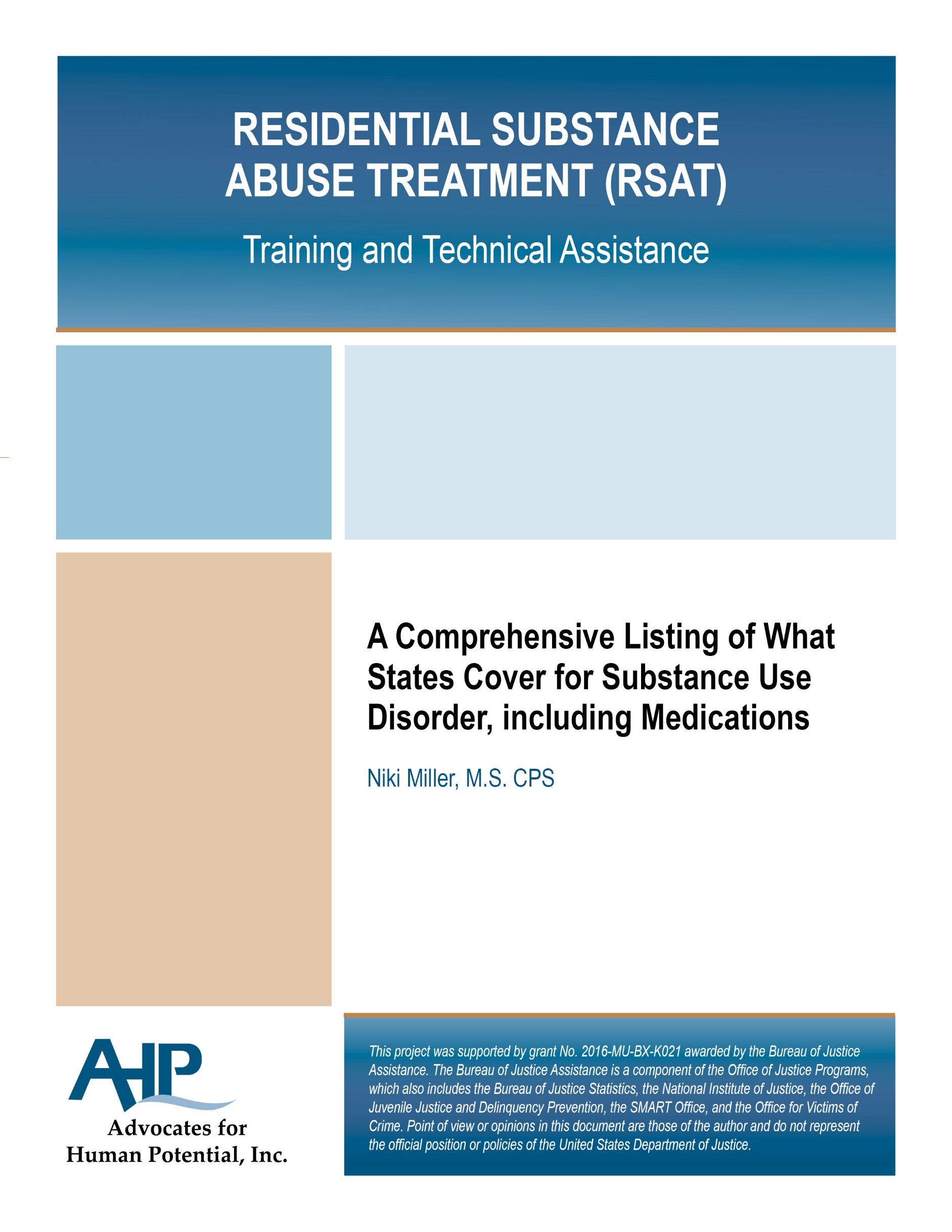
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**Comprehensive Update on State Medicaid Coverage of Medication-Assisted Treatments and Substance Use Disorder Services**

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**Introduction**

In 2013, the American Society of Addiction Medicine (ASAM) released a comprehensive review of state Medicaid coverage for FDA approved medications and treatment services for individuals with opioid use disorders.[[1]](#footnote-1) ASAM engaged a contractor to conduct a 50 state Medicaid survey and to compile other data contained in the report. In 2014, The Substance Abuse and Mental Health Services Administration’s (SAMHSA) review of state Medicaid coverage of medications for substance use disorders [[2]](#footnote-2) added information on medications for alcohol use disorders (AUDs). The following 2017 update builds on this foundational knowledge and provides more current information. The following summaries from the prior reports and the current updates demonstrate progress that has been made, but also the challenges that remain in making all FDA approved medications for alcohol and opioid use disorders accessible.

