Why switching to bundled Medicaid rates matters: a policy memorandum

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Executive Summary

Rates of diagnosed Opioid Use Disorder (OUD) and deaths from opioid overdose are rising in the United States. In the State of Utah, an average of eight adults dies each week from preventable drug overdose. The Utah Department of Health and Human Services (DHHS) reports that from 2006-2015 the average deaths per year from an opioid drug overdose was 323 (Utah Department of Health, 2015). In 2021, all drug overdose deaths increased to 446 individuals (Kaiser Family Foundation, 2021). One means of decreasing overdose and death of this nature, is utilizing a range of evidence-based treatment options for people who are at risk of death from opioid overdose.

Opioid Treatment Programs (OTPs) ---commonly referred to as methadone clinics--- are one option to decrease overdose because people with an OUD can request and receive comprehensive care for their addiction and are given space to work on their recovery. OTPs are specialized clinics that are both federally and state regulated because of the medications they provide, specifically, methadone medication. Methadone is one of a few evidence-based medications proven to decrease opioid cravings and help an individual stop using opioids.

OTPs operate under strict federal rules that dictate dosing and counseling requirements (Substance Abuse and Mental Health Services Administration, SAMHSA, 2015). Each state also has its own set of regulations that OTPs must comply with, and they vary from state to state. Utah's rules are managed by the state legislature via the Utah DHHS Division of Licensing, Single State Authority (SSA) and State Opioid Treatment Authority (SOTA) (Utah Administrative Code, specifically in R156-37-302b, 2021).

There are costs associated with prescribing and administering Medications for Opioid Use Disorder (MOUD). Costs and insurance complexities add a myriad of barriers that prohibit individuals from accessing lifesaving care and services (Conroy et. al., 2020)

While OUD is treatable with evidence-based medications, treatment is only available if an individual has the means to pay. To increase access to substance use disorder (SUD) and OUD treatments, the Pew Research Center recommends (Pew Charitable Trusts, 2021) eight methods of expanding treatment. One of the eight recommendations is to improve OTP access for Medicaid patients. Improving access involves more than physical access, it should include expanded payments for services. This is especially true in Utah for individuals on Medicaid. Currently, not all services applicable to treating OUD are covered by Utah Medicaid plans. This may include the dosing, administration, or cost of medication.

OTPs operate on a tight fiscal margin and can only provide services that are reimbursed by insurance or cash payment. Thus, many individuals are not able to access all MOUD treatment because the clinic cannot bill for their services. The significance of this issue is that while other insurance providers offer a bundled rate for provided MOUD services, Medicaid does not (Utah Department of Health, Medicaid Division, 2021).

This policy memorandum will provide background information, data-based analysis, and make policy recommendations on how to better utilize Utah's Medicaid programs to provide more comprehensive coverage with affordable payment options for Utahans suffering from an OUD who are at high risk of losing their life to an opioid overdose. The centerpiece of the memorandum is an analysis comparing Utah's current payment system for OTPs with two other states that have instituted Medicaid expansion: Idaho and Colorado. These states were chosen

based on various aligning factors including, but not limited to state size, population, political environment, and regional distinctions. Datasets collected from the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention Centers (CDC) in addition to state-specific datasets are for analysis.

The memorandum concludes with Utah-specific recommendations for expanding services that are currently covered or not covered, increasing payment reimbursement rates, and implementing processes that other states have successfully adopted. The findings and recommendations contained within this memorandum are supported by the two-pronged design and methodological approach of (1) comparing states where Medicaid expansion has been instituted and (2) analyzing specific datasets collected from federal and state administrative organizations charged with implementing OTPs services and payment for services.

Introduction

Nationally, the Covid-19 pandemic led to a major increase in social isolation, alcohol use, mental health conditions, a range of substance use disorders, and a decrease in substance, physical, and mental health treatments. These factors likely contributed to a sharp increase in overdose deaths. The opioid epidemic was declared a public health emergency in October 2017 by former President Trump (CMS, 2022).

