

## Considerations in MAT Financing

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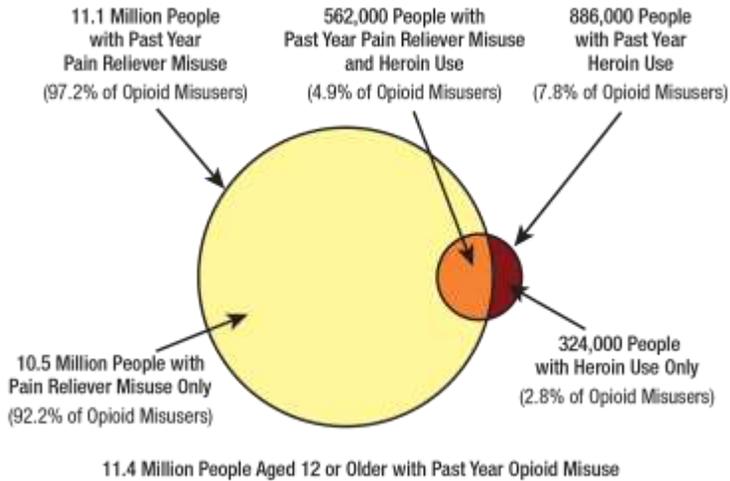
## National Council for Behavioral Health



*3000 Behavioral Health Organizations*

- Advocacy
- Education
- Technical Assistance:

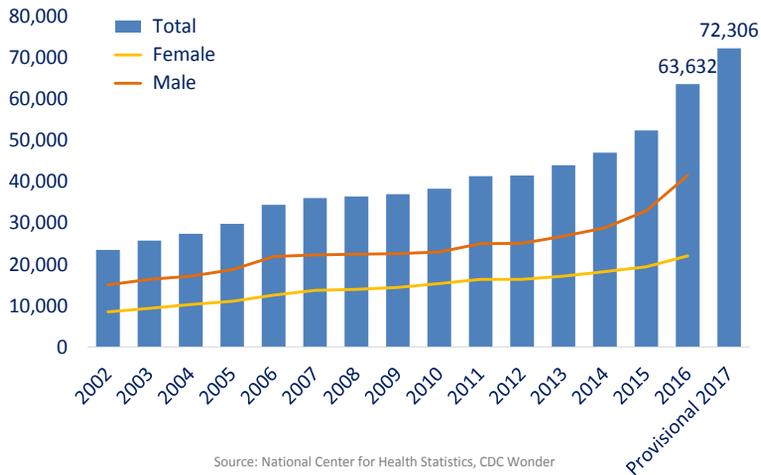
# Past Year Opioid Misuse among People Aged 12 or Older: 2017



**NATIONAL COUNCIL FOR BEHAVIORAL HEALTH**  
NIH NATIONAL INSTITUTE ON DRUG ABUSE  
 Note: Opioid misuse is defined as heroin use or prescription pain reliever misuse.  
 Note: The percentages do not add to 100 percent due to rounding.



## National Overdose Deaths Number of Deaths Involving All Drugs



Source: National Center for Health Statistics, CDC Wonder

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## Medication Assisted Treatment

“We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction.”-  
*Michael Botticelli Former Director ONDCP*



## Medications/Pharmacotherapy for Opioid Use Disorder (OUD)

Medication	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
<b>Methadone</b>	Daily	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.
<b>Buprenorphine</b>	Daily for table or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue	Physicians, NPs and PAs with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waived physician.
<b>Probuphine (buprenorphine implant)</b>	Every 6 months	Subdermal	
<b>Sublocade (buprenorphine injection)</b>	Monthly	Injection (for moderate to severe OUD)	
<b>Naltrexone</b>	Monthly	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R)



# How Are SUD Services Paid For?

- Substance Abuse Prevention and Treatment Block Grant
- Medicaid
- Private Insurance
- Other federal funding
- State and local funding



