State Principles for Financing Substance Use Care, Treatment and Support Services

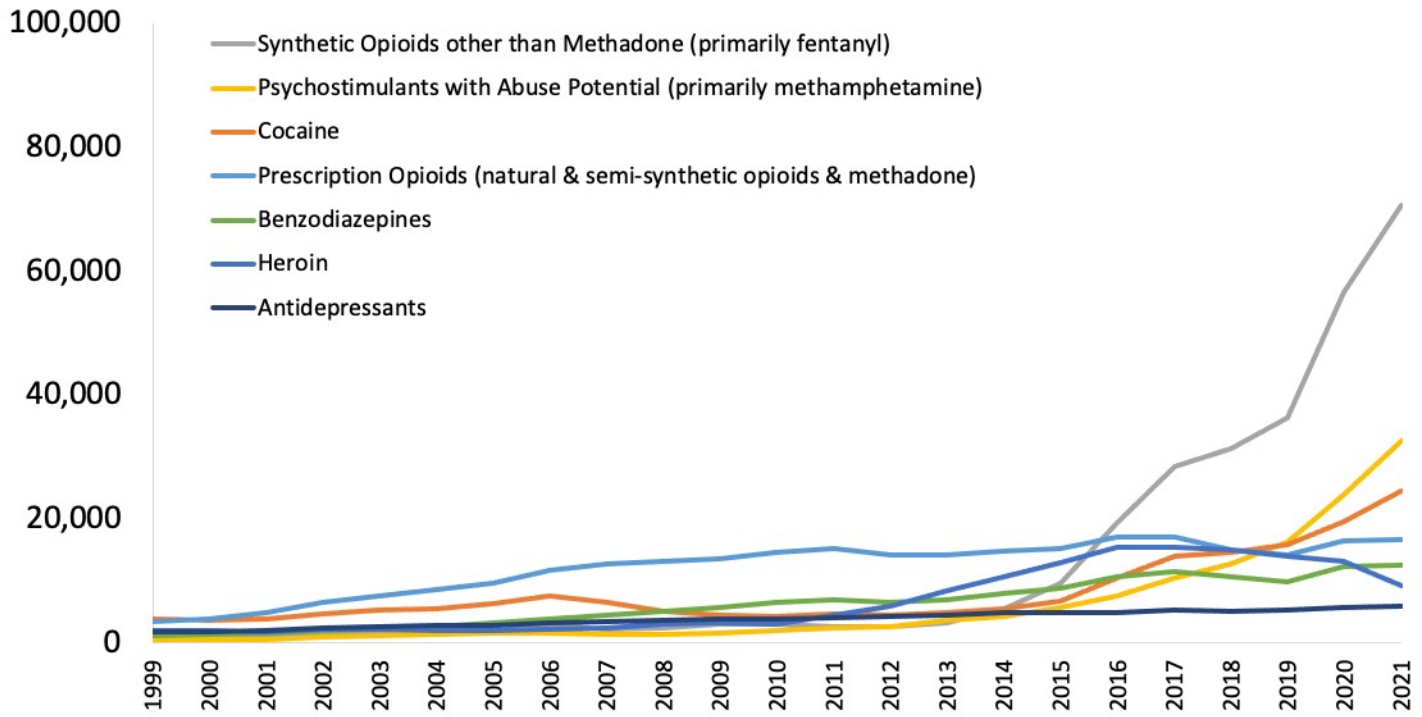
July 10, 2023

Pew

Overview of Current Substance Use Trends and Treatment

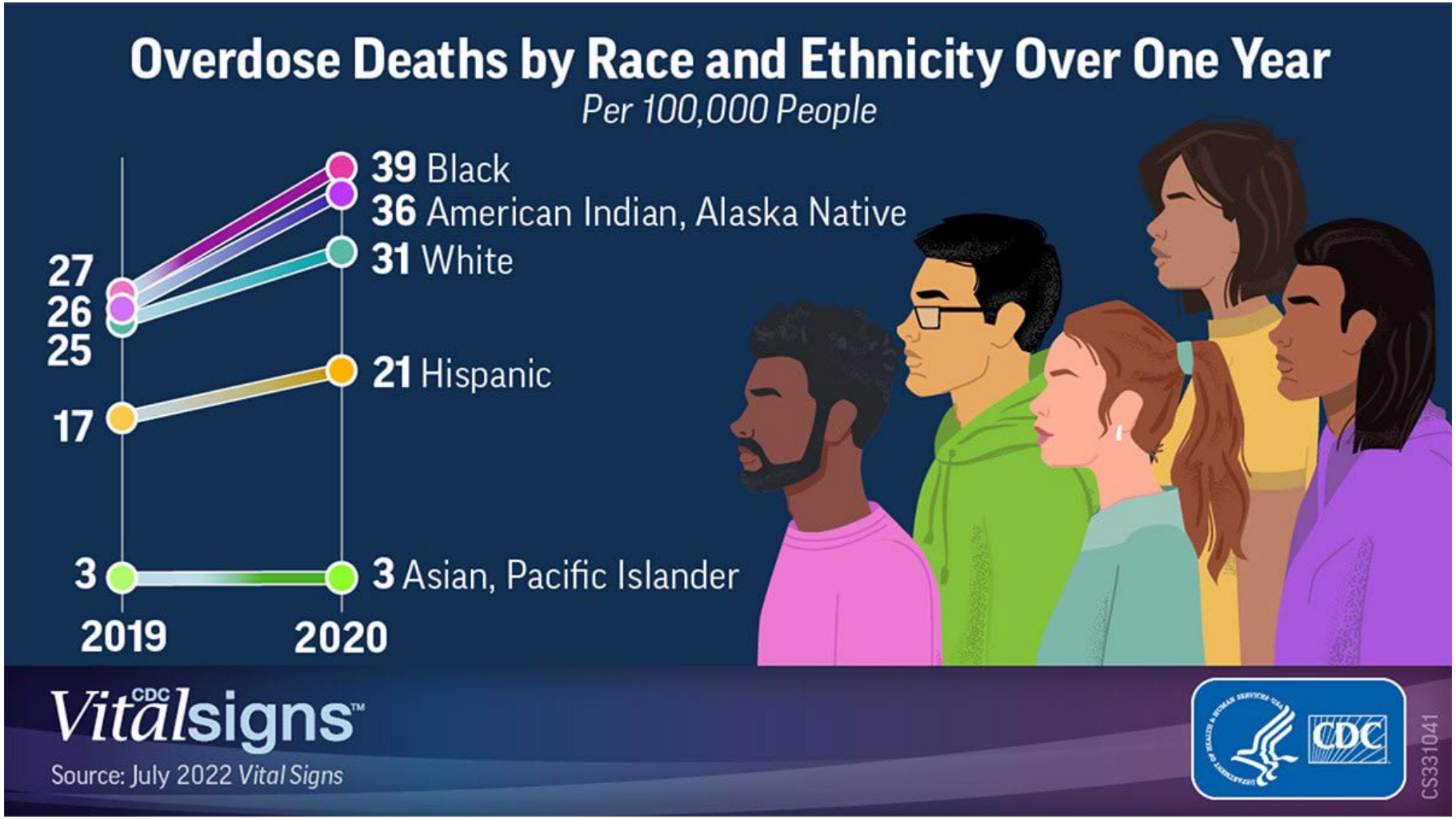
Fentanyl and Stimulant Use is Driving Overdose Deaths

