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Final Opioid Package Should Include Several Medicaid Provisions That Improve Access to Care

But One Remains a Serious Concern

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Negotiations are underway on final legislation to help address the opioid epidemic after the House and Senate passed separate packages. The House and Senate bills would take important steps to improve access to substance use treatment, but fall short of a comprehensive transformation of the substance use treatment system. Even so, both the House and Senate bills include provisions that would take small steps toward improving Medicaid beneficiaries' access to substance use disorder (SUD) treatment. However, the costliest provision passed by the House goes in the opposite direction. It would allow federal Medicaid reimbursement for institutional care, which could undermine current state and federal efforts to ensure that people with SUDs have access to the full continuum of SUD treatment.[1] Policymakers should exclude this provision from the final package.

Medicaid Has Critical Role in Addressing Opioid Epidemic — and Can Do More

The Affordable Care Act's (ACA) Medicaid expansion has dramatically increased coverage for people with SUDs. Prior to expansion, many low-income, non-elderly adults with SUDs weren't eligible for Medicaid — and were largely left uninsured — because they didn't meet the strict eligibility criteria for federal disability programs. The uninsured rate among people with opioid-related hospitalizations fell dramatically in states that adopted the Medicaid expansion, from 13.4 percent in 2013 (the year before expansion took effect) to just 2.9 percent two years later.[2] After

[1] Hannah Katch, "House Bill Partially Repealing the 'IMD Exclusion' Would Do More Harm Than Good," Center on Budget and Policy Priorities, June 20, 2018, https://www.cbpp.org/blog/house-bill-partially-repealing-imd-exclusion-would-do-more-harm-than-good.

[2] Matt Broaddus, Peggy Bailey, and Aviva Aron-Dine, "Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show," Center on Budget and Policy Priorities, February 28, 2018, https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use.

Kentucky expanded Medicaid in 2014, the number of Medicaid beneficiaries using substance use treatment services in the state jumped by 700 percent.[3]

The ACA also required states to include SUD services as a covered Medicaid benefit. People eligible for Medicaid as part of the ACA expansion must receive a benefit plan that's based on commercial health insurance coverage and includes all of the ACA's essential health benefits, including behavioral health services.[4] The ACA doesn't dictate *which* behavioral health services states must cover, but states have flexibility to cover all levels of care in the continuum established by the American Society of Addiction Medicine (ASAM) for substance use treatment. While Medicaid usually doesn't cover residential treatment, which is in the ASAM continuum, an increasing number of states are using so-called "section 1115 waivers" to add coverage of residential treatment.[5] Despite the flexibility Medicaid provides to cover the full continuum, only 12 states cover all levels of care, according to the Medicaid and CHIP Payment and Access Commission.[6]

More needs to be done to take full advantage of Medicaid's potential to help address the opioid epidemic. Because Medicaid covered so few people with SUDs prior to expansion, many SUD treatment providers didn't participate in the program, relying instead on grant funding, fees, and donations. These funding sources often fall short in addressing need — unlike Medicaid, which adjusts based on need and provides a stable source of funding for SUD treatment. Moreover, using Medicaid to pay for treatment frees up grant funding to pay for other necessary supports such as housing and social services. Unfortunately, most state substance use agencies haven't taken significant steps to help treatment providers overcome barriers to participating in Medicaid.[7]

Several Medicaid Provisions Under Consideration Would Improve Access to Care

While the current legislative proposals fall short of a comprehensive approach to the opioid epidemic, several of the provisions could enhance SUD care, by: (1) improving Medicaid provider capacity; (2) broadening the scope of services that states cover in Medicaid and improving coordination of care for Medicaid enrollees with SUDs; and (3) reducing unnecessary gaps in Medicaid coverage. Limited resources can be dedicated to these proposals and there are few ways to

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[3] Foundation for a Healthy Kentucky, "Substance Use and the ACA in Kentucky," December 2016, https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf.

[4] Center on Budget and Policy Priorities, "Essential Health Benefits Under Threat," https://www.cbpp.org/essential-health-benefits-under-threat.

[5] Anna Bailey, "West Virginia's New Medicaid Waiver Promotes Medicaid Objectives," Center on Budget and Policy Priorities, October 24, 2017, https://www.cbpp.org/blog/west-virginias-new-medicaid-waiver-promotes-medicaid-objectives.

