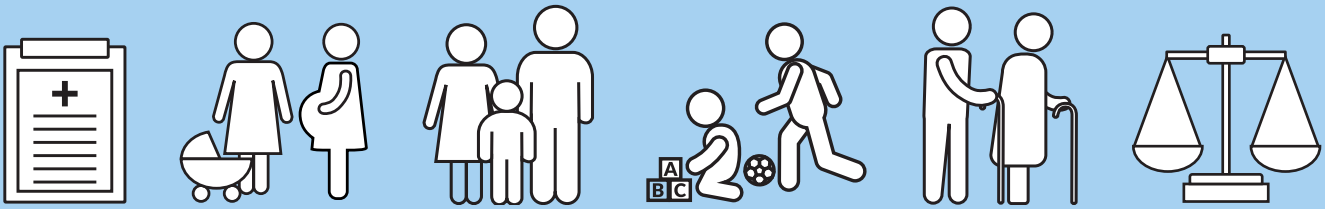
Medicaid's Role in Substance Use Disorder Services



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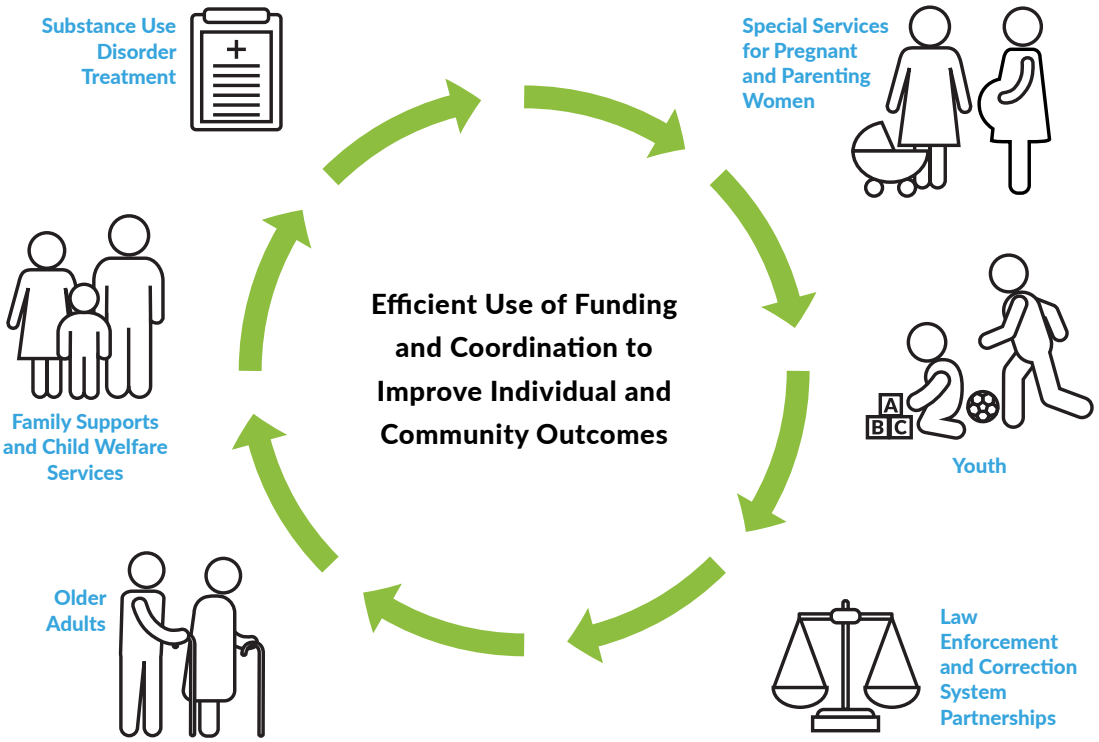
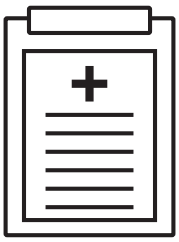
The opioid crisis has drawn needed attention to the health and societal aspects of addiction disorders and state Medicaid agencies have been on the front lines of addressing this crisis.[1] In 2017, more than 2 million adults aged 16 to 64 in the US had a diagnosed opioid use disorder (OUD), and nearly 40% of these individuals were covered by Medicaid.[2,3] Medicaid beneficiaries had higher rates of treatment for OUD than the general population or privately insured individuals, with 44% of Medicaid beneficiaries receiving some form of treatment compared with 34% of the general population and 24% of those privately insured.[1,2]

