



Review of State Strategies to Expand Medication-Assisted Treatment

A REPORT TO THE LAURA AND JOHN ARNOLD FOUNDATION

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Introduction

Objective

This report is intended to support state Medicaid agencies and payers in improving access to substance use disorder (SUD) treatment, quality, and capacity, with a special focus on medication-assisted treatment (MAT) for opioid use disorder (OUD). To prepare this report, the Technical Assistance Collaborative, Inc. (TAC) and its associates conducted a review of state activities (including state Medicaid agencies, Medicaid managed care organizations, and single state agencies for substance abuse) that have significantly increased both the number of individuals receiving MAT for OUD and the number of providers delivering MAT services. The authors used a case study approach and conducted interviews with leaders in six states (California, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington), three Medicaid managed care organizations (Central California Alliance for Health, Partnership Health Plan of California, and UPMC For You), and one provider organization (Staten Island Performing Provider System) that have undertaken significant steps to increase the availability and provision of MAT. Key themes, successful strategies, and significant challenges common to the states and managed care organizations (MCOs) are described in this report.

Why Medication-Assisted Treatment in Medicaid?

Medicaid plays an existential role in combatting the national opioid epidemic. Medicaid accounts for the greatest coverage population with OUD, covering nearly four in ten non-elderly adults with OUD; Medicaid finances more addiction treatment than all private payers combined, accounting for 25 percent of all SUD-related spending in 2014 and projected to account for 28 percent by 2020; and Medicaid members have a higher rate of OUD than privately insured individuals do, are more likely to be prescribed opioids for pain, and have a higher risk of overdose.¹ As states continue to develop strategies to mitigate the dynamic and evolving opioid epidemic, Medicaid presents a pivotal resource for expanding treatment and facilitating access to life-saving services.

MAT has been established by research and clinical science as the best standard of care for treating OUD, and therefore expanding access to evidence-based treatment is paramount for payers and providers to address the opioid crisis.² We believe the “North Star” goals of any payer policy strategy to expand MAT should include reducing opioid-related overdose deaths; increasing the number of individuals with OUD in recovery; improving physical health outcomes and reducing comorbidities associated with OUD; reducing emergency department (ED) and inpatient hospital utilization associated with OUD; and, if possible, achieving savings. These and other goals can readily be achieved by increasing the availability, provision, and quality of MAT services.

Background

There are a number of initiatives being implemented to improve the availability and provision of MAT at the national level, especially for publicly funded providers. For example, recent

federal legislation directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to administer several funding opportunities totaling approximately \$2 billion to address the opioid crisis, including State Targeted Response to the Opioid Crisis grants which support prevention, treatment, and recovery activities; and State Opioid Response grants and Tribal Opioid Response grants which focus especially on MAT. The SUPPORT Act reauthorizes additional state grants until 2021. The Centers for Medicare and Medicaid Services (CMS) has taken steps to improve the availability and provision of MAT for Medicaid beneficiaries by releasing policy guidance to states on MAT coverage options and best practices,³ offering MAT-related tools and technical support opportunities through the Medicaid Innovation Accelerator Program,⁴ revising its Section 1115 substance use disorder (SUD) policy to introduce new requirements regarding the availability of MAT,⁵ and launching new models through the CMS Innovation Center to better align and coordinate care for pregnant women⁶ and children⁷ affected by the opioid crisis.

While all state Medicaid programs currently cover buprenorphine and naltrexone and all but nine cover methadone, federal legislation signed into law in October 2018 (the SUPPORT Act) requires state Medicaid programs to cover *all* forms of MAT from October 2020 through September 2025 unless a state receives a waiver due to provider shortages.⁸ Historically, MAT medications and services have been covered and available to Medicare beneficiaries (depending on the provider type), with the exception of methadone, which was not covered by Medicare for use in OUD treatment. (Opioid treatment programs could not enroll as Medicare providers, and methadone was not a Part D drug because it cannot be dispensed by prescription at a retail pharmacy.) Now, the SUPPORT Act has established Medicare coverage for opioid treatment programs for the first time, bringing Medicare coverage for MAT into closer alignment with Medicaid and private payer benefits packages.⁹

To further contextualize this report within federal and state efforts to expand the availability and provision of MAT, we underscore the dynamic and rapidly evolving nature of the crisis. Several interviewed state officials noted that while most federal and public energy focuses on OUD specifically, they are observing a resurgence of stimulant use disorder driven primarily by rising rates of methamphetamine addiction. Not only has methamphetamine addiction endured in areas with a longstanding history of this problem, states and regions hit hardest by the opioid epidemic are now experiencing the advent of a methamphetamine crisis within the opioid-dependent population. Meth may develop into a compounding factor of the opioid crisis on a larger scale, bringing new public health and addiction treatment challenges to states attempting to mitigate and prevent further incidence of OUD. While the activities and strategies described in this report are centered on MAT for OUD, we suggest that to expand access to evidence-based OUD treatment, payers and providers consider policy strategies related to polysubstance use.