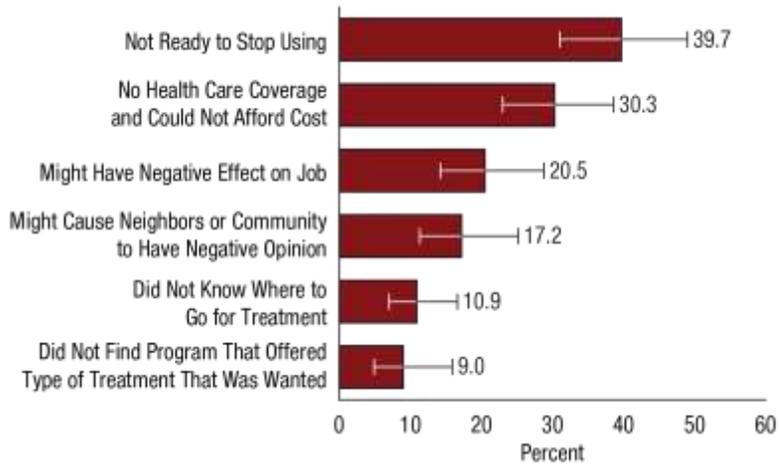
## Current Financing Landscape

- Among those who recognized a need for treatment and made an effort to get it, lack of health coverage was the 2nd most frequently reported reason for not receiving treatment (30.3 percent).\*
- Most states cover some form of opioid dependency treatment through their Medicaid drug formulary.
- However, as of 2013, only 13 Medicaid programs included all available medications for treating alcohol and opioid use disorders in their Medicaid PDLs.

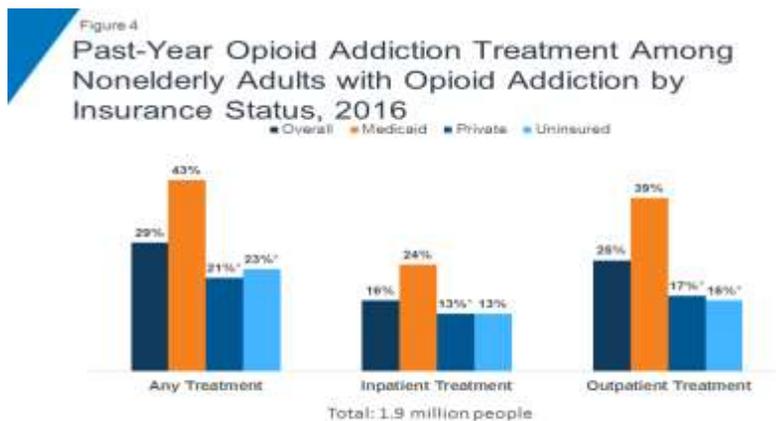
\*Substance Abuse and Mental Health Services Administration, National Survey of Drug Use and Health



## Reasons for Not Receiving Substance Use Treatment in the Past Year among People Aged 12 or Older Who Felt They Needed Treatment in the Past Year: Percentages, 2017



## Insurance Status of Adults seeking Addiction Treatment



NOTE: Differences between Medicaid and private insurance are statistically significant for all three measures. Differences between Medicaid and uninsured are statistically significant for any treatment and outpatient treatment only.

SOURCE: Kaiser Family Foundation Analysis of the 2016 National Survey on Drug Use and Health.

## Current Challenges: Availability vs Access

Many states do not cover all levels of care required for effective treatment, as defined by the ASAM criteria—a well-researched, widely endorsed national standard of care. For treatment providers, limited coverage for the full continuum of treatment settings and modalities constrains their ability to make optimal treatment decisions.



## Current Challenges

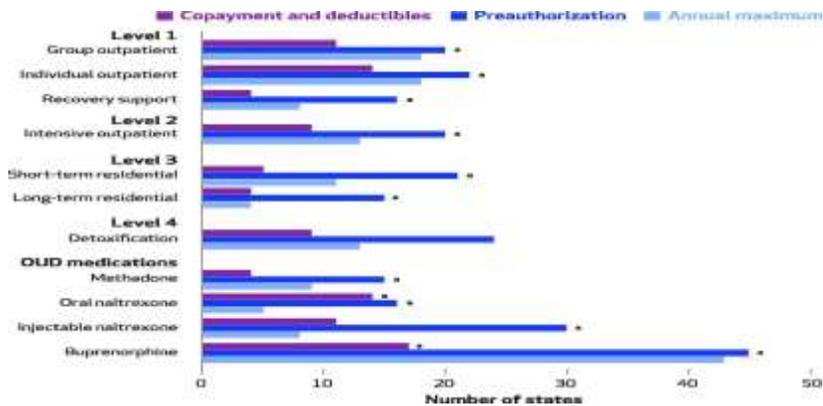
***Prior authorization***, - Getting an agreement from the payer to cover specific services before the service is performed.

***Step-therapy*** - Benefit design that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a branded medication.

***Lifetime limit***- Insurers place a dollar **limit** on what they would spend for your covered benefits during the entire time you were enrolled in that plan (banned under current law)



## Types of limits on substance use disorder services and opioid use disorder (OUD) medications



[Survey Highlights Differences In Medicaid Coverage For Substance Use Treatment And Opioid Use Disorder Medications](#)

Colleen M. Grogan, Christina Andrews, Amanda Abraham, Keith Humphreys, Harold A. Pollack, Bikki Tran Smith, and Peter D. Friedmann Health Affairs 2016 35:12, 2289-2296



## Other Challenges

### Organizational Benefit Silos

One challenge to establishing a benefit design for medications to treat alcohol and opioid use disorders is that the medications can involve four different Medicaid operations

- opioid treatment programs
- pharmacy benefits
- medical benefits
- pharmacy contracting

These areas often function independently in their decision systems, staffing, and approval process (ASAM, 2013).