In the coming years, state governments expect to receive significant funding from legal settlements to help all communities address the wide-reaching impacts of substance use. As the largest payer for substance use disorder (SUD) treatment and recovery services in the country, Medicaid has an important role in helping address this national crisis.

In partnership with other state agencies, local governments, and community agencies, Medicaid programs supply resources, expertise, and assistance to all participants. This brief is an overview of the many ways state Medicaid programs address the SUD crisis in this country. While in no way a comprehensive accounting of all the work state Medicaid agencies have undertaken, this paper aims to show state leaders ways to leverage funding and improve efforts to address SUD by including state Medicaid agencies in planning efforts.



Substance Use Disorder Treatment



State Medicaid agencies have support from the Centers for Medicaid & Medicare Services (CMS), with multiple options to expand SUD treatment services such as adding coverage for residential treatment, hospital inpatient services, medication-assisted treatment for opioid use disorder (MOUD), peer support services, and recovery supports.[1] To improve SUD treatment, Medicaid programs have used Section 1115 waivers to test new delivery models that improve the continuum of care for individuals with SUD,[4] and Section 2703 Health Home options to care for individuals with chronic conditions including SUD.[1,5] States that invested in expanding Medicaid SUD treatment benefits have noted positive impacts on improved quality of care, increased access, and savings to state general fund dollars.[1,6]

Medicaid agencies have more of an opportunity to make an impact on the SUD problems in our communities by forming effective partnerships with the state's Single State Agency (SSA) that manages publicly funded addiction treatment, prevention, and recovery service systems. Each SSA manages federal block grant funding and provides training, continuing education, and oversight for the licensure of facilities and SUD treatment providers.[7] When Medicaid and SSA agency staff work together, efforts can be best coordinated to improve individual and community outcomes.

Some examples of how state Medicaid agencies and SSAs have worked together include:

- **Cooperation on training and continuing education programs:** Many state SSAs have used funding for training on the American Society of Addiction Medicine (ASAM) criteria for treatment providers as well as Medicaid staff and contracted health plans.[8]
- **Blending funding streams:** While Medicaid can pay for certain treatment services, Medicaid cannot pay for room and board in residential treatment facilities. In many states, coordination between Medicaid and SSAs allows treatment providers to receive Medicaid reimbursement for treatment services while SSA funds pay for room and board expenses.[8]
- **Care coordination and case management**: Many state Medicaid programs include care coordination or case management as a benefit for SUD treatment. Care coordinators assist in patient transitions along the continuum of SUD care, can assist beneficiaries in receiving non-SUD-related health care, and also in connecting beneficiaries to other needed social service needs and supports. Los Angeles County's System Transformation to Advance Recovery and Treatment Organized Delivery System (START-ODS) provider manual includes a useful description of case management and how it can support individuals in SUD treatment.[9]

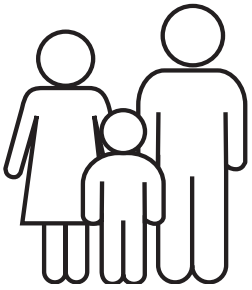
Special Services for Pregnant and Parenting Women

Providing effective treatment and support for pregnant and parenting women (PPW) is a priority for state Medicaid programs who pay for almost half of all births in the US. Substance use during pregnancy is a leading cause of poor maternal and newborn outcomes. Many state Medicaid programs have special programs to assist pregnant and parenting women, including residential treatment options and the Maternal Opioid Misuse (MOM) Model supported by CMS.[10]

