Financing SUD Treatment: Challenges and Opportunity

January 25, 2020
National Council for Behavioral Health

Who Are We

• Over 3,400 members providing or supporting treatment for Mental Illnesses and Addiction

• Services
  – Mental Health First Aid – over 2 million trained
  – Center of Excellence for Integrated Health Solutions (HHS)
  – CDC National Networks
  – Improving Business & Clinical Practices
  – Advocacy and Policy
  – Medical Director Institute
In 2018, **57.8M** Americans had a mental and/or substance use disorder.

**Mental Illness and Substance Use Disorders in America**

- Among those with a mental illness:
  - 1 IN 4 (23.9% or **11.4M**) had a serious mental illness

- Among those with a substance use disorder:
  - 3 IN 8 (38.3% or **7.4M**) struggled with illicit drugs
  - 3 IN 4 (74.5% or **14.4M**) struggled with alcohol use
  - 1 IN 8 (12.9% or **2.5M**) struggled with illicit drugs and alcohol

- **7.8% (19.3 MILLION)** People aged 18 or older had a substance use disorder (SUD)

- **3.7% (9.2 MILLION)** People 18+ had BOTH an SUD and a mental illness

- **19.1% (47.6 MILLION)** People aged 18 or older had a mental illness
Opioids’ & Prescription Pain Reliever Misuse

10.3 MILLION PEOPLE WITH OPIOID MISUSE (3.7% OF TOTAL POPULATION)

9.9 MILLION +
Rx Pain Reliever Misusers
(97.1% of opioid misusers)

808,000
Heroin Users
(7.9% of opioid misusers)

5.5 MILLION +
Rx Hydrocodone

3.4 MILLION
Rx Oxycodone

269,000
Rx Fentanyl

Hydrocodone misuse down from 6.3M in 2017

506,000
Rx Pain Reliever Misusers and Heroin Users
(4.9% of opioid misusers)

Rx = prescription.
Opioid misuse is defined as heroin use or prescription pain reliever misuse.

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018
Methamphetamine Use by State

PAST YEAR, POOLED 2016-2017 NSDUH, 12+

Differences in colors across states do not indicate significant differences in estimates.

Percentages of People Aged 12 or Older

- Dark Blue: 0.98-1.57
- Orange: 0.74-0.97
- Gray: 0.54-0.73
- Green: 0.33-0.53
- Light Green: 0.08-0.32
Current, Binge, and Heavy Alcohol Use Among People Aged 12 or Older: 2017

- 140.6 Million Current Alcohol Users
- 66.6 Million Binge Alcohol Users (47.4% of Current Alcohol Users)
- 16.7 Million Heavy Alcohol Users (25.1% of Binge Alcohol Users and 11.9% of Current Alcohol Users)

Note: Since 2015, the threshold for determining binge alcohol use for males is consuming five or more drinks on an occasion and for females is consuming four or more drinks on an occasion.
How Are SUD Services Paid For?

- Substance Abuse Prevention and Treatment Block Grant
- Medicaid
- Private Insurance
- Other federal funding
- State and local funding
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2018 NSDUH, 12+

Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2018 NSDUH, 12+

*No Treatment for SUD is defined as not receiving treatment at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor’s office, self-help group, or prison/jail.

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Policy Changes

21st Century CURES Act 2016

- FY 2016: Created $1 billion for STR grant program to States to address the opioid crisis
- FY 2018: An additional $1 billion through the SOR grant program
- FY 2019: Congress appropriated $1.5 billion to continue SOR
- Proposed FY 2020: requested $1.5 billion to extend SOR

*(Starting this year states can also use those federal dollars to counter addiction to “stimulants,”)*
Responding to the Opioid Overdose Epidemic
# Medications/Pharmacotherapy for Opioid Use Disorder

<table>
<thead>
<tr>
<th>Medication</th>
<th>Frequency of Administration</th>
<th>Route of Administration</th>
<th>Who May Prescribe or Dispense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Daily</td>
<td>Orally as liquid concentrate, tablet or oral solution of diskette or powder.</td>
<td>SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Daily for tablet or film (also alternative dosing regimens)</td>
<td>Oral tablet or film is dissolved under the tongue</td>
<td>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 waivered physician.</td>
</tr>
<tr>
<td>Probuphine (buprenorphine implant)</td>
<td>Every 6 months</td>
<td>Subdermal</td>
<td></td>
</tr>
<tr>
<td>Sublocade (buprenorphine injection)</td>
<td>Monthly</td>
<td>Injection (for moderate to severe OUD)</td>
<td>Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Monthly</td>
<td>Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>345,443</td>
<td>382,867</td>
<td>450,247</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>520,398</td>
<td>581,613</td>
<td>648,864</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>46,860</td>
<td>64,020</td>
<td>73,260</td>
</tr>
</tbody>
</table>