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Rising Overdose Deaths – Disproportionate Impact by Race



Medications for Opioid Use Disorder is the Gold Standard

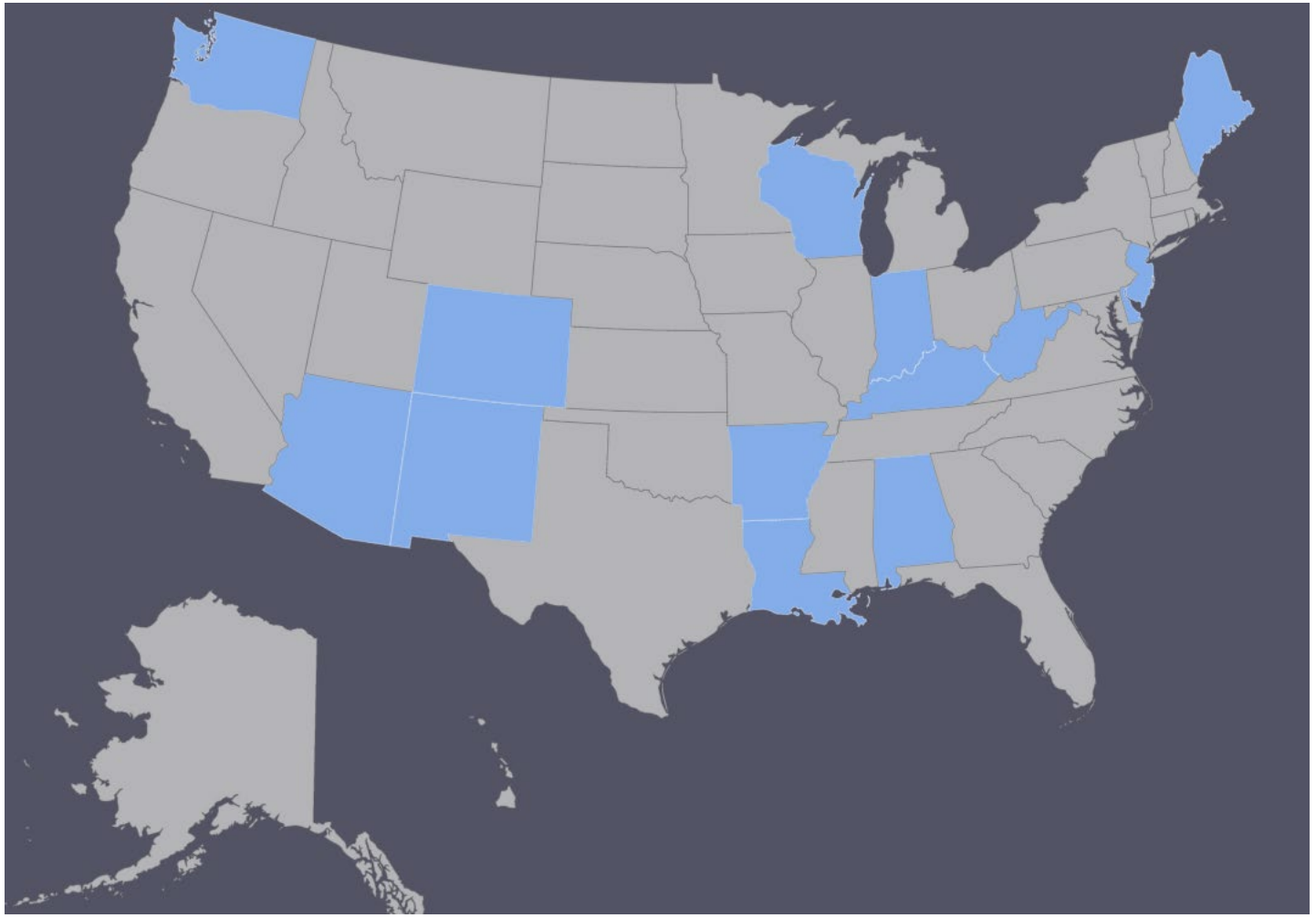
Overview of OUD Medication Effectiveness