Nevertheless, all is not lost, as there are still options and opportunities available across the nation to help combat the opioid epidemic. One such tool is full Medicaid expansion for OUD/SUD and increased coverage and payment reimbursement in states with expanded Medicaid. Utah is one of the states that could increase access and coverage with a few policy

changes to the existing Medicaid expansion. For example, Utah opted into the Affordable Care Act (ACA) with partial expansion in April of 2019 and full expansion in January of 2020. Between Fall 2013 to Spring 2021 Medicaid expansion contributed to an increase of 121,102 individuals having health coverage, almost 4% of Utah's population. Nationally, Medicaid provides health coverage to 40% of all people with a diagnosed SUD. Thus, Medicaid is an important access point for people to get life-changing treatment and support for all SUDs.

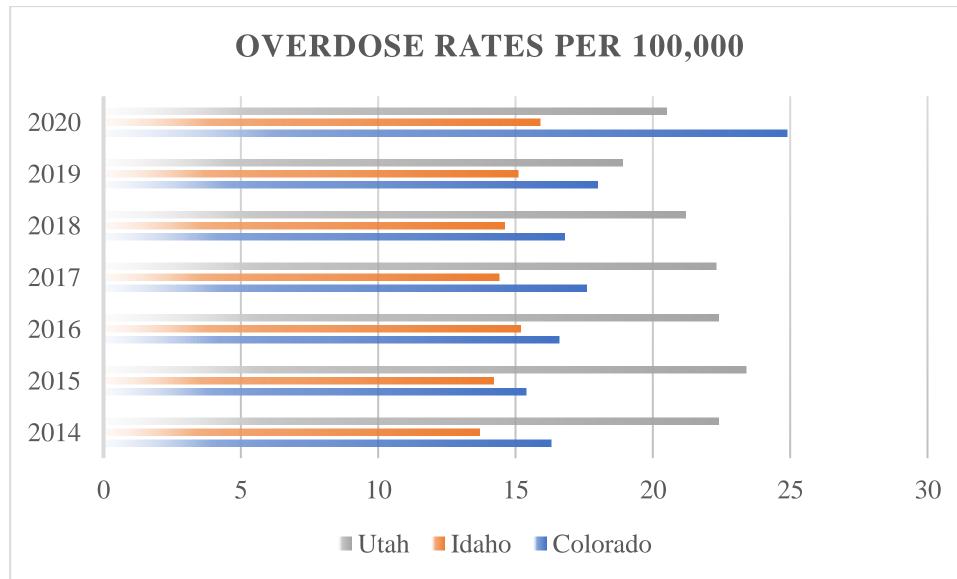
Evidence-based medications offer support in treating OUD and providing long-term recover that is not available for all SUD. Several medications for OUD are available by prescription and can be taken in the comfort of the home. Some of the medications must be dosed daily in an OTP setting. Patients in an OTP setting are federally mandated to follow strict dosing rules to "earn" take-homes and other privileges. Patients in these clinics must meet monthly counseling requirements and pass frequent urine drug screens.

Methadone is the medication sought by most patients visiting the OTP setting, and it is highly regulated by both federal and state governments (SAMHSA, 2015). Patients may receive other types of medications at OTPs if they are better suited for their treatment and want to remain in a more controlled dosing environment. The drawback in Utah to patients choosing medications other than methadone in an OTP clinic is that currently, Utah Medicaid does not offer reimbursement in the clinic setting for some medications or does not cover the dosing or administration costs. Methadone is covered as well as the administration and dosing of it.

The lack of Medicaid reimbursement for MOUD outside of methadone is significant because, in 2012 Utah ranked 4th highest in the nation for deaths by opioid overdose. This is especially tragic as it pertains to treatable and/or avoidable overdose deaths. The state remained

4th worst for two more years from 2013 to 2014, however, the situation has shifted, and Utah's improved. Unfortunately, the paradoxical improvement in ranking of 4th was not really attributed to a decrease in overdose deaths in Utah. Figure 1 and Figure 2 display the overdose death rates per 100,000 in the states included in the analysis.

Figure 1: Table comparing age-adjusted overdose rates in Colorado, Idaho & Utah



Source: Death Rate Maps and Graphs, CDC 2020.