In Oregon, a Medicaid managed care organization created an integrated care program for pregnant women with SUD that provides medical care, SUD treatment, and social and peer supports.[11] The 2016 publication from the Substance Abuse and Mental Health Services Administration, *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*, is a roadmap to develop partnerships to address substance use in the PPW population.[12] The Substance Abuse and Mental Health Services Administration funds SSAs through grants to address SUD in the PPW population, and coordination with Medicaid may help states leverage this funding.[13]

One example of an initiative to coordinate care across state agencies for PPW is the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative Learning Community (OMNI LC). The Centers for Disease Control and Prevention and the Association of State and Territorial Health Officials launched this initiative that helped 12 states build capacity and improve access to and coordination of quality services; provider awareness and training; data monitoring and evaluation; financing and coverage; and ethical, legal, and social considerations.[14] State teams included representatives from public health, Medicaid, SSA, Title V agencies, and treatment providers.[15]

Family Supports and Child Welfare Services



Sometimes, a parental SUD may lead to engagement with child welfare services. Medicaid provides services to almost all children in the foster care system, but many Medicaid programs are doing more to prioritize family stability and help parents and children remain together.

Many state Medicaid agencies are partnering with state child welfare agencies to provide these important services. Examples of how Medicaid can partner with sister agencies include:

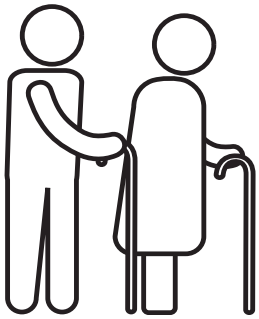
- **Plans of Safe Care:** The Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse and Prevention Treatment Act (CAPTA) require state child protective services systems to develop plans of safe care (POSC) for infants identified as affected by prenatal drug or alcohol exposure. The Administration for Children, Youth and Families, which gives guidance on POSC, recommends multisystem collaboration as a best practice to support infants and their families.[16] Because Medicaid is likely to be the payer, including Medicaid in POSC initiatives may improve service delivery and child and family outcomes. In New Mexico, the legislature passed a bill that requires health professionals creating a POSC to make a referral to the Medicaid managed care organization for care coordination and monitoring of the plan.[17,18] New Mexico also established an online portal where involved staff can share POSC and track de-identified data to identify gaps in services.[19]
- **Family First Prevention Services Act:** The 2018 Family First Prevention Services Act (FFPSA) created new opportunities for state child welfare agencies to keep families together, prevent unnecessary foster care placements, and improve the quality and delivery of needed services.[20] Under the FFPSA, Title IV-E foster care funds are the payer of last resort for any Title IV-E prevention services covered by the Medicaid program.[21] Coordination between Medicaid and child welfare agencies is essential as states implement FFPSA.[20] One specific example is the FFPSA provision allowing states to use Title IV-E foster care funding to pay for food, clothing, and room and board for children who have open child welfare cases and who live with their parents in a residential, family-based SUD treatment facility.[22] Utah, Minnesota, and California worked with key stakeholders including Medicaid programs to develop plans to use Title IV-E funds for children in family-based residential SUD treatment.[22]

Youth

Medicaid covers more than half of Americans younger than 19 years old and CMS has made prevention and treatment of SUD in the youth population a top priority.[23,24] Adolescence is a time of significant brain development, and research has shown most adults who develop a SUD began substance use before the age of 18.[23] Many SSAs and state education departments support prevention programs, and Medicaid can be a key partner in these efforts by paying for services for enrolled beneficiaries.[23-25] Some additional opportunities for Medicaid to support prevention, treatment, and recovery in youth populations include:

- **School Based Health Centers (SBHCs):** CMS policy allows Medicaid agencies to work with SBHCs and provide reimbursement for services to Medicaid beneficiaries.[26,27] At least 7 state Medicaid programs have partnered with SBHCs to serve Medicaid-enrolled youth.[28] In Oregon, SBHCs screen and assess for SUD and have explored using telehealth for recovery support services.[29]
- **Youth and Family Peer Support:** Peer support services are an evidence-based service shown to improve outcomes for individuals in treatment and recovery from SUD.[30] Peer support programs for youth are covered by Medicaid in many communities. SAMHSA published guides on how family and youth peer support can be used,[31] as well as a briefing paper on how Medicaid funds can pay for these programs.[32]