	Reduces opioid cravings	Reduces illicit opioid use	Reduces risk of opioid overdose	Increases rate of treatment retention
Methadone[24]	Yes	Yes	Yes	Yes
Buprenorphine[25]	Yes	Yes	Yes	Yes
Naltrexone[26]	Yes	Yes	Inconclusive	Yes, if initiation is possible

Note: Conclusions in the table above were drawn from a nonexhaustive review of literature on each medication compared with nonpharmacological treatment. Studies included were systematic reviews, retrospective comparative effectiveness, and randomized control trials, with more than 50 participants.

Development of the State Financing Principles

Informed by Pew's State Technical Assistance



What are the State Financing Principles?

Policy-oriented

Built on consensus

Designed to inform state action

What do the State Financing Principles Address?

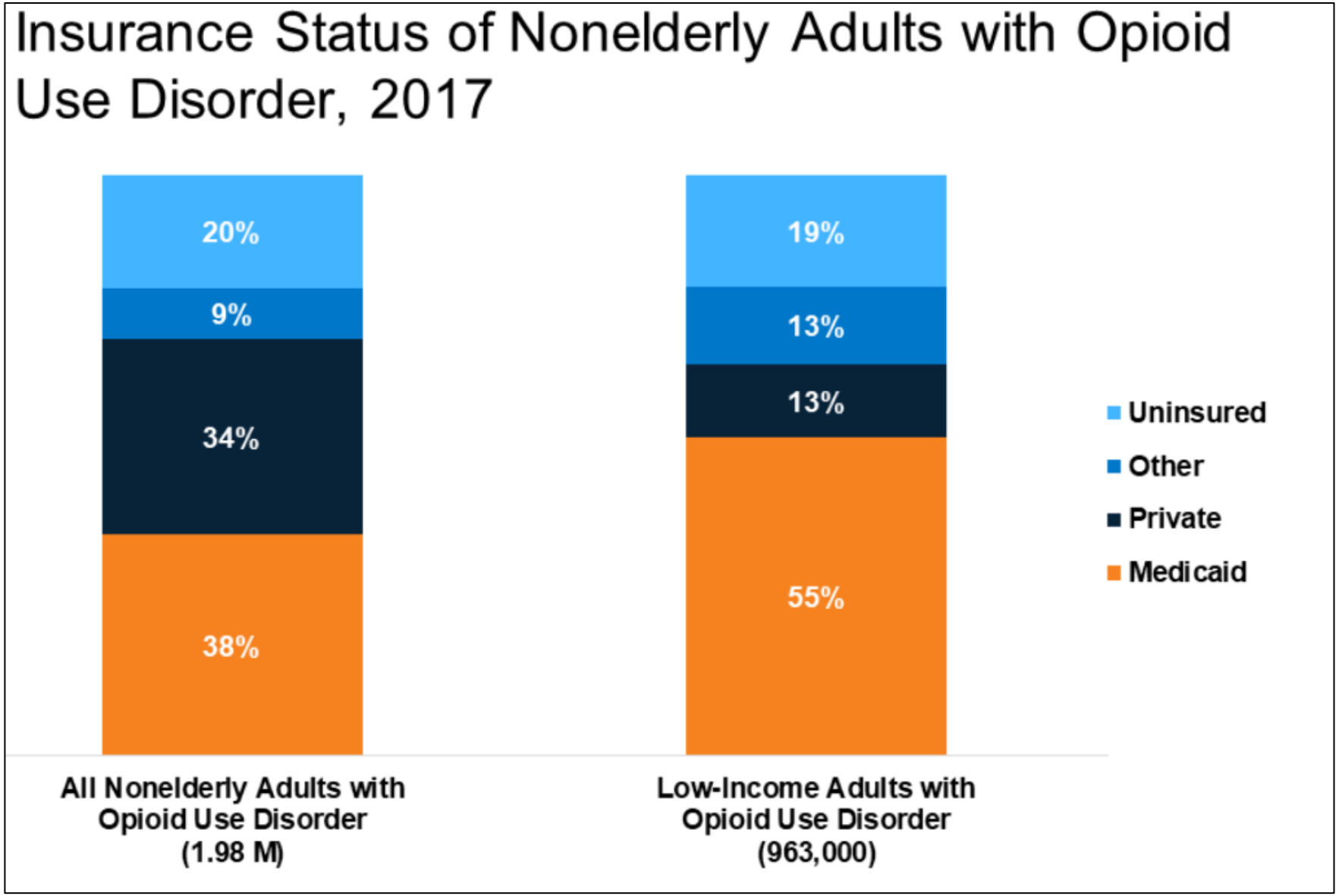
State SUD Funding

- Four key funding areas:
  - Medicaid
  - Substance Use Treatment, Prevention, and Recovery Services Block Grant (SUTPRS) [formerly SABG]
  - State Opioid Response (SOR) grants and other agency funding (e.g. ARPA, HRSA)
  - Opioid settlement funds

State Policy Needs

- Key areas of state policy that impact funding and treatment access:
  - Regulatory and statutory impediments to provider participation in treatment networks
  - Incentives that encourage integration, new providers, or expansion of low-barrier treatment options
  - Prioritizing a health response across systems (criminal-legal, child welfare etc.)
  - Aligning state policy with evidence-based strategies that improve access and quality of care
  - Leveraging data to improve outcomes