Total Number receiving MAT (all types)

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>921,692</td>
<td>1,028,500</td>
<td>1,172,371</td>
</tr>
</tbody>
</table>
Geographic Distribution of Providers With a Drug Enforcement Agency Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update

Policy Changes

The SUPPORT for Patients and Communities Act of 2018

The SUPPORT Act extends the privilege of prescribing buprenorphine in office-based settings to Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (CNSs, CRNAs, and CNMs)* until October 1, 2023.
Policy Changes

HR 2482: Mainstreaming Addiction Treatment Act
A bipartisan bill that would allow doctors and physicians to prescribe buprenorphine for addiction without the DEA waiver, as is currently allowed for pain relief.

HR 3925: Reducing Barriers to Substance Use Treatment Act
Would prohibit state Medicaid programs from using onerous utilization management techniques—including prior authorization requirements—to make it harder for patients to get medication-assisted treatments (MAT) for opioid use disorder.
Financing MAT
All states reimburse for some form of medications for MAT, but.....

• Even if state Medicaid agencies reimburse for specific medications, they may impose certain constraints, or benefit design limits, on obtaining the medication.

• Reimbursement of medications as MAT does not mean that they all have preferred status within state Medicaid programs.

• State Medicaid programs routinely use pharmacy benefit management requirements, such as prior authorization, to contain expenditures and encourage the proper use of medications, including for the treatment of alcohol and opioid disorders.

## Coverage Versus Preferred Status of MAT and Overdose Reversal Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Coverage</th>
<th>Preferred Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acamprosate</td>
<td>40</td>
<td>27</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td>Buprenorphine implant</td>
<td>37</td>
<td>2</td>
</tr>
<tr>
<td>Buprenorphine injection extended-release (ER)</td>
<td>33</td>
<td>7</td>
</tr>
<tr>
<td>Buprenorphine-naloxone</td>
<td>52</td>
<td>51</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>49</td>
<td>32</td>
</tr>
<tr>
<td>Methadone</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Naltrexone (oral)</td>
<td>51</td>
<td>43</td>
</tr>
<tr>
<td>Naloxone</td>
<td>51</td>
<td>44</td>
</tr>
<tr>
<td>Naltrexone ER</td>
<td>51</td>
<td>34</td>
</tr>
</tbody>
</table>

### EXHIBIT 4. Common Financing Approaches for MAT Expansion and Perceived Benefits

<table>
<thead>
<tr>
<th>Financing Approaches in the Five States</th>
<th>Perceived State and Local Stakeholder Benefits</th>
<th>Perceived Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Medicaid coverage of SUD using optional benefits, Covers services needed but previously excluded such as methadone provided in OTPs</td>
<td>• Directly address treatment gaps</td>
<td>• Increases Medicaid expenditures</td>
</tr>
<tr>
<td>Expand Medicaid Eligibility Expands coverage to many adults with OUD disorders, Requires development of a continuum of care using ASAM criteria</td>
<td>• Stability of funding brings more providers into fold, Increases reimbursement rates through enhanced federal match, Expands range of OUD services covered, Frees other state and local funding for OUD services, allowing for infrastructure development and funding services not covered by Medicaid</td>
<td>• May not be viable moving forward for non-expanding states, Reliant on federal funding, Highlights existing workforce and infrastructure challenges</td>
</tr>
<tr>
<td>Medicaid 1115 Waiver Provides Medicaid coverage of SUD residential as long as determined to be medically necessary, Expands range of OUD services covered</td>
<td>• Incentive or disincentive for certain delivery model and services, Build in flexibility to account for regional differences, Increase network capacity through vertical integration or re-organization</td>
<td>• May require other state funds for start-up and adjustment, Could challenge small, independent providers, Change may be slow</td>
</tr>
<tr>
<td>Federal Grant Funding Can be used for infrastructure development, start-up costs, pilot programs, and targeted services/hiring not covered by Medicaid</td>
<td>• Can be applied to specific regions or counties with high need, Can be flexibly administered through local organizations, Can address a variety of local needs, Can bridge different state agencies</td>
<td>• May be limited in scope and sustainability, Funding may be limited to certain organizations</td>
</tr>
<tr>
<td>Public/Private Contracting Require providers to offer MAT, co-location of providers, and performance measures, Leverage county agencies or large, regional providers as a “middle man”</td>
<td>• Allows for regional agencies and providers to directly provide services or further subcontract MAT provision, Allows for increased reimbursement rates or expansion for evidence-based services, Develop contracts with pharmaceutical companies</td>
<td>• Funding may be siloed within state agencies, Overhead costs may be needed to manage networks</td>
</tr>
<tr>
<td>Regulations for Public/Private Insurance Reduce prior authorization requirements, Reduce other limitations and caps on MAT provision, Reduce paperwork, like screening/eligibility requirements for MAT, Reduce barriers to NTP/OTP provider entry</td>
<td>• Increases types of accessible MAT, Eases recruitment of independent providers into local networks or partnerships, Reduces overall need, Reduces time to MAT induction, May increase efficiency of existing capacity</td>
<td>• Changes requiring legislative action are often slow-moving, May not address broader capacity or system issues</td>
</tr>
</tbody>
</table>