## Some Change is happening

- Aetna, starting in March 2017, stopped requiring doctors to seek approval from the insurance company before they prescribe particular medications such as Suboxone.
- Anthem and Cigna also recently dropped prior authorization requirements. – These companies took the step after the New York AG investigated coverage practices that unfairly barred patients from needed treatment. The insurers adjusted their prescribing requirements as part of larger settlements.
- **As of February 2018 all fifty states covered at least 1 of the MAT medications with most covering all three.**



## Key Questions to Consider

As you think about coverages and legislative policies it is important to appropriately assess the current landscape of coverages within your state.

- What do Medicaid and commercial insurers require for the use of MAT in your state?
- Are there limitations on who can prescribe MAT, the length of time patients can use MAT, and/or the type of formulations patients may receive?
- Do Medicaid formularies include all MAT formulations (e.g., injectable naltrexone, sublingual buprenorphine)?
  - If not, who specifically will provide the leadership to get these medications on the Medicaid formulary?
  - Who specifically will talk with health plans and pharmacy benefit managers to get these medications on their formularies?



## Key Questions to Consider (Con..)

- Does the state view the use of MAT as an evidence-based practice? (Some states require that clinicians follow evidence-based practices to be reimbursed under Medicaid and private insurance.)?
- Are clinicians eligible to receive Medicaid or commercial insurance reimbursement?
- Are they on preferred provider lists for commercial insurers and Medicaid managed care programs?



## Key Questions to Consider (Con..)

- Will clinicians be reimbursed for clinical services required for MAT, such as physical examinations and laboratory tests?
- Are you aware of the typical out-of-pocket cost for the medications, and are your patients able to afford these costs?
  - If not, are you aware of ways you may be able to offset these costs for patients who need assistance?
- Are these medications available through the 340B program administered through HRSA and the health centers in your state? (This is particularly important for individuals without insurance)
- Are their other ancillary costs that if not paid for inhibit access to services (i.e. transportation)



# System Redesign



## Options for States via Medicaid

### Section 1115 Waiver

Enables states to experiment with delivery system reforms

Requires budget neutrality

Must be renewed every 5 years

State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in state plan)

With CMS approval, offers opportunity to continue PPS

Subject to CMS approval process; consider timing of request

### State Plan Amendment

Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, requirements, etc.

Does not require budget neutrality

With CMS approval, can continue PPS

Cannot waive statewideness, may have to certify additional CCBHCs

Subject to CMS approval process; consider timing of request



# Health Homes



As of November 2014, 29 states and the District of Columbia have a total of 29 approved Medicaid health home models.

## Six Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care/follow-up
5. Patient & family support
6. Referral to community and social support services



## Enacted in 2014 as Section 223 of the Protecting Access to Medicare Act



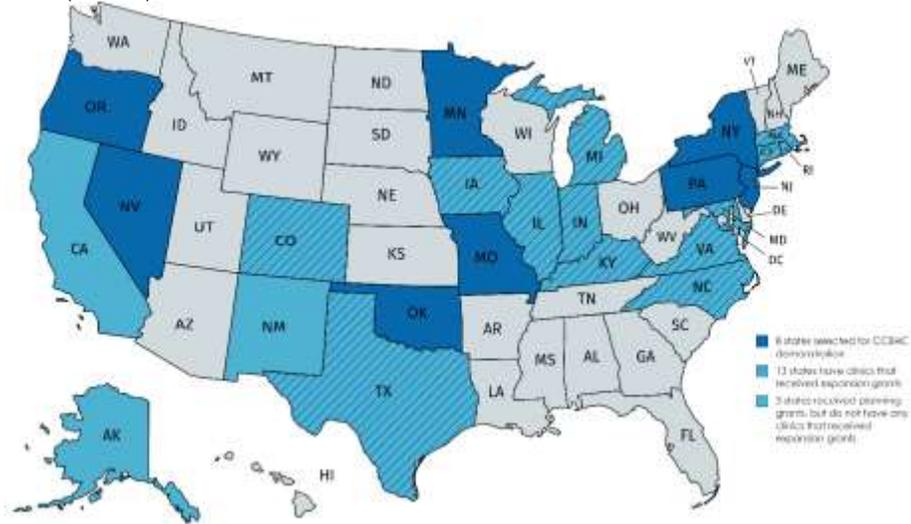
Senators Roy Blunt and Debbie Stabenow



Representatives Leonard Lance and Doris Matsui



Status of Participation in Certified Community Behavioral Health Clinic (CCBHC) Demonstration