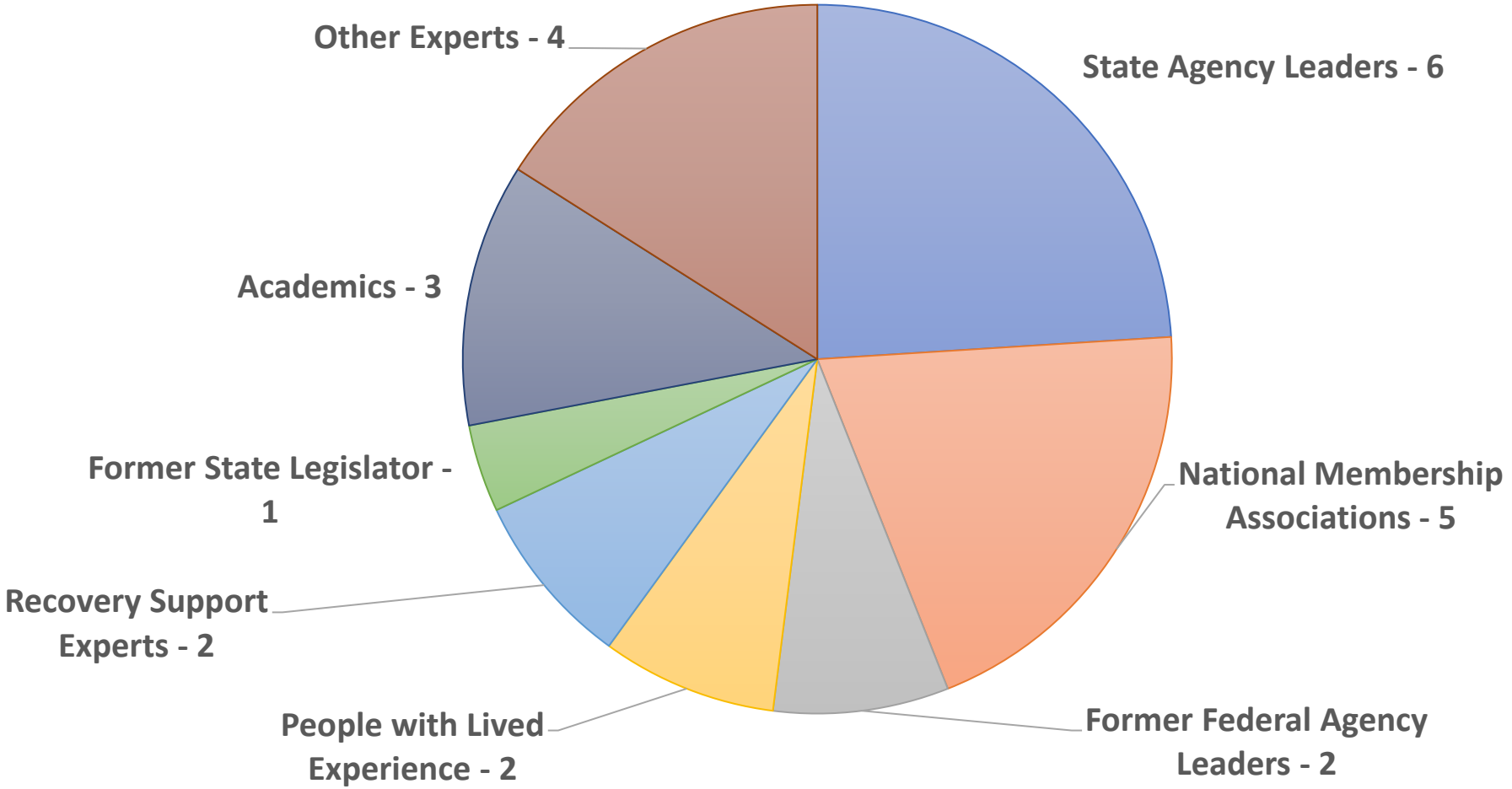
Insurance Status of Nonelderly Adults with Opioid Use Disorder, 2017



Source: Kaiser Family Foundation, The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment, May 2019 Issue Brief

How were the State Financing Principles developed?

Who participated in the development of the State Financing Principles?



Discussion of the State Financing Principles

#1 — Use Medicaid funds strategically to expand and sustain access to evidence-based substance use treatment and recovery support services.

Examples of state policy actions:

- Cover all evidence-based and evidence-informed services, including harm reduction and recovery supports, allowed by Medicaid.
- Provide adequate reimbursement for all Medicaid services. Examples: NJ, WA, CO, VA
  - In 2016, the **Virginia General Assembly** appropriated funds to the Commonwealth's Medicaid program to, among other goals, improve the state's community-based SUD services. Virginia Medicaid subsequently established a workgroup and in less than six months, the workgroup developed, and Virginia Medicaid worked with CMS to create, the Addiction and Recovery Treatment Services (ARTS) benefit. These reforms included:
    - Enhanced reimbursement rates for buprenorphine induction and maintenance (the enhanced rates match what is available from commercial insurance plans in Virginia);
    - A monthly per member payment for care coordination to patients with moderate to severe OUD that receive MOUD.

#2 —Direct flexible federal funds – to the fullest extent allowable – toward boosting infrastructure, harm reduction and recovery support services.

