3.5)	No ²	Yes	Only for pregnant women and adolescents under EPSDT	Yes
Clinically managed population-specific residential (3.3)	No ²	Yes	No	Yes
Clinically managed low intensity residential (3.1)	No ²	Yes	No	Yes
Partial hospitalization (2.5)	Yes	Yes	Yes	Yes
Intensive outpatient services (2.1)	Yes	Yes	Yes	Yes
Outpatient services (1.0)	Yes	Yes	Yes	Yes
Early intervention (SBIRT) (0.5)	Yes	Yes	Yes	Yes
Medication-assisted treatment				
Buprenorphine	Yes	Yes	Yes	Yes
Methadone	Yes	Yes	Yes	Yes
Naltrexone	Yes	Yes	Yes	Yes
Coverage of other SUD-related services				
Peer recovery	No	No ³	No	Yes
Care coordination/ case management	No	No	Limited	Yes
Behavioral health carve-in or carve-out	Carve-out	Carve-out	Carve-out	Carve-in
Use of ASAM criteria	Yes	Yes	No	Yes
Prior authorization required for buprenorphine	Yes; Suboxone film and tablets; Bunavil	Yes; Suboxone tablets	Yes	Removed PA in March 2019 for Suboxone films

1. Also covered for members with a primary diagnosis of substance use disorders and a secondary mental health diagnosis in IMDs as of Jan. 1, 2019.

2. Services available through federal and state grant funds.

3. Peer recovery services are covered under a bundled rate for level 3 services; otherwise, they are reimbursed through grants.

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