Figure 2: Age-adjusted overdose rates in Colorado, Idaho, & Utah

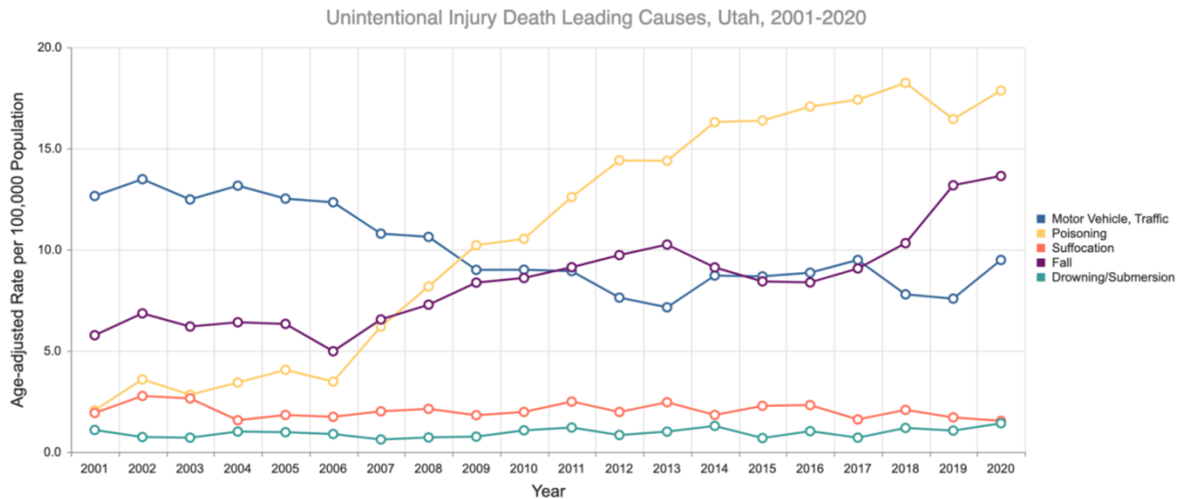
Overdose Rates age-adjusted per 100,000							
State	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Colorado	16.3	15.4	16.6	17.6	16.8	18.0	24.9
Idaho	13.7	14.2	15.2	14.4	14.6	15.1	15.9
Utah	22.4	23.4	22.4	22.3	21.2	18.9	20.5

Source: Death Rate Maps and Graphs, CDC 2020.

Figure 3 below, for example, indicates that overdoses in Utah declined in 2019. This may be due to a variety of factors that include increased access to MOUD, increased access to

treatment services, increased access to naloxone and Narcan, an increased availability of federal funding available for prevention, treatment, and recovery support services, partial Medicaid expansion in April of 2019, and an overall better understanding of SUD and OUD that lead to stigma reduction. The data, however, also suggests that Utah's ranking changed because of increases in death by drug overdose in other states as well. Most overdose deaths in Utah are related to prescription overdose deaths while other states primary overdose deaths are attributed to illegally obtained heroin or other synthetic opioids. Nevertheless, as fentanyl continues to become more widely available, and found in a wider range of illegal drug supplies, no matter the venue for access, death by overdose will continue to be an issue for Utah and across the United States.

Figure 3: Unintentional Injury Deaths in Utah 2001-2020



Source: Utah Department of Health. Unintentional injury deaths by cause. (IBIS).

Overdose deaths rose nationally and in Utah between 2011-2021, with a significant jump in deaths due to the COVID-19 pandemic, Figure 3. In Utah, 67% of drug overdose deaths are attributed to opioid overdose (Utah Department of Health, 2021). According to the Utah

Department of Health, non-Hispanic white adults aged 25-54 are disproportionately affected by opioid overdose in Utah. In 2020, males accounted for nearly 66% of the opioid overdose deaths in the state (Utah Department of Health, 2021). Individuals with a history of SUD and mental health disorders are also at an increased risk of opioid overdose. These factors must be included in the decision-making process of how treatment payments are designed for individuals with Medicaid.