Older Adults



Substance use disorders among older adults are often underdiagnosed and undertreated, and data shows problematic opioid and other substance use among adults older than age 50 has been increasing.[33,34] Substance use among older adults is often associated with other mental health and physical health conditions, and they are at greater risk of harms from substance use including overdose, falls, and impaired cognitive function.[35] Medicaid covers 7.2 million low-income older adults who are also enrolled in Medicare,[36] and state Medicaid agencies have several programs that could be adopted to help address SUD in this population:

- **Home and Community Based Services (HCBS) and Long-term Services and Supports (LTSS):** HCBS services are designed to serve individuals in their communities who might otherwise receive care in institutional settings.[37] CMS offers several options for state Medicaid programs to develop HCBS programs, with 47 states and the District of Columbia offering at least 1 HCBS program.[38] Several state Medicaid programs are addressing the behavioral health needs of older adults through HCBS and LTSS benefits.[34,39,40] For example, California has a demonstration program for dual eligible beneficiaries that requires Medicaid health plans to coordinate specialty mental health and SUD services with county behavioral health programs.[34] North Carolina Medicaid's vision for its LTSS program specifically includes services for SUD treatment.[39]
- **Programs of All-inclusive Care for the Elderly (PACE):** PACE programs provide comprehensive, interdisciplinary health care for certain older adults living in their communities.[41] PACE services can include SUD related treatment and are provided by nonprofit private or public agencies contracted with state Medicaid programs.[42] As of June 2021, 32 state Medicaid agencies offered PACE services.[43]

Law Enforcement and Correction System Partnerships

Many justice-involved individuals are covered by Medicaid before and after spending time in a correctional facility, and 2 out of every 3 inmates meet the criteria for SUD.[44] Individuals leaving correctional facilities are 12 times more likely than the general public to die within 2 weeks of release, largely because of overdoses.[45]

Some examples of how Medicaid agencies partnered with correctional systems to improve individual and community outcomes include:

- **Maintain Medicaid enrollment during incarceration**: 43 states now suspend Medicaid eligibility during incarceration rather than terminating enrollment.[46] Suspension allows benefits to be more quickly reinstated upon an individual's release. In addition, 23 states have electronic data exchange processes to ease suspension and reinstatement of benefits.[46]
- **Conduct outreach to inmates before release**: Medicaid can work with contracted health plans or provider networks to connect with individuals before release, enroll them in benefits, schedule appointments, and link them to social supports.[45]
- **Involve Medicaid in community-based mobile crisis services**: The American Rescue Plan creates a new option for supporting community-based mobile crisis intervention services for individuals with Medicaid insurance coverage. Coordination between Medicaid agencies, correction systems, law enforcement, and first responders can improve justice system outcomes and divert more individuals from the justice system to treatment.[45,47]
- **Explore opportunities to cover certain services before release**: The SUPPORT Act directed CMS to develop guidance on 1115 waiver opportunities for certain services for individuals transitioning out of correctional settings.[45] While CMS has not released this guidance, several states have moved forward with 1115 waiver applications for such services. These waiver applications are pending with CMS.

Summary

State Medicaid programs continue to innovate in programs to address SUD prevention, treatment, and recovery services. The examples included in this briefing paper are a sample of the initiatives at work in the states. Each state has its own structures, resources, and needs. Medicaid is an important partner in addressing SUD in states and local communities because of its role as the safety-net health care provider. States should include Medicaid staff in planning how to spend opioid settlement dollars, to best leverage these funds while also improving individual and community outcomes.

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Suggested citation:

Leof A, Stone J, Evans A, Curtis P, and King VJ. *Medicaid's Role in Substance Use Disorder Services*. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University. 2022.

The Center for Evidence-based Policy would like to thank Children and Family Futures for their assistance in preparing this document.