What Follows

This report highlights the best practices from a set of state Medicaid agencies and MCOs that have successfully designed and executed coverage, program, and payment policies to increase

the availability, provision, and quality of MAT. Other states and payers can leverage the successful approaches, early findings, and lessons learned from these leader states to support implementation and planning purposes. This review of effective Medicaid MAT strategies is organized by core topics of SUD delivery system design, including service coverage and benefit design, payment approaches, provider training, and quality monitoring. Challenges that states confronted during their planning and implementation phases are highlighted, as are their solutions for addressing those challenges. The report concludes with a snapshot of how the reviewed states have increased the availability and provision of MAT, in addition to improving the quality of care, reducing ED and inpatient hospital utilization associated with OUD, and decreasing medical expenditures.

Effective Strategies to Expand MAT

Benefit Design to Incentivize Team-Based Care

A prerequisite for delivering MAT services to Medicaid beneficiaries and commercial MCO members is coverage for the medications and associated treatment services under their particular health insurance plan. All of the officials we interviewed indicated they had historically covered all three FDA-approved medications for OUD treatment, with several states noting low historical utilization of Vivitrol.

Every state Medicaid program covers both buprenorphine and naltrexone, and all but nine cover methadone.¹⁰ States demonstrating high increases of MAT availability and provision are differentiated by their coverage approaches to the underlying clinical and support services that form a comprehensive path of care for MAT, beyond basic coverage of drug products and physician office visits. The states and managed care plans we interviewed took the step of formally articulating a team-based model of care for MAT, and designed benefits to reflect that model.

For example, states such as Vermont and Rhode Island introduced coverage for health home services for beneficiaries with OUD as an optional benefit in their Medicaid State Plan (established by Section 2703 of the Affordable Care Act and authorized by Section 1945 of the Social Security Act). Pursuant to the Medicaid health home benefit option, health home providers in Vermont and Rhode Island use a multidisciplinary, team-based approach to deliver a range of services designed to address the chronic care needs of their patients, including:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional and follow-up care
- Patient and family support
- Referral to community and social services

In Virginia, the Preferred Office-Based Opioid Treatment (OBOT) program establishes a “Gold Card” option for OBOT providers that meet enhanced standards to receive additional and

enhanced payments. Virginia’s Preferred OBOT program outlines a set of mandatory criteria for clinical services and staffing, including a waived physician or mid-level practitioner with a collaborative practice agreement or supervision by a physician; a licensed behavioral health provider co-located at the same practice site; counseling services; interdisciplinary care coordination; and risk management/patient monitoring.ⁱ

When states cover and develop explicit benefit design features for MAT services that correspond to clinical and staffing requirements, many of the concerns raised by primary care providers who are reluctant to begin providing MAT are ameliorated. Allowing providers to receive reimbursement for a collaborative, team-based care model for MAT is critical to address these concerns. Explicit benefit design features for team-based MAT care models provide a pathway for primary care offices to deliver sustainable, high-quality, evidence-based treatment. Furthermore, clearly delineated expectations for nursing, behavioral health, and care coordinator professionals in managing the practice’s buprenorphine panel guarantees physicians the clinical support staff and administrative resources necessary to treat a complex patient population with chronic care needs. Team-based MAT care models are also optimally cost-efficient, allowing prescribers to practice at the top of their license while nurses, behavioral health professionals, and care coordinators provide the care management, counseling, and coordination services vital to ensuring good outcomes.

Regarding benefit management, many of the states we reviewed had recently eliminated or relaxed prior authorization (PA) requirements for MAT. States have continued their PA for some forms of MAT — for instance for newer medications to track clinical appropriateness which can be common for newer medications in general. They may also keep PA in place to encourage less expensive forms of MAT that may have comparable effectiveness. Washington and Rhode Island have eliminated PA for all forms of MAT in Medicaid. Pennsylvania eliminated PA for all plans regulated by the state, including those participating in Medicaid, the individual market, and the fully insured group market. California Medicaid removed PA for buprenorphine in 2015 but continues to apply PA for Vivitrol for non-justice-involved populations, for reasons pertaining to clinical appropriateness and fiscal control (although counties participating in the state’s 1115 SUD waiver have the option of paying for the state share to bypass PA). Vermont removed PA for buprenorphine dosages under 16 milligrams for its “Spoke” providers in 2018 but continues to apply PA for Vivitrol and Sublocade to ensure clinical appropriateness.ⁱⁱ Officials in all states spoke favorably of removing PA for buprenorphine, with several lamenting that it did not happen earlier.

ⁱ “Waivered physicians” are those who have received a waiver from SAMHSA to prescribe buprenorphine for opioid dependence treatment in accordance with the Drug Addiction Treatment Act of 2000.

<https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management>

ⁱⁱ “Spoke” refers to physician practices providing buprenorphine, nursing, and counseling services as part of the Hub and Spoke program, Vermont’s system for delivering MAT.