Examples of state policy action:

- Use SUPTRS [formerly Substance Abuse Prevention and Treatment Block Grant] to fund service pilots, including for harm reduction, recovery supports and other innovative SUD services, that can be evaluated and brought to scale through Medicaid in the future.
- Prioritize financing the IT infrastructure (e.g., EHR) that SUD providers need in order to review their data, conduct reporting, coordinate with other providers, and set up billing infrastructure.

What is harm reduction?

- U.S. Department of Health & Human Services describes harm reduction as “Helping people where they are, without judgment, stigma, or discrimination.”
- General idea is to decrease negative consequences associated with behaviors or activities
  - Examples: sunscreen, helmets, seatbelts, and syringes

Source: https://www.hhs.gov/overdose-prevention/harm-reduction

Why is harm reduction important for substance use disorder?

- There are negative consequences associated with substance use, including death, overdose, and infectious disease transmission
- Harm reduction can help decrease these negative consequences and save lives
- Emerged in the public health field as a response to HIV/AIDS
- Has grown to respond to issues including hepatitis C and overdoses
- Has worked to provide services to people that need them

Naloxone

- Naloxone is a medication that reverses the respiratory depression caused by an opioid overdose
- Naloxone:
  - Reduces the rate of opioid overdose deaths
  - Can be safely administered by medical professionals and by lay people
  - Does not increase non-medical opioid use
- Enacting naloxone access laws reduced the incidence of opioid overdose deaths by 14 percent in the 28 states that passed laws by the end of 2014
- In these states the incidence of opioid overdose deaths decreased by 23 percent among African Americans
- Naloxone access laws do not increase in non-medical opioid use

Source: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/10/expanded-access-to-naloxone-can-curb-opioid-overdose-deaths
Source: https://pubmed.ncbi.nlm.nih.gov/29610001/

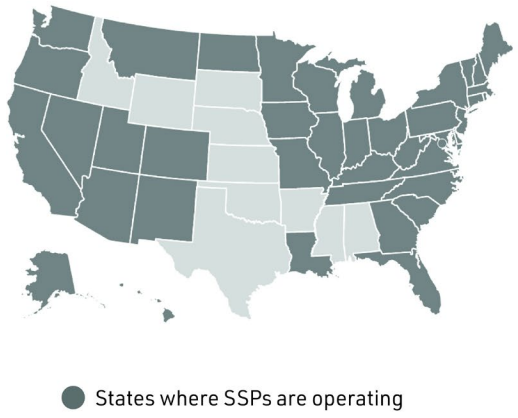
Syringe service programs

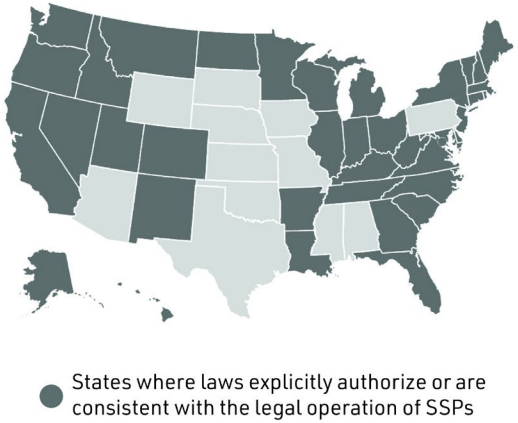
- Over three decades of peer-reviewed research on syringe service programs
- Syringe service programs:
  - Reduce rates of HIV and hepatitis C by 50%, and by more than two-thirds when combined with medication for opioid use disorder treatment
  - Save lives
  - Increase proper disposal of used syringes
  - Build trust with participants and reduce stigma
  - Ramp up participants' engagement with treatment (participants are five times more likely to enter substance use treatment and three times more likely to stop injecting drugs than those who do not use syringe service programs)
  - Save money

Source: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/03/syringe-distribution-programs-can-improve-public-health-during-the-opioid-overdose-crisis
Source: https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs/
Source: https://www.cdc.gov/ssp/syringe-services-programs-summary.html#prevention-of-id
Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7393740/
Source: https://journals.sagepub.com/doi/full/10.1177/0033354920921817#bibr5-0033354920921817
Source: https://journals.lww.com/jaids/Fulltext/2019/12012/Using_Interrupted_Time_Series_Analysis_to_Measure.14.aspx

Syringe service programs

- Syringe service programs do not:
  - Increase crime in areas surrounding the programs
  - Initiate new drug use or drug use among youth
- As of 2019, syringe service programs are operating in 41 states, and 39 states have laws that remove legal impediments to, explicitly authorize, and/or regulate syringe service programs, with 32 of these explicitly authorizing syringe service programs





Source: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/03/syringe-distribution-programs-can-improve-public-health-during-the-opioid-overdose-crisis
Source: https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs/
Source: https://www.cdc.gov/ssp/syringe-services-programs-summary.html#prevention-of-id
Source: https://journals.sagepub.com/doi/full/10.1177/0033354920921817#bibr5-0033354920921817

Fentanyl test strips

- Fentanyl test strips are used to detect the presence of fentanyl in a person's drug supply
- Research has shown that fentanyl test strips:
  - Effectively identify fentanyl in the drug supply
  - Help people take measures to prevent an overdose
  - Modify drug use and are associated with behavior change
  - Are easy to use and people are interested in using them
- As of August 2022, drug paraphernalia laws in 20 states prohibited fentanyl test strips
  - Additional laws allowing for fentanyl test strips going into effect this year

Source: https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/10/opioid-overdose-crisis-compounded-by-polysubstance-use
Source: https://pubmed.ncbi.nlm.nih.gov/30991301/
Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6701177/
Source: https://americanhealth.jhu.edu/themes/custom/bahi/assets/pdfs/Fentanyl_Onepager_080618.pdf
Source: https://pubmed.ncbi.nlm.nih.gov/30292493/
Source: https://www.networkforphl.org/wp-content/uploads/2023/01/Legality-of-Drug-Checking-Equipment-in-the-United-States-August-2022-Update.pdf

#3 — Conduct an inclusive decision-making process for allocating opioid settlement funds and prioritize funds for investments in services and infrastructure needs not covered by Medicaid and other existing state/federal funding streams.