[6] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP, Chapter 4: Access to Substance Use Disorder Treatment in Medicaid," June 2018, https://www.macpac.gov/publication/june-2018-report-to-congress-on-medicaid-and-chip/

[7] Christina Andrews *et al.,* "Despite Resources From The ACA, Most States Do Little To Help Addiction Treatment Programs Implement Health Care Reform," *Health Affairs*, Vol. 34 No. 5, May 2015, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1330.

offset the potential costs. Therefore, Congress should invest only in the proposals that are most likely to improve coverage and access to the full continuum of SUD services and supports.

Improving Provider Capacity

Increasing Medicaid provider capacity is essential to expanding access to SUD treatment. While Medicaid offers a more reliable funding stream than grants and donations, many SUD treatment providers need help meeting the requirements to participate in Medicaid. For example, providers new to Medicaid may need help launching information and electronic medical records systems, setting up a process for reviewing utilization of services, and tracking quality measures that grant-funded programs often don't require. Helping providers create these systems would not only allow providers to participate in Medicaid but also enhance the quality of the services they provide.

House and Senate negotiators should therefore prioritize a House-passed provision in the final legislation that would create a five-year demonstration project to help a small group of state Medicaid programs increase SUD provider capacity by adding new providers and increasing current providers' capacity.[8]

Under the House provision, at least ten states would receive 18-month planning grants to assess current provider capacity, identify gaps in treatment, and develop strategies to increase provider capacity through recruitment, education, training, and technical assistance. Up to five of those states would receive federal funds at an enhanced matching rate during the following 42 months for increases in SUD services over what the state provided in 2018. In addition to building Medicaid provider capacity and increasing access to much-needed care in the selected states, the demonstration program would offer lessons for other states about how best to boost provider capacity in their Medicaid programs. The Congressional Budget Office (CBO) estimates this program would cost $256 million over ten years.[9]

Increasing Services and Care Coordination

While all state Medicaid programs cover some SUD services, states vary in the types and breadth of SUD services they cover.[10] Several provisions that House and Senate negotiators should consider for the final legislation would help people get the specific treatment and services they need by:

- **Ensuring that the Children's Health Insurance Program (CHIP) covers substance use treatment.** States currently don't have to provide behavioral health services, including SUD treatment, in their CHIP programs, which in some states cover pregnant women as well as children. One of the House-passed provisions would add mental health and substance use

[8] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, H.R. 6, §103, 115th Cong. (2018), https://www.congress.gov/115/bills/hr6/BILLS-115hr6ih.pdf.

[9] Congressional Budget Office (CBO), Preliminary Estimate of the SUPPORT for Patients and Communities Act, June 20, 2018, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr6amendedby11578.pdf.

[10] Medicaid and CHIP Payment and Access Commission, "State Policies for Behavioral Health Services Covered under the State Plan," June 2016, https://www.macpac.gov/publication/behavioral-health-state-plan-services/; Kaiser Family Foundation, "Medicaid's Role in Addressing the Opioid Epidemic," February 27, 2018, https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/.

disorder care as categories of services that CHIP programs must cover.[11] CBO estimates that this provision would have no budgetary effect.[12]

- **Increasing access to medication-assisted treatment (MAT).** MAT, which combines medication with therapy, is an underutilized, evidenced-based treatment for opioid use disorders.[13] A House-passed provision would require states to cover all forms of MAT for five years, with an exception for states lacking the provider capacity to carry out the requirement, as determined by the Secretary of Health and Human Services (HHS).[14] While most states cover all types of MAT, not all do.[15] The provision would ensure availability of all MAT drugs in all states.
- **Improving access to housing-related services for people with chronic health conditions and histories of homelessness.** Homelessness is closely connected to many chronic health conditions and negatively affects health care use and health outcomes. Many states use Medicaid to provide housing-related services and supports to people experiencing homelessness or housing instability, many of whom also have SUDs. Senate-passed provisions require HHS to issue a report describing innovative state initiatives that provide such services to people with SUDs and to provide technical assistance to states to support the development and expansion of strategies to provide housing-related supports and care coordination services to people with SUDs through Medicaid.

Reducing Unnecessary Coverage Gaps for Vulnerable Groups

Losing Medicaid coverage even briefly can interrupt treatment and jeopardize the recovery of people with SUDs who rely on Medicaid. Gaps in coverage are especially dangerous for people at pivotal life junctures, such as youth aging out of the foster care system and people preparing to return to the community from jail or prison. Lack of health coverage after leaving jail or prison can delay or prevent access to treatment in the community, jeopardizing recovery and the ability to remain out of jail or prison.[16] The final opioid package should include several House-passed

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[11] CHIP Mental Health Parity Act, H.R. 3192, 115th Cong. (2018), https://www.congress.gov/115/bills/hr3192/BILLS-115hr3192rfs.pdf.