Figure 4: Drug overdoses in Utah compared to the USA 2011-2021

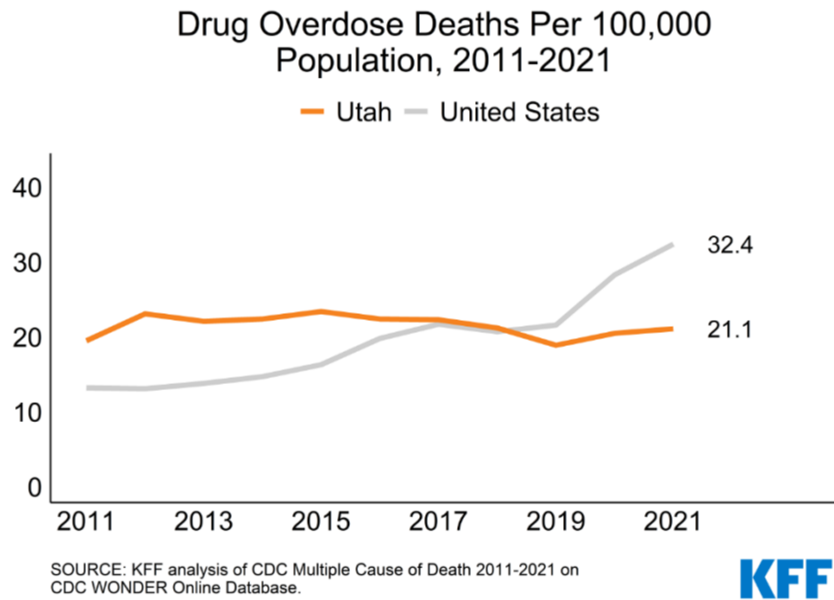


Figure 5: Drug overdoses in Colorado compared to the USA 2011-2021

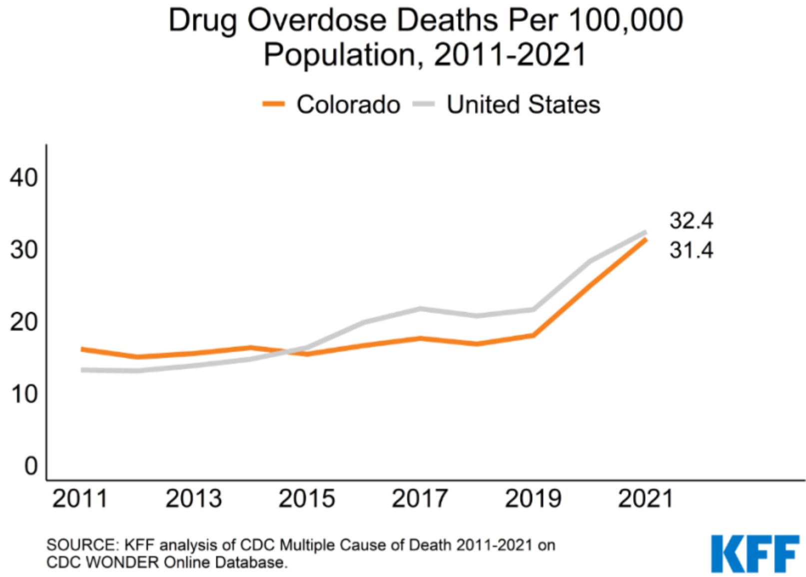
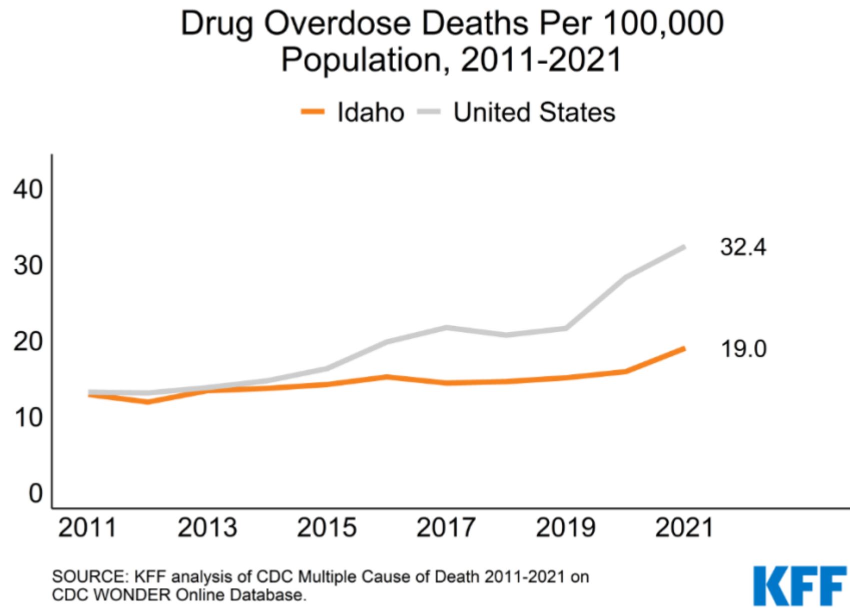