**Scope of the Current Problem**

Medication-assisted treatment (MAT) refers to combining psychosocial/behavioral treatments with FDA approved medications for opioid or alcohol use disorders. Currently, two medications are approved for opioid replacement therapy: methadone and buprenorphine. A third medication, long-acting injectable naltrexone, is approved for preventing relapse among individuals with opioid use disorders (OUDs). Ensuring effective treatments are at least as accessible and affordable as continued illicit opioid use is a critical component of a public health and public safety response to the current epidemic.

The ASAM report alluded to increases in drug overdose death attributable to opioids. Since then, the situation has gotten much worse. There has been a dramatic rise in opioid overdose deaths, which is reflected in the 2014 overdose fatality data included in this review. It is important to note overdose deaths attributed to opioids are underestimated, since at least one in five overdose deaths do not specify the type of drug and other reported fatalities result from a combination of drugs.[[3]](#footnote-3)

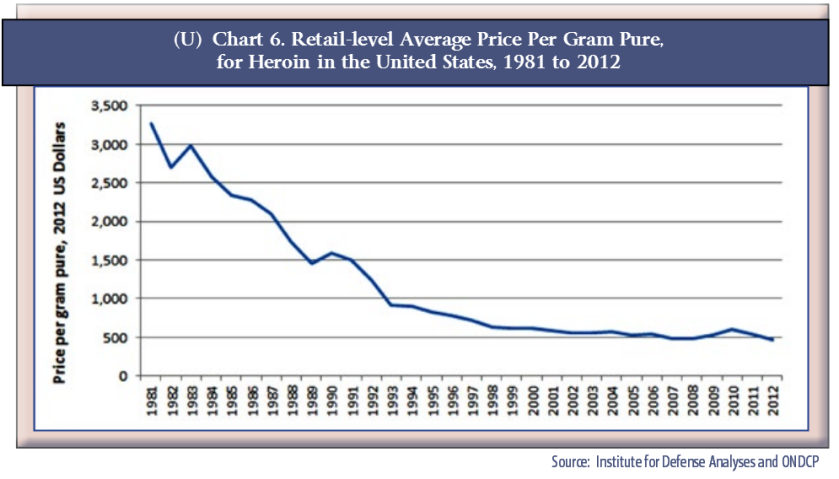
Moreover, the 2015 age-adjusted opioid-involved death rate increased ***15.6%***, driven largely by deaths involving heroin and synthetic opioids other than methadone (presumably fentanyl). [[4]](#footnote-4) From 2014 to 2015 only four states reported decreases in overdose fatality rates of a one per 100,000 or more while several states reported significant increases.[[5]](#footnote-5)

In 2013, ASAM noted that individuals with OUDs are far more likely to have a history of being prescribed opioid analgesics and/or illicit use of these medications than histories of heroin use. According to the CDC, more rural and more impoverished counties tend to have higher prescription drug overdose death rates. The opioid epidemic is affecting non-Hispanic whites and Native Americans/Alaska Natives between 45 and 54 years old the hardest. [[6]](#footnote-6)

Despite the growing opioid epidemic, the Government Accounting Office estimates that MAT is accessible to only a maximum 1.4 million of the 2.3 million people who reported opioid problems. As of 2016, there were 1,400 Opioid Treatment Programs (OTPs) qualified to dispense methadone and 32,000 physicians qualified to prescribe buprenorphine for opioid addiction.[[7]](#footnote-7) Passage of the Comprehensive Addiction Recovery Act (CARA) should increase treatment capacities with regard to buprenorphine, raising the maximum patients physicians can treat and allowing nurse practitioners and physicians’ assistants to prescribe buprenorphine for OUDs.[[8]](#footnote-8)

Medications that could help curtail the epidemic are substantially underutilized by state Medicaid programs. They are also underutilized by community-based treatment providers, with documented disparities between publically-funded and privately-funded treatment in access to pharmacotherapies, attributed to the scarcity of on-staff physicians in publically-funded programs.[[9]](#footnote-9) Research shows that community-based providers are significantly more likely to offer MAT when drugs are included on Medicaid formularies and if they perceive MAT is supported by the Single State Agency responsible for substance use disorder services. [[10]](#footnote-10)