Payment to Incentivize Team-Based Care

Many of the state agencies and MCOs we interviewed have created new financing mechanisms to incentivize the team-based care approach described above. For example, during initial engagement efforts in Vermont to increase the prescribing of buprenorphine in primary care, small practices told the state they wanted to treat their buprenorphine panels like high-risk pregnancy panels, with dedicated nursing staff. Practices also told the state that due to 42 CFR Part 2 data restrictions, it was too hard to coordinate with specialty SUD treatment providers to track whether buprenorphine patients were receiving counseling. Vermont's solution was to embed nursing and counseling services directly into its primary care practices. The state collaborated with primary care physicians to design a core staffing model of one registered nurse and one licensed counselor per 100 patients, developed the payment rates to finance those positions, and performed cost modeling to demonstrate cost neutrality to state policymakers. To pay for the nurse and counselor services made available to individual Spokes, Vermont makes monthly capacity payments for the Spoke MAT teams based on the average monthly number of unique patients for whom Medicaid paid a buprenorphine or Vivitrol pharmacy claim during the most recent three-month period. In Vermont, Hubs receive monthly "enhanced health home" payments for patients who receive at least one face-to-face treatment service encounter and one health home service.

In Rhode Island, the opioid treatment programs (OTPs) participating as Medicaid Health Home providers receive a weekly bundle for providing standard OTP services, and a monthly supplemental health home payment for the six required Medicaid Health Home services described above. Several years after implementation, Rhode Island also developed an alternative funding model for OTPs that receive state certification as a Center of Excellence (COE). In Rhode Island, COEs can be, but are not exclusively, OTP health home providers that demonstrate enhanced clinical staffing, service, and programmatic capacity. The COE model is intended to expand and enhance the state's MAT statewide capacity and to improve the quality of care and patient satisfaction.

To purchase the full array of clinical and support services and the team-based staffing model in the "Preferred OBOT" designation described above, Virginia established a monthly bundled rate (\$243) for SUD-specific care coordination.ⁱⁱⁱ Virginia also reimburses Preferred OBOTs at enhanced payment rates for peer recovery specialists and counseling. The state requires its Medicaid MCOs to pay the monthly SUD care coordination payment and enhanced rates for SUD care coordination, peer recovery support services, and counseling. In addition, as described in the quality and performance monitoring section below, Virginia is pursuing a value-based purchasing strategy for its Preferred OBOTs with payment incentives contingent on quality reporting thresholds. The state identifies its enhanced payments and Preferred OBOT program as the linchpin of its success; in materials provided to the Senate Finance Committee regarding Medicare/Medicaid Policy Ideas in Addressing the Opioid Crisis, the state identified increased reimbursement for MAT as the top recommendation for state Medicaid agencies and Medicare to consider for increasing effective treatment for OUD.¹¹

ⁱⁱⁱ Virginia implemented its monthly SUD care coordination fee to Preferred OBOTs per 42 CFR 447 Subpart 4.

Pennsylvania provided capacity funding both to its opioid-focused COEs and to its Pennsylvania Coordinated MAT (PAC-MAT) programs, and provides grant funding to its COEs specifically for care management services. In 2019, Pennsylvania’s grant-based payments to COEs for care management are being converted to a care management bundle that will be included in MCO capitation rates; plans will be encouraged to pay a care management bundle to non-COEs as well. Independently, some Pennsylvania MCOs have made value-based purchasing arrangements with certain providers, through which the providers receive a bundled payment for buprenorphine and naltrexone with performance measures that can enhance that payment.

At the local level in Pennsylvania, the Medicaid MCO UPMC For You has implemented a per member per month fee for OUD-focused case management for a number of primary care practices and is evaluating strategies for further expansion. The state of Washington is providing funding to add nurse care managers and care navigators to medical practices. In California, the Medicaid MCO Central California Alliance for Health offers extra fee-for-service payments in addition to capitated payments to support waived primary care clinicians in providing MAT best practices (such as urine drug screens and prescription drug monitoring program review) and a team-based staffing model.

Notably, each of these states developed or is developing distinct payments to OBOT, OTP, or other Center of Excellence providers to purchase care management and care coordination services delivered by non-physician medical and behavioral health staff who had not previously been reflected in reimbursement rates and billing options for these provider types. Typically disbursed in the form of monthly (Vermont, Virginia, Pennsylvania) or weekly (Rhode Island) fees, new payment rates sufficient to cover the costs of nurse care managers, counselors, and/or care coordinators are integral to each state’s strategy to increase access to MAT for opioid-dependent beneficiaries. Enhanced payments to MAT providers can be designed and implemented in both fee-for-service delivery and managed care environments. In accordance with applicable federal managed care rules pertaining to provider payment initiatives, states are permitted to direct MCOs to provide increased payment and implement value-based purchasing models.

Implementation and Practice Transformation

One challenge to increasing the availability of MAT in provider networks across payers is reluctance by providers to obtain the federally required waiver to prescribe buprenorphine and, for those who are waived, to actively prescribe in numbers reaching their patient limit. Would-be OBOTs cite concerns about “hanging a shingle” and attracting a new set of addiction patients to their practice; lacking experience with OUD and other SUDs as clinical conditions; and not having sufficient clinical supports, bandwidth, or resources to provide the care and case management, coordination, and psychosocial services required to treat OUD patients. Asking non-specialty clinicians to deliver new pharmacologic therapies to treat complex behavioral and medical conditions in a vulnerable patient population without providing resources to support such practice transformation may dilute a state’s MAT strategy.

