

Primer

Medicaid’s Role in Improving Substance Use Disorder Treatment in the US

Julie Donohue, PhD, Amy C. Raslevich, MPP, MBA, and Evan Cole, PhD

As the nation’s largest payer for substance use disorder treatment (SUD) and recovery services, Medicaid plays a significant role in shaping the delivery and reimbursement of such services not only for the program’s beneficiaries but more broadly for commercially insured and Medicare populations. Nationally, Medicaid covers nearly 40% of all individuals with an opioid use disorder (OUD) and a greater share in states that expanded Medicaid under the Affordable Care Act. Medicaid plays an even larger role for high-risk populations with SUDs, including pregnant women and justice-involved persons who are disproportionately insured by Medicaid.

State Medicaid programs influence SUD treatment and recovery systems in several different ways (Figure 1). This primer examines the policy levers available to improve access and quality of SUD treatment and recovery services.

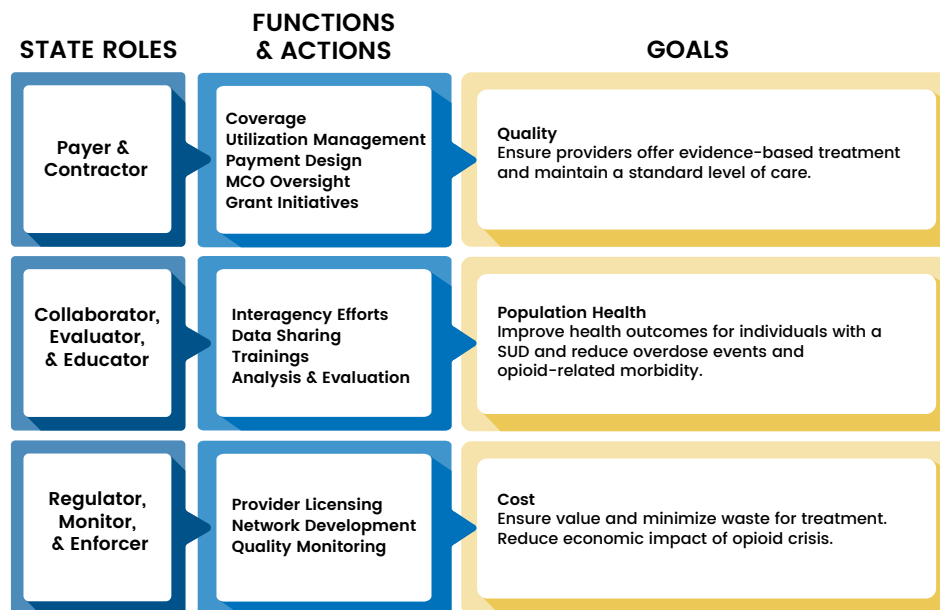


Figure 1. State Medicaid Agency Roles and Actions to Address the Opioid Epidemic

Medicaid as Payer and Contractor

As the single largest payer for SUD treatment, Medicaid coverage, utilization management (e.g., prior authorization, quantity limits), payment models, network composition and size, and managed care contracting have profound effects on the delivery of treatment and recovery services across payers.

Broadening coverage of SUD treatment. To expand the continuum of services available to treat SUDs,¹ several state Medicaid programs have added new services as covered benefits. For example, some states are covering higher levels of care, such as partial hospitalization and residential treatment,² where gaps in coverage have long existed.³ States are using a variety of Medicaid policy mechanisms to expand the continuum of services covered to include peer support, inpatient services, and more. These mechanisms include Section 1115 demonstration waivers, state plan amendments, and managed care organization (MCO) contracts. In addition, the SUPPORT Act of 2018 requires states to cover all US Food and Drug Administration–approved medications for OUD until 2025.

Loosening utilization management tools. Some Medicaid programs have historically applied utilization management tools to SUD treatment and recovery services to improve efficiency and, in the case of medications for OUD, to reduce risk of misuse and diversion, such as patients selling or giving buprenorphine to others. Recently, several states have loosened or removed these restrictions to reduce administrative barriers for providers and patients. For example, between 2013 and 2018, 18 states removed requirements that providers seek prior authorization before prescribing buprenorphine-naloxone, an evidence-based treatment for OUD.⁴

Leading the way in reforming SUD treatment delivery systems. States such as Maryland, Pennsylvania, and Vermont have implemented new models of SUD treatment delivery including health homes that specialize in serving those with behavioral health conditions, programs that coordinate care across settings for enrollees with a SUD, or those that facilitate warm handoffs between emergency departments and SUD treatment and recovery

providers.⁵ States like Virginia have mandated coverage for the entire spectrum of SUD treatment and recovery services.⁶ These reform efforts are often, although not always, undertaken as part of a Section 1115 demonstration waiver.⁷

Shifting to value-based payment. The vast majority of SUD treatment is currently reimbursed by Medicaid and other payers using fee-for-service payments that are not tied to performance. States are poised to develop and test alternative payment models for SUD treatment providers both in primary care and in specialty settings. Thus, as quality measure stewards advance performance measures for SUD treatment and recovery,⁸ Medicaid programs will likely lead payers on implementing these measures and tying them to reimbursement.