The proportion of out of pocket expenditures for prescribed opioid drugs for both publically and privately insured patients has decreased from 54% of total costs in 1999 to 18% of costs in 2012.[[11]](#footnote-11) Medicaid spending on Central Nervous System (CNS) drugs comprises one of the largest categories of medication expenditures. The Medicaid population is at greater risk for overdose. Studies show that Medicaid beneficiaries are prescribed opioids at higher rates and at higher doses than privately insured individuals. But the cost of MAT for individuals without coverage can range between $750 to $1,200 a month or more. Out of pocket costs for covered individuals may include co-pays for counseling, medications, physician visits and more. [[12]](#footnote-12)

This information is particularly important to justice professionals working with individuals with opioid use disorders. Investments into substance use treatment in custody are less likely to pay off without access to follow-up care upon re-entry into the community. The re-entry population tends to rely on public ally-funded substance use disorder treatment or public health care coverage.  As MAT utilization increases among justice programs, sustaining access to appropriate care must be a major consideration. Increased vulnerability to overdose fatality among re-entering individuals during the immediate post-release period is well documented.[[13]](#footnote-13) According to a June 2106 unclassified DEA Intelligence Report, heroin prices are decreasing as purity increases (see above chart). Seizures of cheap and potent illicitly manufactured fentanyl are also increasing.[[14]](#footnote-14) These factors may elevate fatality risk if treatment access is delayed upon re-entry.

**Methodology, Terminology and Health Literacy**

This review relies on primary source material available from state Medicaid websites, including: explanations of covered services; member handbooks; Medicaid brochures; memos pertaining to coverage for MAT; reports compiled by various states; and Medicaid Managed Care plans and contracts. The Kaiser Family Foundation State Health Facts website and their Medicaid Benefits Data Collection was also a source of information. In some cases, Medicaid state plans, waivers submitted by states to the Center for Medicaid and Medicare Services, and materials available on websites of Single State Agencies responsible for substance use services were also reviewed. Finally, the most current Medicaid preferred drug lists (PDL) and/or drug formularies from 49 out of 50 states and the District of Columbia were also reviewed in detail.

Language was simplified when possible, but much of the terminology used by the verification source was retained to ensure the information was accurately represented. Health literacy has recently become a focus of research and of initiatives aimed at improving consumer understanding of health care information. The ASAM report pointed out examples of Medicaid and health plan terminology that was confusing and inconsistent. This review found that some states provided clear information on MAT coverage, while others required a search of multiple documents and used ambiguous language and imprecise grammatical constructions that made a precise interpretation of coverage difficult for a health policy researcher. Presumably beneficiaries seeking care would find it even more difficult.

**Explanation of selected terminology and examples of how terms may be used**

***Medicaid Fee for Service Reimbursement—***State Medicaid plans pay for services through either fee-for-services or managed care arrangements. Each state can set their own Medicaid reimbursement rates for services as long as they fall within federal guidelines. Some of the ways states determine reimbursement rates for specific services include:

* a review of the cost of a service for commercial payers in the private market; or
* a percentage of what Medicare pays for an equivalent service.

Medications for opioid use disorders are frequently covered through fee for services reimbursement. This is because Medicaid discounted rates for prescription drugs are obtained through drug company rebates. Prior to the Affordable Care Act, Medicaid managed care plans were excluded from rebate programs. Many states carved out pharmacy benefits from managed care contracts and have left them as fee for service benefits.

***Categorically Needy and Medically Needy Populations*—**Federal Medicaid requirements designate categorically needy populations that state Medicaid programs are mandated to cover. State may extend Medicaid benefits to additional groups that they designate as medically needy. These groups are usually determined by how their income compares to Federal Poverty Level.

***Medicaid Managed Care—***delivers services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set monthly payment per member. At least 70% of Medicaid beneficiaries are now enrolled in managed care plans. Some states offer eight or more different managed care plans that vary in covered benefits they offer. Some states require consistent coverage for specified services from MCOs; other states allow flexibility and only require contracted MCOs to offer plans that meet federal standards and adhere to various quality assurance and performance benchmarks.

***Capitated Payment—***is a set monthly payment per beneficiary enrolled in a Medicaid managed care plan. Other types of negotiated rates for fee for services plans are detailed in the utilization controls section below.