Several of the states and Medicaid MCOs we interviewed managed such concerns aggressively by making proactive, state-facilitated quality improvement and clinical training opportunities available to providers. These clinical training initiatives were designed to address providers' reluctance to deliver MAT and were implemented as part of broader, system-wide strategic initiatives designed to improve MAT availability and quality. For example, as Vermont officials designed the state's Hub and Spoke program, they recognized that provider readiness would be critical to successful implementation. Vermont leveraged its prior experience establishing patient-centered medical homes in which nurses, social workers, and other staff supported practices managing chronic conditions like asthma, hypertension, and diabetes. A similar framework was built into the Hub and Spoke model. Vermont initially contracted with clinical faculty from Dartmouth-Hitchcock Medical Center to run regional learning collaboratives for OBOTs, with approximately 50 practices participating with their teams. Since 2013, learning collaboratives composed of OBOTs participating in the Hub and Spoke initiative have reported metrics to benchmark their performance, process, and patient status; rapidly implemented best practice protocols; and collectively increased OBOTs' capacity to offer MAT.

Virginia also supplemented its new MAT coverage and payment policies with a robust provider training initiative as part of an overall MAT expansion strategy. Through state- and contractor-led efforts, Virginia offered online and in-person training to hundreds of prescribers and support staff, developed statewide hotlines to provide clinical consultative support to new MAT providers, implemented case conferencing opportunities through Project ECHO, provided Regional MAT Champions to serve as mentors to new MAT providers in their region and provide advice about difficult patient challenges, established quarterly collaborative meetings for OBOTs, and offered Continued Medical Education credits for participation. Their work paid off, with the number of beneficiaries who received pharmacotherapy for OUD increasing by 34 percent during the first year of implementation.¹²

As part of New York's Section 1115 Delivery System Reform Incentive Payment program, the Staten Island Performing Provider System offers buprenorphine detailing and coaching opportunities for waived providers, which has resulted in high rates of active buprenorphine prescribing: 77 percent of waived prescribers who received support prescribe buprenorphine.¹³ Rhode Island has provided training support to over 300 physicians to obtain the waiver.¹⁴ Medicaid MCOs such as UPMC For You have supported training for PCPs to receive the waiver and provided technical assistance and case conferencing opportunities for providers regarding MAT. Partnership HealthPlan of California previously offered incentive payments of \$500 for primary care physicians to receive the waiver in tandem with efforts to mitigate billing issues posing a barrier to MAT in primary care. Another Medicaid MCO in California, Central California Alliance for Health, also offered incentive payments of \$1,000 to physicians and eligible mid-level practitioners to receive the waiver.

Policy and Operational Barriers

The interviewed state officials and Medicaid MCO representatives identified various barriers to increasing access to MAT. While the states and MCOs did address these barriers, they were not able to overcome all of them. The most substantial barrier was provider stigma among both physicians and specialty SUD providers. For different reasons, these provider groups were uncomfortable or unwilling to provide MAT in their organizations. For example, primary care physicians are concerned that addiction patients may be problematic and non-adherent to treatment. In addition, physician practices are concerned about not having the competencies to offer medication and about lacking relationships with addiction treatment professionals who can provide psychosocial supports. In addition to widespread prejudice among primary care physicians towards agonist-based pharmacotherapies, a sizeable percentage of addiction treatment providers, too, are still abstinence-based. This stance may lead them not to offer MAT, not to accept new patients who are on medications, or not to offer the environment needed for someone to continue on MAT.

Several states indicated a major challenge with their OTP providers. First, many of these providers have operated apart from physical health care systems for many decades. Most of these programs have historically offered only methadone. Convincing these programs to add practitioners who could prescribe other SUD medications was a heavy lift. Second, states are conflicted in how to expand the availability of OTPs. In some instances, the states have developed restrictive Certificate of Need processes to limit network participation by unsavory OTP providers. The demand for MAT has increased and states are struggling to identify strategies that will increase access without either creating significant program integrity issues or inviting shady marketing practices by potential OTP providers.

States also identified challenges with making the necessary adjustments to payments to promote MAT and specific models. Internally, agencies indicated that leadership was concerned by moving from a fee-for-service model to a bundled rate. Issues regarding establishing the rate and ensuring accountability were barriers that needed to be discussed and addressed throughout states' MAT strategic initiatives.

Lastly, all the state officials we interviewed indicated that they had little bandwidth to move their MAT initiatives to the next phase. While significant progress has been made over the past several years, they are by no means satisfied that they are close to meeting the demand for MAT. They recognize that the next phase of work will be more challenging — the initial physician practices that offered OBOT, while having major concerns at first, were the organizations that were the “pace cars.” Efforts to work with the next subset of possible OBOT or OTP organizations may require a different strategy, and the process may take longer depending on the interest and concerns of these providers. Such efforts will help states meet new federal requirements that states offer MAT, whether by implementing the requirements of the SUPPORT Act or by meeting CMS' 1115 SUD waiver requirement that every residential provider either offer MAT on-site or facilitate access off-site.

Quality and Performance Measurement

Accompanying payers' commitment to expanded MAT access for OUD is a parallel commitment to quality of care. Many of the organizations interviewed are beginning to use performance measures to evaluate various aspects of clinical care.