Figure 6: Drug overdoses in Idaho compared to the USA 2011-2021



Treatment can be cost-prohibitive and that is true of both in-patient and out-patient settings. Cash pay and other forms of insurance outside of Medicaid are not typically an option for most people with a SUD (Utah DHHS, Medicaid Division, 2021). Medicaid expansion is

relatively new in Utah since it began in April of 2019, and full expansion in January of 2020. With expansion just beginning, many people who are eligible do not know they are eligible. Lack of insurance is a leading barrier for people seeking treatment.

Literature Review

The literature reviewed for this memorandum offers two primary considerations for increasing access to treatment in reference to Medicaid covered patients. First is to cover all approved medications used to treat OUD. Second is that federal and state laws should ensure continued ease of access to those medications. Law changes would include removing required training for providers as is the case for buprenorphine prescribing (SAMHSA, 2023). This announcement removed barriers for medication pickup at the pharmacy level, continued allowance of telehealth visits, and continued flexibilities in methadone prescribing and dispensing.

Telehealth rules and methadone prescribing rules were first relaxed during the public health emergency in the Spring of 2020 and have led to long-term policy changes and pending policy changes, both at a federal and state level. The temporary rule changes led to a relaxation of federal regulations related to take-home doses of methadone. Prior to the public health emergency, methadone was only dispensed at OTPs, typically daily and under strict supervision where a patient must be observed taking their dose. The public health emergency has allowed looser regulations on methadone take-homes for patients who meet certain criteria (SAMHSA, 2023).

While there have been some concerns about diversion and misuse of methadone, overall, the evidence in Utah and nationally (Amram et al., 2021) indicates there has not been an increased misuse of methadone or overdoses from methadone (Utah Department of Health, 2023). The Substance Abuse and Mental Health Services Administration (SAMHSA), for example, is recommending the temporary changes be approved and implemented by the federal Department of Health and Human Services citing "increased treatment engagement, improved patient satisfaction with care, with relatively few incidents of misuse or medication diversion." (SAMHSA, 2023).

Secondly, it is notable that most patients succeed in treatment when available and when access is expanded through (e.g., telehealth, more providers, more clinics), when medications are easier to obtain (e.g., less federal oversight of medications and prescribing practices), and when providers are paid for services they provide. Thus, large-scale policy change must occur at both the federal and state levels. These changes will lead to long-term access to medications, removal of barriers, and better care, all while providing appropriate payment and reimbursement for the wrap around services needed (e.g., counseling, group therapy, physical health access) for OUD treatment. Patients need to be incentivized to enter and stay in treatment, not punished, or challenged by the systems in place lending to patient-centered care.

Research Design & Analysis

A variety of approaches are employed to collect data for this study. First, interviews were conducted with stakeholders from Utah, Colorado, and Idaho, including representatives from the

State Opioid Treatment Authorities (SOTA), Medicaid teams, OTP directors, and the Utah Department of Health and Human Services representatives working in the substance use disorder (SUD) space. The same set of questions was sent via email to each of the SOTAs, and in-person and phone interviews were also conducted, in addition to email correspondence.

Second, information was gathered from journal articles, State and Federal Medicaid websites, reviews of studies conducted by the Pew Charitable Trust, and other SUD specific web portals, such as the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Finally, data from the National Vital Statistics System (NVSS) and the Centers for Disease Control and Prevention (CDC) were analyzed utilizing the Kaiser Family Foundation (KFF) State data reporting tool.

Idaho and Colorado were chosen as comparable states based on various aligning factors including, but not limited to state size, population, political environment, and regional distinctions. Idaho has 6 OTPs, Colorado has 35 OTPs, and Utah has 18 OTPs. All three states have Medicaid expansion with Colorado implementing it in 2014 and both Idaho and Utah implementing full expansion in January of 2020. Before this analysis began, it was unknown if Idaho or Colorado offered bundled rates for OUD and SUD treatment and has since been found that currently, neither state does so. This is true of Utah as well. No bundled rates are offered and not all medications are reimbursed for patients with Medicaid. All three states are, therefore, fee-for-service treatments. Meaning every service is billed individually. However, billing fee-for-service is hard to do because the fiscal margins an OTP operates on are slim. Payment reimbursement dictates what treatment a patient with Medicaid can receive. Such a system fails

then to have insurance determine care instead of care being a medical professional based assessment.