[12] CBO, Cost Estimate for Opioid Legislation, June 6, 2018, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53949-opioid.pdf.

[13] Pew Charitable Trusts, "Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder," November 22, 2016, http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder.

[14] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, H.R. 6 §107(b), 115th Cong. (2018) as amended, https://www.congress.gov/115/bills/hr6/BILLS-115hr6ih.pdf. The requirement would extend from October 2020 through September 2025.

[15] Kaiser Family Foundation, "States Reporting Medicaid Coverage of Medication Assisted Treatment (MAT) Drugs," https://www.kff.org/medicaid/state-indicator/states-reporting-medicaid-coverage-of-medication-assisted-treatment-mat-drugs.

[16] Jhamirah Howard *et al.,* "The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities," Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, April 2016, https://aspe.hhs.gov/system/files/pdf/201476/MedicaidJustice.pdf.

provisions that would take small but practical steps to limit unnecessary gaps in Medicaid coverage for these vulnerable populations by:

- **Avoiding coverage gaps for youth who have aged out of foster care.** Adults previously in foster care have high rates of substance use disorder diagnoses.[17] While the ACA allows youth who have aged out of foster care to keep their Medicaid coverage until they turn 26, this extension of coverage doesn't apply if they move to a different state. This provision would extend the guarantee of coverage to youth aging out of foster care when they move to a new state.[18] CBO estimates that it would cost $171 million over ten years.[19]
- **Maintaining continuity of coverage for youth under 21 who are involved in the criminal justice system.** When people enter jail or prison, many states terminate their Medicaid enrollment, meaning they must reapply once back in the community. This often leads to gaps in coverage and delays in access to treatment. This provision would prohibit states from terminating Medicaid enrollment for youth under 21 who are incarcerated. It would also require states to redetermine their eligibility prior to release so coverage is immediately available when they return to the community.[20] CBO estimates this provision would cost $75 million over ten years.[21]
- **Identifying best practices to ensure continuity of coverage for people involved in the criminal justice system.** People in jail and prison have high rates of SUDs, and adults, like youth, can have difficulty accessing critical SUD care after their release.[22] This provision would require the HHS Secretary to develop best practices to ensure smooth transitions of treatment between jail or prison and the community.[23] It would also require HHS to issue guidance explaining how states can use section 1115 Medicaid demonstration waivers to improve care transitions for Medicaid beneficiaries reentering the community. CBO estimates that the provision would cost less than $500,000 over five years.[24]

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[17] Jordan M. Braciszewski and Robert L. Stout, "Substance Use Among Current and Former Foster Youth: A Systematic Review," National Center for Biotechnology Information, December 1, 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3596821/.

[18] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, as amended, *op. cit.*

[19] CBO, Preliminary Estimate of the SUPPORT for Patients and Communities Act, *op. cit.*

[20] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, as amended, *op. cit.*

[21] CBO, Preliminary Estimate of the SUPPORT for Patients and Communities Act, *op. cit.*

[22] Department of Health and Human Services, Office of the Surgeon General, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," November 2016, https://www.ncbi.nlm.nih.gov/books/NBK424857/pdf/Bookshelf_NBK424857.pdf.

[23] Medicaid Reentry Act, H.R. 4005, 115th Cong. (2018), https://www.congress.gov/115/bills/hr4005/BILLS-115hr4005rfs.pdf.

[24] CBO, Cost Estimate for Opioid Legislation, *op. cit.*

IMD Proposal Would Crowd Out Critical Investments in Community-Based Care

In contrast to the proposals that would modestly enhance access to SUD treatment, one House-passed provision could crowd out other critical investments in community-based care. It would partially repeal a longstanding policy — known as the Institutions for Mental Disease (IMD) exclusion — prohibiting the use of federal Medicaid funds for care of patients ages 21 to 64 receiving SUD treatment in facilities with more than 16 beds.[25] Repealing or partially repealing the IMD exclusion risks doing more harm than good.[26]

The legislation would partially repeal the IMD exclusion for five years but would only allow states to use federal Medicaid funds to pay for care delivered in IMDs for people with opioid use disorders (OUD) and those who use cocaine; it *wouldn't* allow them to use those funds to pay for residential treatment for Medicaid beneficiaries with other SUDs.[27] Nor would it require states to increase investments in community-based services, which are badly needed in many states. These services are important both to people not treated in residential facilities and to people who leave residential treatment and need community-based services to continue their treatment and recovery and get treatment quickly in the event of a relapse.