As Virginia created its credentialing program for Preferred OBOTs, it also published a set of quality measures that the state intends to use initially for performance monitoring and ultimately within a value-based purchasing arrangement. Virginia's set of Preferred OBOT measures includes:

- Urine drug screening
- Appropriate prescribing of buprenorphine mono product
- Prescription opioid drug dosage monitoring
- No tolerance to benzodiazepines
- Screening for HIV and Hepatitis B and C
- Opioid overdose presentation
- Monitoring of patients at initiation

Currently, Virginia is revising these measures and will reissue them in early 2019 based on initial reporting experience.

Using its Patient Centered Medical Home Transformation Project as a framework, Vermont initially used a small set of metrics for Spoke providers participating in its learning collaboratives, including:

- A clear diagnosis of OUD for patients receiving buprenorphine to ensure MAT is medically necessary and appropriately documented
- Checking the Prescription Drug Monitoring Program at intake and quarterly thereafter to ensure patients are not receiving concomitant prescriptions for opioids or benzodiazepines
- Evidence of monthly urinalysis
- Patients on high dosage
- Percentage of unstable patients seen weekly

Now, Vermont publishes regional profiles for both Hubs and Spokes that include quality, cost, and utilization data such as MAT enrollment per 1,000 Medicaid beneficiaries, inpatient discharges, ED visits, and MAT and health care expenditures per capita.¹⁵

For the OTP health home providers certified as COEs, Rhode Island tracks utilization, successful discharges to community OBOTs, reduction of illicit substance use, reductions in hospitalizations and ED visits, engagement, and retention. Washington is starting to look at hospitalization rates, ED visits, soft tissue infection rates, continuation in care, and overall health care costs for those receiving MAT. UPMC For You is developing a special credentialing process for providers that prescribe MAT with the goal of creating a provider network to adhere

to certain quality metrics, and is considering making the credential mandatory to enhance high quality MAT. Examples of quality metrics that UPMC For You assesses include:

- Length of engagement in treatment
- Screenings for concurrent medical problems such as infectious disease (e.g. HIV and Hepatitis B and C)
- Contraindicated prescription drugs (e.g. opioids and benzodiazepines)
- Engagement in concurrent psychosocial services

Pennsylvania tracks the same preliminary measures developed by Virginia, with the addition of patient engagement in treatment, duration of treatment, receipt of SUD counseling, receipt of mental health counseling, and several measures related to postpartum services for women. In 2019, Pennsylvania will also launch a hospital quality incentive program in which each emergency department will have the opportunity to earn benchmark and incremental improvement incentive payments for establishing up to four clinical pathways for patients with OUD:

- ED initiation of buprenorphine with warm handoff to the community
- Direct warm handoff to the community for MAT or non-MAT treatment
- Specialized protocol to address pregnant women with OUD
- Direct inpatient admission pathway for methadone or observation for buprenorphine induction

Criminal Justice Intersection

Officials and MCO representatives in the states we interviewed emphasized their progress in serving justice-involved people with OUD. In general, these payers are pursuing targeted strategies that fall into three buckets: efforts to retain Medicaid enrollment; efforts to provide MAT within correctional facilities and prior to release; and efforts to collaborate with and engage counterparts in the state and local criminal justice systems.

Vermont, for example, has incorporated all three strategies. Not only does Vermont suspend (in lieu of terminating) Medicaid eligibility upon incarceration, the state automatically reinstates eligibility upon release (in lieu of requiring an individual to reapply at release). Vermont has also developed a statewide policy that any inmate who spends less than 120 days incarcerated will continue receiving MAT therapies while incarcerated. This innovative policy means that the jails and prisons communicate with Hub and Spoke providers to confirm inmates' MAT protocols, provide daily dosing and transportation services for methadone, and coordinate for release. Per recently passed legislation, jails and prisons in Vermont are also required to provide inductions.¹⁶ Currently, approximately one in three incarcerated individuals in Vermont receives MAT.¹⁷ Rhode Island is the only other state reviewed that currently provides all three forms of MAT within the walls of its corrections facility. (Notably, there is only one correctional facility in the state, which serves as both a jail and a prison). Rhode Island continues MAT for incarcerated individuals for up to one year, provides induction for all three forms of MAT and maintenance for up to one year, and provides induction for all three forms of MAT prior to release when clinically appropriate.

Generally, criminal justice entities in the states we reviewed — including detention facilities such as jails, prisons, and some drug courts — have preferred providing Vivitrol (as an antagonist) over buprenorphine and methadone products (as partial and full agonists) to inmates as part of pre-release and transitional service programming, due to Vivitrol’s lack of potential for abuse. However, during interviews several Medicaid and substance abuse agency officials attested to incremental progress in collaborating with their criminal justice system counterparts to deliver additional forms of MAT within correctional facilities. For example, Pennsylvania officials reported that one state correctional institution currently offers methadone maintenance to pregnant inmates suffering from OUD, and another recently started a Sublocade pilot program using the first FDA-approved extended release injectable form of buprenorphine. Vivitrol is currently available at all 25 state correctional facilities in Pennsylvania. The long-term goal is to have all three FDA-approved medications (buprenorphine, methadone, naltrexone) available throughout the system. California described a pilot project in which 23 jails provide all three FDA-approved medications, and reported that the Los Angeles County Sheriff’s Department recently requested \$17 million from the city’s Board of Supervisors to provide MAT inside jails over a three-year period.