Altering contracts with managed care organizations. Access to SUD treatment, as well as treatment quality and outcomes, are affected by factors such as: 1) Whether states carve out treatment and recovery services to separate behavioral health MCOs, 2) The degree of oversight states exert over MCOs, 3) The performance standards set, and 4) The financial incentives incorporated in the contracts. Some states are requiring MCO and fee-for-service programs to more uniformly apply utilization management tools to SUD treatment,⁹ which may reduce administrative complexity for providers and improve access to care. Likewise, states are beginning to include specific requirements for network composition, scope, and size to ensure individuals have sufficient access to the full continuum of SUD providers.

Medicaid as Collaborator and Educator

Through opioid task forces, Medicaid agencies frequently coordinate with corrections departments, state boards of pharmacy, behavioral health licensing agencies, health departments, prescription drug monitoring programs, and other agencies and groups that serve individuals with SUDs, including community-based organizations. Some states have advanced data sharing across these groups to better understand the impact of policy interventions on a broad set of outcomes.

By collaborating with state insurance regulators, Medicaid agencies can also have indirect influence over the ways in which state insurers regulate SUD coverage. And by informing private insurers of current best practices and standards of care for SUDs, Medicaid can affect private payers' utilization management decisions.

Medicaid agencies also serve a critical role as an educator for SUD treatment providers by facilitating trainings to increase the number of providers offering medications for SUD, as well as to improve the quality of care delivered.

Medicaid as Monitor, Regulator, and Enforcer

Medicaid programs serve as regulators, monitors, and enforcers of SUD treatment provider networks to ensure that they deliver evidence-based and high-quality care.

Monitoring quality of care. Medicaid agencies must track several quality measures through the Center for Medicare and Medicaid Services' Adult and Child Core Quality programs;¹⁰ however, few of these measures have focused on SUD treatment and recovery. Recently, the National Quality Foundation performed an environmental scan of available OUD treatment measures and found multiple, high-priority domains with too few measures, including long-term recovery from OUD and special populations in OUD treatment.¹¹ Medicaid agencies can play an active role in developing, testing, and expanding quality measurement efforts at both the population and provider levels.

Regulating SUD treatment providers. Authority to license specialty SUD treatment providers typically rests outside of a state's Medicaid agency (e.g., in departments of health or drug and alcohol programs). Medicaid programs can work closely with these departments to implement licensing standards that ensure the provider workforce is appropriately trained to serve individuals with SUDs. Medicaid programs often have additional requirements for Medicaid provider participation, including standards that Medicaid MCOs must meet or exceed to form their provider networks. Together, these levers help improve

the quality and supply of SUD treatment providers within and beyond the Medicaid program.

Developing networks of SUD treatment and recovery providers. Medicaid programs must develop network adequacy criteria that meet minimum federal standards. Criteria typically include patient driving time or distance standards, but they can also include wait times and provider-to-patient ratios. The details of these network adequacy requirements, their ongoing measurement, and their enforcement have direct bearing on the accessibility of SUD treatment providers both in specialty and general medical settings.

Implications for Policymakers

State Medicaid programs have numerous policy levers available to them to shape the systems that deliver SUD treatment and recovery services. Yet our understanding of the impact of state policy changes is limited. As many states have implemented changes to SUD coverage using Section 1115 demonstration waivers, evaluations required under federal law will help to fill some knowledge gaps on the impact of SUD policy changes. However, the rigor and timeliness of these evaluations may need to improve if they are to be of value to state and federal policymakers.¹²

States have made several crisis-driven adaptations to payment and delivery of SUD care in response to the coronavirus pandemic. Rising unemployment resulting from the pandemic will likely increase Medicaid enrollment across the US, particularly in states that have expanded Medicaid. Additional states have revisited their expansion status, with Oklahoma passing a ballot initiative in June to amend their state constitution to expand Medicaid, and Missouri following suit in August.¹³ Economic insecurity and social isolation brought about by virus mitigation strategies are expected to increase the prevalence of SUDs as well as mental health conditions. The burden of meeting these behavioral health needs will fall disproportionately on state Medicaid programs, which have the opportunity to meet this challenge while making significant and lasting changes to our national system of SUD treatment and recovery.

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Notes

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About MODRN

The State University-Partnership Learning Network's Medicaid Outcomes Distributed Research Network (MODRN) was launched in 2017. MODRN uses a common data model and standard analytic code to produce and aggregate state analyses of Medicaid data. MODRN's first project—funded by the National Institute on Drug Abuse—is focusing on the quality and outcomes of opioid use disorder (OUD) treatment among Medicaid beneficiaries.

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