Medicaid Section 1115 Demonstration Policy to Address Opioid and Other Substance Use Disorders

State Medicaid Director Letter # 17-003
"Re: Strategies to Address the Opioid Epidemic"

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Agenda

1. Overview and Goals for Section 1115 Substance Use Disorder (SUD) Demonstrations
2. Key Milestones and Process for 1115 SUD Demonstrations
3. 1115 SUD Demonstration Monitoring and Evaluation Approach

Prevalence of SUD/OUD and Access to Care in Medicaid

- Medicaid beneficiaries are at higher risk for substance use disorders (SUD) but often do not receive treatment:
  - Drug overdose deaths have continued to increase over past 15 years driven by opioid abuse
  - Only 1 in 5 people who need treatment for opioid use disorder (OUD) receive it
  - Beneficiaries have higher rates of OUD than general population – comprising 25% of adults with OUD in 2015
  - Only about 1/3rd of Medicaid beneficiaries with OUD received treatment in 2015

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Widespread SUD Treatment Delivery System Issues

- Following acute care for withdrawal management, engaging in outpatient treatment within 14 days has been shown to reduce readmissions
  - But many (over 2/3rd of beneficiaries in 2008) do not receive any follow-up care – leading to risk of overdose
  - 2 of top 10 reasons for Medicaid hospital readmissions are SUD-related
- Lack of providers
  - 40% of U.S. counties did not have a single outpatient SUD treatment provider that accepted Medicaid in 2009
- People with SUDs often have serious co-morbid conditions
  - Most spending on individuals with SUDs is on treatment for co-morbid physical conditions
  - At least one state found significant reductions in medical costs for beneficiaries receiving SUD treatment

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Evidence-based Treatment for OUD and other SUDs

- Ensure access to a continuum of care and certain critical services:

  Outpatient, Intensive Outpatient, Residential/Inpatient, Medically Supervised Withdrawal Management, and Medication Assisted Treatment
- Residential treatment - targeted to those with serious co-morbid medical, cognitive, or mental health conditions, pregnant, or homeless
- Intensive outpatient programs - transitional post-acute care and community-based alternative to residential/inpatient
- Medication assisted treatment (MAT) - highly effective for treatment of opioid use disorder
  - But underutilized: among 500,000 episodes of OUD treatment in 2014 less than 25% included MAT

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Overarching Goals of this Section 1115 SUD Demonstration Initiative

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly due to opioids;
- Reduced utilization of emergency departments and inpatient hospital settings through improved access to continuum of care;
- Fewer readmissions to the same or higher level of care for OUD and other SUD treatment; and
- Improved access to care for physical health conditions among beneficiaries.

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Six Milestones for 1115 SUD Demonstrations

- What are the elements of an SUD service delivery system that will achieve the demonstration goals?
  - Access to critical levels of care
  - Evidence-based, SUD-specific patient placement
  - SUD-specific program standards for residential treatment
  - Sufficient provider capacity at critical levels of care, including medication-assisted treatment (MAT)
  - Comprehensive prevention and treatment opioid strategies
  - Improved care coordination and care transitions

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Monitoring and Evaluation: Monitoring

- Monitoring Protocol - due 150 days after approval of the demonstration
- Three quarterly reports and 1 annual report - every year
- Mid-Point Assessment, performed by an independent assessor – between years 2 and 3
- Interim Evaluation - with renewal request or one year prior to the end of the demonstration
- Summative Evaluation - 18 months after the end of the demonstration period

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Monitoring and Evaluation: Evaluation

- Evaluations will be required to include a cost analysis.
- Evaluation Reports:
  - Interim Evaluation Report due at time of renewal request or if not renewing, one year prior to the end of the demonstration
  - Summative Evaluation Report due 18 months after the end of the approved demonstration period as represented in the STCs.

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Questions

For Further Information

- The SUD SMD Letter is posted here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
- For more information about the section 1115 SUD opportunity described in the SMD Letter, please email Kirsten.Beronio@cms.hhs.gov or Judith.Cash@cms.hhs.gov
- For more information about the Medicaid IAP, please email Tyler.Sadwith@cms.hhs.gov or Karen.Llanos@cms.hhs.gov

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs

Center for Medicaid and CHIP Services

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Timeline

The Mental Health Parity Act of 1996	• Prohibited lifetime and annual dollar limits for mental health if aggregate limits not also applied to medical
Mental Health Parity and Addiction Equity Act of 2008	• Requires full parity for financial requirements and treatment limitations; expands aggregate limits requirements to substance use disorders

February 10, 2010: Interim Final Rules for Commercial Plans

November 13, 2013: Final Rules for Commercial Plans published

March 30, 2016: Final Rule for Medicaid/CHIP published

October 2, 2017: Compliance required

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Key Requirements

- Generally prohibits the application of more restrictive limits and requirements to mental health/substance use disorder (MH/SUD) benefits than limits/requirements that generally apply to medical/surgical (M/S) benefits.
- Prohibits the application of lifetime or annual dollar limits to MH/SUD benefits unless dollar limits apply to at least one-third of M/S benefits.
- Prohibits the application of financial requirements (FR) and quantitative treatment limitations (QTL) to MH/SUD benefits that are more restrictive than the ***predominant*** financial requirement or treatment limitation of *that type* applied to ***substantially all*** M/S benefits in that same classification.

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Key Requirements

- Prohibits application of non-quantitative treatment limits (NQTL) to MH/SUD benefits in any classification unless strategies, standards, or other factors are ***comparable to and applied no more stringently*** than those used in applying the same NQTL to M/S benefits in the classification.
- MH/SUD and M/S benefits must be defined consistent with a "generally recognized independent standard of medical practice."
- For purposes of comparing benefits to assess parity, benefits must be mapped to one of four classifications: inpatient, outpatient, prescription drugs, and emergency care.

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Key Requirements

- Parity does not mandate coverage of MH/SUD benefits, however, when coverage for MH/SUD benefits is provided in any classification, coverage must be provided in every classification in which M/S benefits are provided.
- The criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request.
- The reason for any denial of reimbursement or payment for a MH/SUD benefit must be made available to beneficiaries.

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Additional Resources

- Medicaid and CHIP Behavioral Health Resources
  - https://www.medicaid.gov/medicaid/benefits/bhs/index.html
- Parity Compliance Toolkit
  - https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf
- Parity Implementation Roadmap
  - https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf
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Questions