State officials pointed to the ongoing need to continue to engage in dialogue and collaboration with their criminal justice counterparts, including corrections and parole leaders, prosecutors, and the judiciary. For instance:

- California is leveraging its 1115 SUD waiver as a basis for bridge-building and to educate jail, prison, and parole officials about the MAT and SUD benefits and delivery system available to the justice-involved population.
- Vermont officials lauded the state’s criminal justice leaders for approaching the opioid crisis with a public health frame, with district and state attorneys prioritizing treatment over incarceration.
- Virginia officials have elsewhere testified to emerging relationships with judicial leaders regarding SUD benefits, clinically-based assessments, and individual treatment planning.

Opium Treatment Program Improvements and Innovation

Although most payers have focused on expanding OBOT capacity, the officials we interviewed have provided opportunities for OTPs to expand their role as well. For example, Vermont increased OTP rates by 30 percent and established expectations for collaboration with the general health care system, including that OTPs act as consultants to primary care physicians and OB/GYNs providing MAT. California developed licensing authority for OTPs to create medication units in order to expand access and increase the OTP footprint in rural and underserved areas of the state. Virginia made its Preferred OBOT reimbursement enhancements available to OTPs, with higher rates for individual and group counseling and the availability of case-rate-funded care coordination. Virginia also unbundled methadone reimbursement and added a new buprenorphine dispensing code for OTPs. Rhode Island first expanded OTPs’ role through its Section 2703 Medicaid Health Home State Plan Amendment, and thereafter expanded the role of OTPs again through the COE program, with enhanced rates

for dispensing buprenorphine and Vivitrol. Although Washington has not changed reimbursement for OTPs, its newly integrated managed care plans are beginning to reimburse OTPs for buprenorphine outside the methadone bundle. In the future, Washington will consider requiring OTPs to provide all OUD medications and to be formally linked to the health care system.

Impact Findings

Every state reviewed achieved considerable increases in the availability of MAT (expressed by the number of OTPs and waived prescribers in a state’s Medicaid network) and in the provision of MAT (expressed by Medicaid service utilization). These advances in Medicaid can help accelerate system-wide progress in providing evidence-based drug treatment. In addition, most states demonstrate improved quality of care for MAT services, indicated by the concurrent delivery of physical health and psychosocial services, care management and coordination, medication management, and monitoring services. Readily available data from several of the reviewed states also shows positive outcomes in terms of reductions in ED visits associated with OUD, inpatient hospitalizations associated with OUD, and expenditures.

Availability and Provision of MAT¹⁸

Table 1. Increase in Number of Medicaid Beneficiaries Receiving Any Type of MAT

State	Beneficiaries receiving MAT (pre-implementation)	Beneficiaries receiving MAT (post-implementation)	% Change	Notes
California	45,911	56,779	24%	Reflects change 2015-2018
Pennsylvania	18,778	44,883	139%	Reflects change 2013-2017 (excludes methadone)
Rhode Island	7,857	12,790	63%	Reflects change since 2013
Vermont	2,315	6,748	191%	Reflects change since 2011
Virginia	6,444	8,616	34%	Reflects change April 2017-March 2018 42% of beneficiaries with OUD received MAT, an increase of 34%
Washington	4,947	22,558	356%	Reflects change 2013-2017

Table 2. Increase in Number of Beneficiaries Receiving Buprenorphine

State	Beneficiaries receiving buprenorphine (pre-implementation)	Beneficiaries receiving buprenorphine (post-implementation)	% Change	Notes
California	7,051	16,045	127%	Reflects change 2015-2018

Pennsylvania	18,001	36,791	104%	Reflects change 2013-2017
Rhode Island	2,991	6,500	117%	Reflects change since 2013 State notes much utilization is withdrawal management only.
Vermont	1,700	3,931	131%	Reflects change since 2013
Virginia	5,215	6,376	22%	Reflects change April 2017-March 2018
Washington	984	12,129	1,133%	Reflects change 2013-2017

Table 3. Increase in the Number of Beneficiaries Receiving Methadone

Payer	Beneficiaries receiving methadone (pre-implementation)	Beneficiaries receiving methadone (post-implementation)	% Change	Notes
California	38,756	40,398	4%	Reflects change 2015-2018
Pennsylvania	N/A	N/A	N/A	N/A
Rhode Island	4,866	6,152	26%	Reflects change since 2013
Vermont	615	2,698	339%	Reflects change since 2011
Virginia	6,444	8,616	34%	Reflects change April 2017-March 2018
Washington	4,017	5,429	35%	Reflects change 2013-2017

Table 4. Increase in the Number of Beneficiaries Receiving Naltrexone

Payer	Beneficiaries receiving naltrexone (pre-implementation)	Beneficiaries receiving naltrexone (post-implementation)	% Change	Notes
California	104	336	223%	Reflects first year of Hub and Spoke pilot, August 2017-July 2018 (all payers)
Pennsylvania	777	8,092	941%	Reflects change from 2013-2017
Rhode Island	37	138	273%	Reflects change since 2016
Vermont	N/A	N/A	N/A	State reports low utilization
Virginia	N/A	N/A	N/A	N/A
Washington	N/A	N/A	N/A	N/A

Table 5. Increase in the Number of Buprenorphine Providers

Payer	Waivered prescribers (pre-implementation)	Waivered prescribers (post-implementation)	% Change	Notes
California	2,400	4,300	79%	Reflects change 2015-2017
Pennsylvania	N/A	N/A	N/A	N/A
Rhode Island	192	434	126%	Reflects change since 2014 51% are actively prescribing, an increase from 43%
Vermont	114	232	104%	Reflects change since 2013 50% increase in prescribers with caseloads >10
Virginia	N/A	848	N/A	Reflects change April 2017-March 2018
Washington	532	2,126	300%	Reflects change 2013-2018 58% are actively prescribing to beneficiaries The 2013 figure only includes prescribers listed on SAMHSA's Buprenorphine Practitioner Locator website; the 2018 figure includes all waived prescribers.