***Utilization Controls—***are measures designed to manage the costs of health care services. Several different types of controls are referenced in this review.

* ***Negotiated reimbursement rates—***Medicaid agencies may use different methodologies to determine the rate for reimbursement of treatment services. Some use a ***per diem*** or daily rate. Other types of negotiated reimbursement rates include: ***percentage of cost, capitated,*** and ***cost-based or prospective cost rates***.
* ***Pre-approval or prior authorization—***refers to needing permission for a specific service to make sure the health plan will pay for it before the beneficiary can get care. Providers/prescribers usually submit pre-authorization requests. Medicaid managed care plans often require these requests to come from the beneficiary’s primary care provider.
* ***Dosage limits—***refer to the maximum dosage of a medication that a health plan will cover. Some standardized dosage limits do not correspond to clinical guidelines. They also fail to account for biological conditions that can influence drug metabolism. For example, pregnancy and certain drugs prescribed for other medical conditions can require dosage adjustments. “Dosage limits” are also applied to counseling and outpatient and residential treatment services. For example, counseling might be limited to 36 session per year or residential treatment to 30 days.
* ***Lifetime limits on MAT for methadone and/or buprenorphine—***are limits on how long a plan will pay for a medication. These limits are seldom applied to medications for other chronic conditions (asthma, hypertension, depression, etc.). In some cases, long-term MAT may help repair damage to opioid receptors; but how long it can take and the extent of the healing is highly individualized. MAT is most likely to be effective when treatment duration is between 9 months and two years. Sometimes certain individuals function better when they remain on a reduced maintenance dose for an extended period.
* ***Frequent Reauthorization Requirements—***refers to needing permission to continue to get a prescribed medication. Criteria may become more demanding with each reauthorization period. Sometimes multiple re-submissions are required before the minimum recommended time in treatment is reached.
* ***Prescription refill limit*s—**are limits on the number of refills a plan will cover. These limits may not reflect chronic disease expectations and are not typically imposed on medications for other chronic conditions
* ***Pre-authorization requires documentation of participation counseling—***refers to a requirement to ensure a beneficiary is receiving counseling before the plan will cover the cost of a medication. Sometime details of counseling sessions or progress notes are demanded. Plan may offer limited coverage for the required counseling or wait lists and other capacity issues can delay treatment.
* ***Requiring documentation a beneficiary has had an OUD for a specified time period—***refers to having to document that an individuals has had an OUD for a certain period, for often a year or more. Fortunately, some states waive this requirement for individuals recently released from prison or jail and for pregnant women. Early detection and intervention is usually encouraged for other health conditions.
* ***Step therapy or fail first criteria—***is a requirement for documentation that other therapies have been attempted but were ineffective before MAT is covered. This is not always possible in certain geographic areas where access to treatment is limited. MAT has been shown to be far more effective than behavioral treatments alone. Treatment failures can translate into fatalities in some cases.

* ***Dictating specific clinical approaches—***Examples of this include demanding providers introduce a plan to taper as soon as patients are stabilized on a medication or dictating tapering schedules. These requirements can jeopardize patient engagement and retention.

***Preferred Drug List (PDL) and Formulary—***Typically, preferred drugs lists are comprised of medications that health plans routinely cover. Formularies are broader listings of all medications, preferred and non-preferred, with notations that indicate higher co-pays, pre-approval criteria, dosage or duration limits and other coverage restrictions. The ASAM report pointed out their review found terminology was inconsistent and ambiguous. This update found the same issue. Many “preferred drugs” for opioid use disorders had pre-approval criteria and other limitations. Some states had a universal formulary that listed preferred and non-preferred drugs and noted restrictions for non-preferred medications. Some state Medicaid agencies indicated that one universal formulary applied to all benefit plans, including various managed care plans. In other cases, managed care plans had their own drug lists. Some formularies allowed information on coverage of each FDA approved medications for opioid and alcohol use disorders to be looked up so it could be included in this report.

***1115 Waiver—*** Section 1115 demonstration waivers allow state Medicaid agencies to gain approval from the Center of Medicaid and Medicare Services to test new ways to deliver and pay for health care services in Medicaid and the Children’s Health Insurance Program (CHIP).