The research presented here shows positive outcomes are associated with Medicaid bundled rates. This is because providers can tailor a patients’ treatment plans and provide what is needed in one place. It creates an opportunity for the patient to receive integrated healthcare. The patient can access needed services without long waiting periods or having to “earn” treatment services. The dosing and administration of medications need to be similarly reimbursed in addition to medication costs. Thus, reimbursement availability is inherently necessary for all evidence-based medications, not just methadone or buprenorphine.

Figure 7: State facts for Colorado, Idaho, and Utah

	Number of counties	2020 Population (million)	Percent of rural area	Percent of Population uninsured	Total number covered by Medicaid	Percent of Population w/ Medicaid	% of Population using substances between 2017-2019
Colorado	64	5.808	73%	8%	1,563,445	27%	8%
Idaho	44	1.827	88%	8.80%	415,131	22%	8.8%
Utah	29	3.25	77%	9%	394,436	13%	9%

Source: State Behavioral Health Barometer, 2019 National Survey on Drug Use and Health SAMHSA, 2020

Findings

The main finding is that bundled Medicaid rates are necessary for billing and reimbursement in the integrated treatment of SUD and OUD. The ability of a clinic to determine the best treatment for a patient based on a needs assessment versus what Medicaid will reimburse leads to longer-term recovery outcomes for individuals with a SUD and/or OUD (Hodgkin et.al.,

2020). The study outcomes indicate an increase in Medicaid reimbursement for SUD treatment services is associated with lower rates of patients returning to substance misuse and increased rates of long-term recovery (Hodgkin et.al., 2020).

Nationwide a lack of access to treatment exists in both urban and rural settings. The data suggests that White male adults is the group most likely to die from an overdose, however, the data also indicates that there has been a corresponding rise in the deaths of American Indian and Alaskan Native (39%) and Black individuals (44%) from opioid overdose at a significantly higher rate between 2019-2020 (CDC, 2022). Simply stated, overdose deaths rose sharply due to several factors during 2020 and totaled 91,799 drug overdose deaths. This rate includes all drug overdoses. The age-adjusted rate increased by 31% between 2019-2020. The rate in 2019 was 21.6 per 100,000 and 28.3 per 100,000 in 2020 (CDC, 2022).

Utah is, in turn, experiencing the same difficulties seen across the country. The age-adjusted rate of overdose deaths increased by 7% in Utah from 20.7 per 100,000 in 2019 to 22.2 per 100,000 in 2020 (Utah Department of Health, 2023). Nationally, and in Utah more specifically, there is a shortage of addiction medicine providers who can prescribe MOUD and trained clinicians to provide counseling and lead group therapy. As the evidence suggests, the COVID pandemic further increased a need for providers in all treatment settings. Counselors are expected to have a high case load of patients, see their patients quickly for billing purposes, all while earning a low salary considering their education and training. The incentive to stay in the field is, for example, low for master's level clinicians (Roberts et. al., 2019). Beyond pay and incentives, it is hard to get counselors to locate to more rural areas of states where populations do not have the same ability to access treatment programs as do more urban areas of states. Clinics

are also not incentivized to provide the range of medications to patients that are available to treat OUD because of lack of Medicaid reimbursement. Medicaid does not, for example, pay for the dispensing or administration of medications other than methadone in the OTP setting.

Conclusion & Recommendation

According to SAMHSA, in the United States, roughly 18 million people needed substance use treatment in 2019, but only 1 in 10 received it. One of the main reasons for not seeking treatment included a lack of financial resources. By offering bundled payment options for Medicaid participants, clinics, specifically OTPs can better promote more cost-effective, integrated, quality healthcare. It is more cost-effective because it simplifies the billing process for clinics and state-based Medicaid programs. Providing this reform means that providers only need to submit a single claim for all the services participants receive. They are also incentivized to provide high-quality direct services to avoid unnecessary or duplicated services leading to cost savings. Providers can then work together to provide a more integrated healthcare experience leading to better patient outcomes and longer, more sustained recovery. This is important for a patient-centered care model and continuity of treatment for people with SUD.

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