Table 6. Increase in the Number of Opioid Treatment Programs

Payer	Opioid Treatment Programs (pre-implementation)	Opioid Treatment Programs (post-implementation)	% Change	Notes
California	N/A	N/A	N/A	N/A
Pennsylvania	N/A	N/A	N/A	N/A
Rhode Island	12	22	83%	Reflects change since 2013
Vermont	6	9	50%	Reflects change since 2011
Virginia	6	39	550%	Reflects change April 2017-March 2018
Washington	25	25	0%	Reflects change since 2013

Quality of Care for Buprenorphine

By developing and promulgating an explicit MAT care model through coverage and payment policies delineating required clinical staffing patterns and treatment services, the reviewed states improved the quantity, frequency, and types of clinical and care management services delivered concurrently with the pharmacologic therapies used in MAT. Within the primary care setting of an OBOT provider, the concurrent treatment services in a team-based MAT care model can include:

- Physician evaluation and management
- Comprehensive care management, including nurse care management
- Psychosocial therapy and counseling
- Recovery support services
- Care coordination
- Drug screening
- Prescription drug monitoring
- Naloxone co-prescribing
- Family support services
- Linkages to social and community-based services

Virginia, for example, increased the rate of co-prescribing of naloxone (a rescue agent used to reverse opioid-related overdoses) by 800 percent and decreased the rate of concomitant benzodiazepine prescribing to buprenorphine patients through its Preferred OBOT and 1115 SUD initiatives. In Pennsylvania, the number of Medicaid beneficiaries simultaneously receiving buprenorphine and contraindicated prescription drugs (such as benzodiazepines and opioids) increased by only 358 between 2013 and 2017, which is remarkable considering that the number of beneficiaries receiving buprenorphine increased by nearly 19,000 over the same period.

Prior to the implementation of Virginia’s Preferred OBOT and 1115 SUD projects, only 30 percent of buprenorphine patients also received other treatment services, such as therapy, counseling, or specialty treatment delivered by intensive outpatient or residential providers. Now, 48 percent of buprenorphine patients receive these treatment services concurrently with the medication. Focusing on its Preferred OBOT initiative specifically, Virginia shows higher quality of care for buprenorphine patients treated by Preferred OBOT providers compared to buprenorphine patients of other providers, as conveyed in Table 7 below.

Table 7. Patients of Preferred OBOT Providers Receive Higher Quality Care

	Type of Provider where Buprenorphine Prescription was Received		
	Preferred OBOT Provider	Other Provider in Health Plan Network	Out-of-Network Providers
Percent received other OUD treatment services	72%	51%	36%

Percent received counseling/psychotherapy/physician evaluation	63%	43%	23%
Percent received urine drug screen	55%	35%	26%
Percent received benzodiazepines	17%	22%	31%
Percent received gabapentin	37%	34%	371%
Percent received naloxone	14%	8%	8%
Percent received mono-product buprenorphine	12%	25%	32%

Source: [VCU Health Behavior & Policy School of Medicine ARTS Evaluation Update \(March 2018\)](#)

Additional Outcomes

In addition to increased availability and improved quality of MAT services, many states reviewed also achieved positive outcomes associated with their MAT initiatives by reducing medical expenditures, illicit opioid use, and inappropriate utilization of ED and inpatient hospital settings:

- Virginia demonstrated a 25-percent decrease in ED visits related to OUD.¹⁹
- Virginia also saw a six-percent decrease in inpatient hospital admissions related to OUD.²⁰
- Over two years, Rhode Island saw a reduction of approximately \$500,000 in pharmacy, inpatient, outpatient, and nursing facility expenditures for its OTP health home clients with more than six months of treatment.²¹
- Rhode Island also increased its treatment retention rates for OTP patients by 50 percent, a key predictor of reduced substance use.²²
- Among its Hub and Spoke patients, Vermont has achieved the following²³:
 - 96-percent decrease in opioid use
 - 89-percent decrease in ED visits
 - 92-percent decrease in injection drug use
 - 90-percent reduction in illegal activity and police detentions/arrests
 - \$6.7 million decrease in health care expenditures
 - Zero overdoses reported in the 90 days prior to patients' self-reporting, versus 25 percent who had overdosed within 90 days prior to entering treatment

Conclusion

Over the next several years, state Medicaid programs and hopefully other payers are likely to continue to seek to develop and sustain approaches for MAT for their Medicaid beneficiaries with SUD. The SUPPORT Act, 1115 SUD requirements, and implementation of the Mental Health and Addiction Parity Act will provide additional momentum for states to develop an effective benefit design for SUD medications and related services for Medicaid beneficiaries.