Examples of state policy action:

- Set up a separate fund to ensure that these funds are not used for things unrelated to opioid abatement. Examples: MA, KY, NY
  - 35 state legislatures created a separate fund to attempt to ensure that money is spent on opioid abatement.
- Ensure that these funds do not supplant funding for related services. Examples: NY
- Support innovative harm reduction strategies that cannot be funded by other sources.

#4 — Incentivize and sustain "no wrong door" approaches to substance use care, treatment, and support services.

Examples of state policy action:

- Explore ways for mobile treatment providers to deliver integrated care. Fund and facilitate the provision of mobile, community-based harm reduction services, including basic medical care and linkage to treatment services when appropriate. Ensure providers who operate mobile units (e.g., opioid treatment programs, substance use treatment providers) can bill Medicaid for services delivered in-person and via telehealth.
  - The Arizona and Delaware state legislatures created telehealth payment parity requirements.
- Adopt Certified Community Behavioral Health Clinics (CCBHCs) in order to better deliver integrated care.
  - The Kansas Legislature enacted a law that directs relevant state agencies to establish CCBHCs, including applying to CMS to receive the enhanced funding.
    - Illinois and Indiana, among several other states, also passed legislation to establish CCBHCs.

#5 — Ensure patients are placed in the most appropriate level of care, including considering non-residential, community-based substance use treatment and recovery support services.

Examples of state policy action:

- Standardize routine screening and assessment of people in the SUD treatment system to ensure placement into clinically appropriate treatment and recovery supports.

#6 — Address substance use treatment disparities at the point of care for historically marginalized groups and communities.

Examples of state policy action:

- Identify and eliminate barriers for community-based providers to become Medicaid providers, including support with data infrastructure to better manage burdens related to data collection, billing, coding, etc., which can lead to enhanced organizational and programmatic sustainability. Examples: NM
- Ensure State Medical Board guidance does not contradict best practice guidance from the American Society of Addiction Medicine (ASAM) (e.g., no requirements for forced tapering).
- State Legislatures could develop statutory requirements that set aside state funding for community-based organizations (CBOs).

#7 — Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement.

Examples of state policy action:

- Use title IV-E foster care funding for family-based facilities that treat substance use disorders. Examples: MN, UT
- Deliver services across locations in which older adults receive care (skilled nursing facilities, assisted living centers, and adult day programs).
- In 2022, the Kentucky General Assembly passed legislation to create a pilot program in 10 counties that diverts people from the criminal legal system to substance use treatment that offers access to MOUD. These providers all must accept Medicaid patients and conduct a full clinical assessment.

#8 — Use data to drive effective, equitable care, and outcomes.

Examples of state policy action:

- Use available data sources to better understand the effectiveness of the treatment system, disparities in access, and treatment utilization trends by using the OUD cascade of care framework to organize data and identify areas of the treatment system where improvement is needed. Examples: IN, MA, OR, CO, AL
- Include patient-reported outcome measures (including patient satisfaction) in SUD treatment system planning efforts. Examples: NC

#9 — Require specialty substance use treatment providers to provide evidence-based treatments, particularly MOUD.

Examples of state policy action:

- Build a comprehensive on-ramping support strategy and provide a reasonable window of time for providers to meet new requirements before ending state funding for providers who do not meet new requirements. Examples: VT, VA, LA
  - In 2019, **Louisiana's legislature** passed a law (Act 425) which requires residential facilities, licensed as behavioral health services providers, to offer at least two forms of MOUD on-site, as a condition of licensure. Providers were given time to prepare for the requirement and technical support from the state licensing agency to meet the new regulations.
- Allocate public funding and resources to providers offering evidence-based treatment options for people with SUDs, such as MOUD. Examples: LA

#10 — Bolster the substance use treatment and recovery support service network for children and youth.

Examples of state policy action:

- Use title IV-E foster care funding for family-based facilities that treat substance use disorders. Examples: MN, UT
- Leverage the Families First Prevention Services Act (FFPSA) to expand residential family-based treatment options and outpatient family-focused treatment options with access to supportive housing when possible. Examples: UT
- In 2021, the New Jersey Legislature passed Senate Bill 3000 which establishes network adequacy standards for pediatric primary and specialty care in the state's Medicaid program. The bill leverages contract language with MCOs to require that plans have a sufficient number of pediatric primary care physicians, pediatric oncologists, and developmental and behavioral pediatricians within specified geographic standards. MCOs that are not able to meet these requirements face severe financial penalties and are asked to meet standards within 30 days of notification.