Guidance issued by the Obama and Trump Administrations provides a better alternative to relaxing the IMD exclusion for SUD treatment, which makes repeal unnecessary and likely counterproductive. The guidance allows states to obtain limited waivers from the exclusion if they *also* take steps to ensure that people with SUDs have access to other care they need, including preventive, treatment, and recovery services, all provided in accordance with evidence-based standards.[28] Eleven states have SUD waivers, and 12 others have proposals pending; the Trump Administration has encouraged other states to apply.[29]

SUD waivers allow states to address the full range of SUDs, which may vary by state and over time and by demographic group. For example, alcohol-related deaths are much more common than

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[25] IMD CARE Act, H.R. 5797, 115th Cong. (2018), https://www.congress.gov/115/bills/hr5797/BILLS-115hr5797ih.pdf.

[26] Katch, *op cit.*

[27] For purposes of defining which individuals with opioid use disorders would have access to care in an IMD under the legislation, the bill defines "opioid prescription pain relievers" as including "fentanyl products." It doesn't specify whether *illicitly* manufactured fentanyl — in contrast with *prescription* fentanyl — would be included. Illicitly manufactured fentanyl is primarily responsible for the rapid increase in U.S. drug overdose deaths. See Centers for Disease Control and Prevention, "Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July-December 2016," November 3, 2017, https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm.

[28] Centers for Medicare & Medicaid Services, "Strategies to Address the Opioid Epidemic," November 1, 2017, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[29] Paige Winfield Cunningham, "The Health 202: HHS chief pushes Trump opioid commission's top recommendation," *Washington Post,* March 2, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/03/02/the-health-202-hhs-chief-pushes-trump-opioid-commission-s-top-recommendation/5a9821f030fb047655a06a2e/.

opioid overdose deaths,[30] both nationally and in certain states such as Alaska, where the rate of alcohol-related mortality is more than double the national rate.[31] Other states may have greater needs for services to treat people using methamphetamines and other substances in addition to opioids and cocaine.

In contrast, the House proposal's extremely limited approach ignores the harm of SUDs other than opioid use disorders. Nearly 8 in 10 adults with an SUD *don't* have an opioid use disorder, yet they (other than those using cocaine) would be excluded from IMD treatment services under the proposal. The proposal could also have racially disparate effects: among adults with an SUD covered by Medicaid, only 17 percent of black adults and 13 percent of adults of other races/ethnicities have an opioid use disorder, whereas 26 percent of white adults do. While the proposal would also give states the option to pay for residential treatment for those using cocaine (in addition to opioids), it would nevertheless create an arbitrary hierarchy within SUD treatment.[32]

The IMD proposal would also cost the federal government almost $1 billion during the five years it would be in effect, and there would likely be pressure to extend the policy at additional cost.[33] Rather than spending scarce resources on narrow legislation that wouldn't help many people with SUDs or invest in community-based substance use treatment for those with opioid use disorders, Congress could pass legislation to direct the Administration to create a template SUD waiver. That would streamline the process for submitting waivers while also helping expand access to needed community-based treatment.

Meanwhile, any resources available to enhance SUD treatment should go to further enhancements of care beyond the modest steps in the House-passed bills. Any new funding that federal policymakers provide to address the opioid crisis should support a full continuum of services, rather than funding care in IMDs for which states can already receive federal funds through SUD waivers.

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[30] German Lopez, "The Deadlier Drug Crises That We Don't Consider Public Health Emergencies," Vox, October 27, 2017, https://www.vox.com/policy-and-politics/2017/10/27/16557550/alcohol-tobacco-opioids-epidemic-emergency.

[31] Alaska Department of Health and Social Services, "Health Indicator Report of Alcohol Consumption — Binge Drinking," August 16, 2018, http://ibis.dhss.alaska.gov/indicator/view/AlcConBinDri.AK_US_time.html.

[32] MaryBeth Musumeci, "Key Questions About Medicaid Payment for Services in 'Institutions for Mental Disease,'" Kaiser Family Foundation, June 14, 2018, https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/.

[33] CBO, Cost Estimate for Opioid Legislation, *op. cit.* The CBO cost estimate was prepared before adoption of the amendment adding cocaine to the list of substances triggering eligibility for residential treatment.