The six states reviewed all expanded Medicaid to low-income adults, which extended coverage to a greater share of the population that needs SUD services.

It is highly likely that challenges faced by states in expanding the availability, provision, and quality of MAT that are highlighted in this report will exist in states that are just now undertaking such efforts. These challenges included reluctance and ambivalence from physicians concerned that offering MAT would attract a new set of addiction patients to their practice. In addition, many physicians lacked experience with OUD and other SUDs and did not feel that they had sufficient clinical supports, bandwidth, or resources to provide the care management, coordination, and psychosocial services required to treat OUD patients. Perhaps the most substantial barrier was stigma among both physicians and specialty SUD providers. For different reasons, these provider groups were uncomfortable or unwilling to provide MAT in their organizations. Several states also indicated a major challenge with their OTP providers who have operated apart from physical health care systems and have historically offered only methadone. Convincing these programs to add practitioners who could prescribe other SUD medications was an unanticipated challenge. Other challenges included crafting changes in operational and reimbursement policies that would provide more flexibility in the delivery and financing of MAT.

At the core of addressing these and other challenges and developing a sustainable MAT strategy should be clear policy goals for expanding the availability and provision MAT. These goals may include reducing opioid-related overdose deaths; increasing the number of individuals with OUD in recovery; improving physical health outcomes and reducing comorbidities associated with OUD; reducing ED and inpatient hospital utilization associated with OUD; and, if possible, achieving savings.

To achieve these goals payers should consider developing a clear clinical model for their MAT expansion. The states and managed care plans we interviewed took the step of formally articulating a team-based model of care for MAT, and designed benefits and payment rates to reflect that model. These teams included nursing, behavioral health, and care coordinator professionals to help manage the practice's buprenorphine panel, thereby providing physicians with the clinical support staff and administrative resources necessary to treat a complex patient population with chronic care needs. As illustrated by our case studies, a team-based MAT care model is cost-efficient, allowing physicians to practice at the top of their license while nurses, behavioral health professionals, and care coordinators provide the care management, counseling, and coordination services vital to ensuring good outcomes.

In addition, state strategies must also include the necessary training and ongoing supports for practitioners, especially newly waived prescribers. Statewide hotlines to provide clinical consultative support to new MAT providers, case conferencing opportunities through Project ECHO, local MAT Champions to serve as mentors to new MAT providers in their region and provide advice about difficult patient challenges, regular (e.g. quarterly) collaborative meetings for OBOTs, and offering Continuing Medical Education credits are all strategies that states should consider to ensure successful implementation as they stand up their MAT approaches.

Clinical and practice change at the provider level designed to increase the availability, provision, and quality of MAT should be supported with sound policy and reimbursement changes at the payer level. This includes reviewing existing utilization management policies that inhibit rapid and sustained access to MAT, including prior authorization, fail first policies, onerous assessment requirements, limitations on same-day billing, dosage limits, lifetime treatment limits, counseling requirements, and termination policies. In addition, states are encouraged to analyze actual service delivery and overhead costs of providing MAT and develop reimbursement strategies that adequately cover a team-based care model.^{iv} Over time, alternative payment models that are tied to key performance measures may further incentivize high-quality care for Medicaid beneficiaries receiving MAT.

Within recent years, considerable progress has been made in terms of states' coverage and benefit design features for medications used to manage OUD. For example, extended-release naltrexone and at least one form of buprenorphine were covered in at least 51 Medicaid programs in 2018, and methadone was covered in 42 programs. In addition, at least 51 Medicaid programs assigned preferred status to at least one formulation of buprenorphine. Lifetime treatment limits that were historically applied to buprenorphine products despite a lack of clinical evidence and potential parity implications have all but disappeared.²⁴

However, opportunities remain to streamline provision of the first line of treatment for OUD, even in states where buprenorphine products have preferred status. For example, as recently as 2018, prior authorization was required by 40 states for the buprenorphine monoproduct, and by 26 and 25 states for implantable and extended-release buprenorphine, respectively. Perhaps most notably, at least 31 states still required prior authorization for the widely used buprenorphine-naloxone combination product.²⁵ State officials interviewed in this report spoke favorably of removing prior authorization for buprenorphine, with several lamenting that it did not happen earlier.

Lastly, a key takeaway from this report is that MAT strategies for OUD should complement MAT and other treatment strategies for other SUDs. Several interviewed officials noted that while most federal and public energy focuses on OUD specifically, they are observing a resurgence of stimulant use disorder driven primarily by rising rates of methamphetamine addiction, contributing to a methamphetamine crisis within the opioid-dependent population. Alcohol use disorders continue to represent almost 70 percent of all SUD diagnoses.²⁶ Targeted MAT policy and program initiatives may be most effective within an evidence-based framework encompassing polysubstance use disorder and without being limited exclusively to opioid use disorders.

^{iv} In addition to Vermont's use of cost modeling as described in this report, Missouri collaborated with providers to review MAT implementation costs and revise payment rates accordingly. See "State and Local Policy Levers for Increasing Treatment and Recovery Capacity to Address the Opioid Epidemic." U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, September 2017.

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