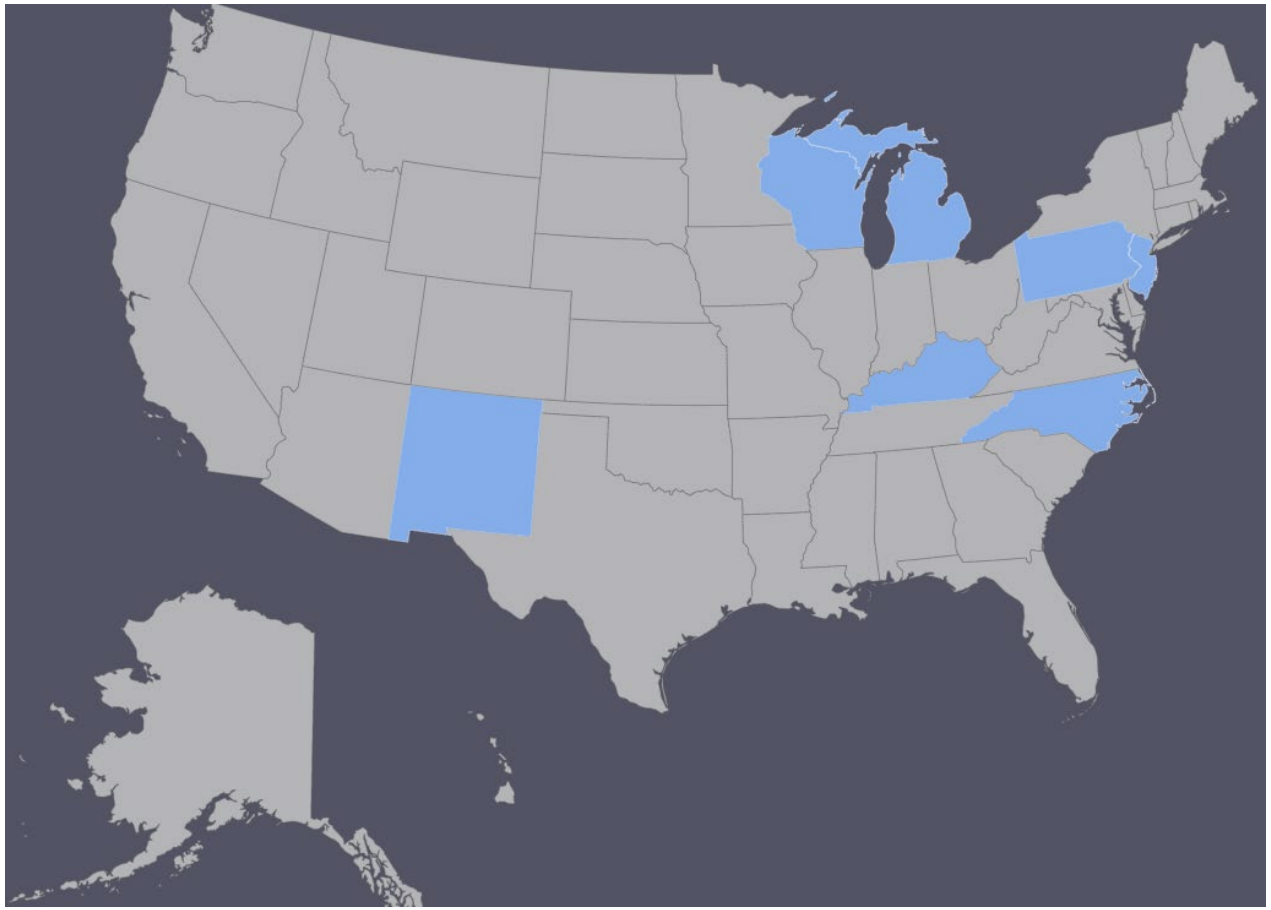
Next Steps

Upcoming Publications

- Comprehensive issue brief – late July/early August
- “Principles in Action” resource series – late August/early September
- Webinar – late Summer

Pew's State Technical Assistance

- Pew will deliver technical assistance over the next three years to seven states using the State Financing Principles



Contact

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Discussion of Strategies for Select State Financing Principles

#1 — Use Medicaid funds strategically to expand and sustain access to evidence-based substance use treatment and recovery support services.

What does Medicaid Cover?

State Plan Services	Other Medicaid Authorities
Inpatient Hospital-Withdrawal Management (required)	Residential Services (35 and 5 pending states)
Screening	• Intensive
Brief Intervention	• Clinically Managed Low-Intensity
Assessment	• Clinically Managed Population-Specific High-Intensity
Counseling	• Clinically Managed Medium-Intensity
MOUD (required)	Contingency Management
IOP	
Peer/Recovery Supports	

#1 — Use Medicaid funds strategically to expand and sustain access to evidence-based substance use treatment and recovery support services.

What is covered under the Substance Use Prevention, Treatment, and Recovery Services Block Grant?

SUPTRS BG Services	
Screening	**Withdrawal Management**
Brief Intervention	**Inpatient/Residential**
Assessment	Aftercare/Continuing Care
Counseling	
IOP	
Peer/Recovery Supports	

#1 — Use Medicaid funds strategically to expand and sustain access to evidence-based substance use treatment and recovery support services.

Decision Points for States:

- Has there been a comparison of benefits between Medicaid and SUPTRS (and state funds).
- Are there coverage gaps?
- Can Medicaid address the gaps?
  - Change in service definition allowable to CMS
  - Individuals eligible but not enrolled in Medicaid
  - Providers offer a service covered
  - Payment differential between payment sources
- SUPTRS (and state general revenue) funds may be seen as easier $$ for providers--are there changes to billing that can incent providers to bill Medicaid first?
- Is Medicaid and the Behavioral Health Authority actively aligning what and how they buy services for Medicaid beneficiaries?

#6 — Address substance use treatment disparities at the point of care for historically marginalized groups and communities.