*Note: Demonstration ends on March 31, 2019 in OR & OK, and on June 30, 2019 in the remaining 6 demonstration states*

## CCBHC Certification Requirements

### Scope of SUD Services

Required CCBHC Addiction Treatment Services
Crisis care: 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization
Evidence-based outpatient substance use services (e.g., addiction counseling, medication-assisted treatment, addiction technologies, assertive community treatment, cognitive behavioral therapy)
Ambulatory and medical detoxification
Treatment for co-occurring addiction and mental illness
Screening, assessment and diagnosis, including risk assessment for substance use
Brief intervention and referral to treatment for problematic substance use identified during screening
Peer recovery support and family support services
Treatment planning, including risk assessment and crisis planning
Referral to outside providers for specialized substance use services outside the expertise of the CCBHC
Targeted case management

## Why pursue CCBHC status?

For many organizations, CCBHC status offers an improvement over the status quo:

-  Payment **based on anticipated costs** supports hiring new staff, filling vacancies, expanding service lines
-  Ability to fund **services outside the four walls** and **include expenses not traditionally billable** (like EHRs, care coordination, outreach)
-  **Coverage for services** not otherwise in the Medicaid state plan (e.g. peer services)



## Key staff expansions

Within the first 6 months, CCBHCs hired:

**72**  
psychiatrists

**64%** hired peer  
recovery specialists



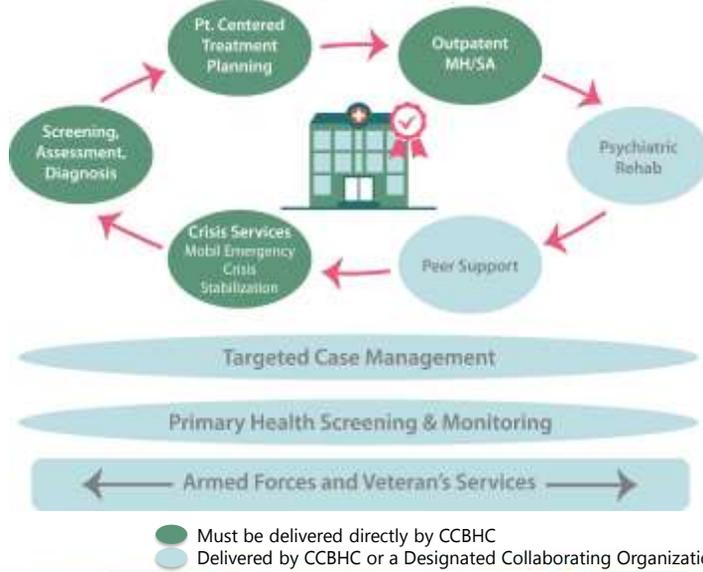
**90%** of CCBHCs have a psychiatrist on staff with an addiction specialty/focus

Within the first year:

**398** new staff with an addiction specialty or focus



# CCBHC Scope of Services



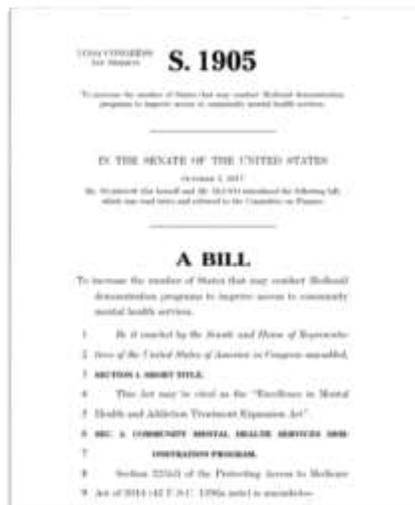
# Excellence Act Expansion: S. 1905/H.R. 3931



Sens. Roy Blunt and Debbie Stabenow



Reps. Leonard Lance and Doris Matsui



## Resources

The [Medication Assisted Treatment Implementation Checklist](#), from CIHS, outlines the key questions to consider before engaging in efforts to increase access to medication assisted treatment for addictions.

[Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders](#) The primary purpose of this report is to present information about Medicaid coverage of medications used to treat alcohol and opioid use disorders.

### [Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans](#)

This report highlights the coverage gaps that remain in health plans across the US and provides suggestions for how to resolve them.



## Questions



## CONTACT INFORMATION

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