Innovative programs

Nurse Care Management Model, Massachusetts

• The model allows waived physicians more time to manage a larger group of patients by having NCMs work with program coordinators or medical assistants to perform much of the initial assessment, education management, referral to addiction treatment, adherence monitoring, admission paperwork, and communication with prescribing physicians, addiction counselors, and pharmacists.

Statewide Integration of MAT into SUD Treatment, Missouri

• The Missouri Division of Behavioral Health works to integrate MAT into all SUD treatment in the state, requiring any SUD treatment provider who contracts with the Division to offer MAT either directly or by formal arrangement.

https://store.samhsa.gov/system/files/medicaidfinancingmatreport_0.pdf
Other Considerations

• Reconsideration of whether to require prior authorization or other benefit limitations is another step states may wish to take toward addressing treatment access.

• Consider revising licensing laws, that restrict scope of practice to preclude prescribing by nurse practitioners and physician assistants

• Revisit regulations related to buprenorphine prescribing that specifically refer only to physicians as buprenorphine prescribers.

https://store.samhsa.gov/system/files/medicaidfinancingmatreport_0.pdf
Certified Community Behavioral Health Clinics (CCBHCs): A New Model

Built on the concept that the way to expand care is to pay for it

- **National definition** re: scope of services, timeliness of access, etc.
- Standardized **data and quality reporting**
- **Medicaid payment rate** that covers the real cost of opening access to new patients and new services...
  - ...including non-billable activities like outreach, care coordination, and more...
## CCBHCs Across the Country

<table>
<thead>
<tr>
<th>States Participating in Medicaid Demonstration</th>
<th>Clinics in Demo (# also Receiving Expansion Grants)</th>
<th># Receiving Expansion Grants Only</th>
<th>Total CCBHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Missouri</td>
<td>15 (3)</td>
<td>N/A</td>
<td>15</td>
</tr>
<tr>
<td>Nevada</td>
<td>3 (1)</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>New Jersey</td>
<td>7 (4)</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>New York</td>
<td>13 (3)</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>3 (2)</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Oregon</td>
<td>12 (2)</td>
<td>N/A</td>
<td>12</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7 (2)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>66</strong></td>
<td><strong>12</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

### States Receiving Expansion Grants Only

<table>
<thead>
<tr>
<th>States Receiving Expansion Grants Only</th>
<th># Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>1</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1</td>
</tr>
<tr>
<td>Illinois</td>
<td>1</td>
</tr>
<tr>
<td>Indiana</td>
<td>2</td>
</tr>
<tr>
<td>Iowa</td>
<td>2</td>
</tr>
<tr>
<td>Kentucky</td>
<td>2</td>
</tr>
<tr>
<td>Maryland</td>
<td>2</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>5</td>
</tr>
<tr>
<td>Michigan</td>
<td>9</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1</td>
</tr>
<tr>
<td>Texas</td>
<td>6</td>
</tr>
<tr>
<td>Virginia</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

There are currently 113 CCBHCs across the U.S.
CCBHCs Addressing the Addiction Crisis

- Major increases to the number of clients with addiction served
  - Most are newly referred clients or existing clients who had not previously been diagnosed with SUD due to lack of screening/treatment services being available at the clinic.
- Expansion of scope of addiction services available in communities
- Universal access to MAT and crisis care
- Increased hiring of addiction-focused clinicians
Key staff expansions

Within the first 6 months, CCBHCs hired:

- **72** psychiatrists
- **64%** hired peer recovery specialists

Within the first year:

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

90% of CCBHCs have a psychiatrist on staff with an addiction specialty/focus
What’s next for CCBHCs?

- Broad bipartisan support in Congress and the Administration
  - Medicaid demonstration program extended through May 22
  - $50 million increase to CCBHC Expansion Grants in FY 2020 (total = $200 million); eligibility extended nationwide
- Legislation to extend and expand the demonstration gaining support
  - Extends current 8 demonstration states for 2 years
  - Adds 11 new demonstration states
Options for States

- States don’t have to wait for Congress to act
- Options available to implement now:
  - Section 1115 waiver
  - State Plan Amendment
  - Prepare for future participation in an expanded demonstration
Questions

CONTACT INFORMATION

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