Consider Use of Medicaid for Reentry Strategies

- An estimated 65%-90% of individuals in jails and prisons have an SUD
- 55% of individuals in prisons are Black or Hispanic
- 75% of individuals in jails are Black
- Upon release individuals are at extremely high risk of overdose death or reincarceration
- An estimated 90% are eligible for Medicaid
- Social Security Act excludes Medicaid payments for “inmates of a public institution” (e.g., including jails and prisons).

#6 — Address substance use treatment disparities at the point of care for historically marginalized groups and communities.

- **CMS released guidance allowing Medicaid payments for healthcare (including OUD) services in jails and prisons 90 days pre-release. Goals:**
  - **Increase coverage, continuity of coverage, and appropriate service uptake ;**
  - **Improve access to services**
  - **Improve coordination and communication**
  - **Increase additional investments in health care and related services**
  - **Improve connections between carceral settings and community services**
  - **Reduce all-cause deaths**
  - **Reduce number of ED visits and inpatient hospitalizations**

#6 — Address substance use treatment disparities at the point of care for historically marginalized groups and communities.

States are required to cover:

- Case Management
- Medication Assisted Treatment (MAT)
- 30-day supply of all prescription medications upon release

States Can Cover other important physical and behavioral health services prior to release:

- Medical supplies, equipment, and appliances
- Reentry supports includes peers or community navigators
- Mental health services—for individuals with co-occurring MH and SUD

#6 — Address substance use treatment disparities at the point of care for historically marginalized groups and communities.

CMS is allowing States to cover infrastructure costs for jails and prisons:

- Electronic Health Record Capacity or Enhancements
- Electronically share clinical and demographic information
- Connect to national networks—Health Information Exchanges
- Initial start up costs:
  - Development of new business and operational practices (e.g., billing and documentation)
  - Hiring and training of staff
  - Outreach, education, and stakeholder convening

#7 — Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement.

Populations of focus:

- **Adults with co-occurring SUD and chronic conditions**
- **Youth involved in child welfare, juvenile justice, ID/DD and mental health systems**

Medicaid Strategies:

- **Section 1945--Health Homes**
  - Integrate provider delivery models provide whole person care
  - Provides time-limited enhanced match for care coordination strategies
  - **Require outcome reporting**
- **System of Care**
  - **Care management model for youth and families**
  - **Coordinates across systems and allowable state plan services**
  - **Identified outcomes measures for tracking progress**

#7 — Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement.

Section 1945 Health Homes:

- Provides 90% match for care management services to individuals with SUD for 10 quarters
- Requires individual to have an SUD and one chronic condition
- Flexible payment models to providers
- Allows SUD providers (including OTPs) to be care management agencies

Targeted Case Management (TCM):

- Allows payments to states for assessment, planning, referral, linkage and monitoring
- States have used TCM for:
  - Rendering standardized assessment
  - Coordinating child and family teams with multi-system involvement
  - Ongoing and intensive care coordination to ensure youth are receiving needed services
- Specific outcomes for youth have been developed:
  - Improved school participation
  - Less juvenile justice involvement

#9 — Require specialty substance use treatment providers to provide evidence-based treatments, particularly MOUD.

- Deaths from methamphetamine and other stimulants have almost quadrupled since 2010
- Medications are still in development for other SUDs
- Gold standard for treatment of some SUDs is Contingency Management
  - Individuals are 'reinforced', or rewarded, for evidence of positive behavioral change.
  - Involve provision of monetary-based reinforcers for submission of drug-negative urine specimens.
  - Has produced important results--enhanced length of time in treatment and abstinence

#9 — Require specialty substance use treatment providers to provide evidence-based treatments, particularly MOUD.

- Medicaid is paying for contingency management programs
- Contingency management is NOT a covered Medicaid State Plan Services requiring States to use alternative Medicaid Authorities (e.g., 1115 Waivers)
- Three states have approved or are requesting Medicaid coverage:
  - California
  - Montana
  - West Virginia

#10 — Bolster the substance use treatment and recovery support service network for children and youth.

The EPSDT benefit:

- Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
- Ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
- Requires states to provide comprehensive services and furnish all ***Medicaid coverable, appropriate, and medically necessary*** services needed to correct and ameliorate health conditions.

#10 — Bolster the substance use treatment and recovery support service network for children and youth.

Screening under EPSDT

- States are required to screen Medicaid-insured children for substance use disorders.
- States have the flexibility to identify the screens to be used
- States often require a “set” of behavioral health screens for primary care practitioners to use
- States have established various methods to track behavioral health screenings for children and adolescents
- States screening efforts vary—even in well performing states 35%-45% of children and adolescents have not received a regular behavioral screen.

#10 — Bolster the substance use treatment and recovery support service network for children and youth.

Treatment under EPSDT

- States must cover all state plan services to meet the behavioral health including SUD needs of Medicaid enrolled youth.
- State plan services typically include:
  - Assessments
  - Outpatient (individual, family and youth)
  - MOUD medications for older adolescents
  - Intensive Outpatient
  - Taregeted Case Management
  - Recovery Supports—e.g., peer supports
- Congress requires CMS to perform state-by-state reviews by 2025

#10 — Bolster the substance use treatment and recovery support service network for children and youth.

2023 Consolidated Appropriations Act

- Requires State by January 2025:
  - Provide EPSDT screenings to eligible juvenile youth in “public institutions” (e.g., juvenile justice facilities) 30 days prior to the youth’s release from the facility.
  - Provide targeted case management (TCM) services that include referrals and linkage to aftercare services and supports.
- Allows State to:
  - Provide Medicaid and CHIP coverage to juvenile youth in public institutions during the initial period pending disposition of charges