***Opioid Treatment Programs—***or OTPs are specially designated treatment programs that can dispense methadone for treatment of OUDs. These programs are highly regulated and must meet at least two layers of federal requirements (SAMHSA certification and DEA registration) and other requirements states may impose. Methadone can’t be prescribed to treat opioid addiction, but OTPs can dispense it for these purposes (usually daily, in liquid form, under direct observation). They adhere to specific guidelines that govern limited take-home dosing for patients making satisfactory progress. OTPs are also mandated to link patients to behavioral health, medical, and social services that support recovery. Many OTPs have begun to also offer buprenorphine and/or long-acting injectable naltrexone. Other addiction treatment programs and qualified primary care providers may also offer these medications to treat opioid addiction, but only a finite number of OTPs can dispense methadone.

***ASAM Criteria—*** are a set of guidelines for patient placement, comprised of five broad levels of care that correspond to the assessed severity of an individual’s substance use disorder. American Society of Addiction Medicine patient placement criteria has helped standardize addiction treatment services for more than two decades and are now required in over 30 states. They guide the intensity and duration of initial levels of care as well as transfer/discharge and aftercare for patients with addiction and co-occurring conditions. ASAM has more recently developed practice guidelines for MAT of addictions involving opioid use.

***Substance Abuse Treatment and Prevention—***or SAPT block grants are a non-competitive funding source for publically funded treatment and prevention programming. The amount of funding is based on a formula that accounts for state population and other factors the influence demand for services.

**Note: Note:** Most of terminology that appears in the state summaries that follow comes from materials provided by each state. When terms appeared to be misused (such as ‘opiate’ instead of opioid) or terms could be interpreted to convey several different meanings, in the interest of accurate representation, text was generally left as it appeared. Corrections or questions about the intended meaning of other terms that are not included in the above list should be directed to the appropriate state. Brand names of medications were used when relevant references appeared in PDLs or formularies.

**Alabama:** has not expanded Medicaid eligibility.

1. **In 2013 ASAM reported:** AL responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated all medications used to treat SUDs were on the Medicaid preferred drug list including those used to treat alcohol use disorders

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse, Data Set &* ***Kaiser State Health Facts*** showed: Alabama Medicaid covered treatment of substance use disorders on a fee for service basis. Specific sets of procedures were billable only for specific diagnoses (in 290-316 range) with varying limits. As of 2014, some copayments were required for dually eligible Medicare and Medicaid beneficiaries when the State was asked to pay the coinsurance and/or deductible amount for a service. Any identified copayment requirements were applicable to adult beneficiaries 18 or older.

**4. Current Medicaid Covered Services - verified of as of 3/2017:**

**Alabama Medicaid Covered Services Handout, 9/2016**: “Mental Health Services:Medicaid pays for treatment of people diagnosed with mental illness or substance abuse. The services received from a mental health center **do not** count against regular doctor’s office visits or other Medicaid covered services.” Mental health and substance abuse treatment are listed as services that do not require co-payments.

**Prescription Drugs - Medicaid PDL Formulary**: lists generic methadone products and buprenorphine/naloxone formulations with prior approval required.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 4,858,979 (adults and children = 21 % state population). Total Medicaid spending in 2015 was 5.3 billion; Medicaid spending on prescribed drugs: $282,668,250

**6.** **Drug overdose fatality rate** in 2014 was: 15.2 (per 100,000); rate of fatalities attributed to opioids - 5.6 (per 100,000).

**Alaska:** hasexpanded Medicaid eligibility.

**1. In 2013 ASAM reported:** AK responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance with some SAPT Block grant funding
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated the only medication excluded from AK’s preferred drug list was methadone. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse, Data Set &* ***Kaiser State Health Facts*** showed: Alaska Medicaid covered residential substance abuse services provided by participating in state-certified facilities only; services delivered in psych residential and day treatment centers were not covered. Notes indicate as of 2014, any identified copayment requirements are applicable to beneficiaries age 18 and older.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**Alaska Medicaid Recipient Services Handbook, revised August 2016: “**Medicaid recipients can access integrated behavioral health services at Community Behavioral Health Services providers throughout the state.” Clinical and rehabilitation services are available for adults or children experiencing a substance use disorder. Covered servicesinclude: assessments; case management; medication administration; comprehensive community support services for adults; substance use disorder treatment (outpatient, detoxification, residential treatment), and peer support.

**Prescription Drugs - PDL Formulary (updated 8/2014):** Preferred medications for opioid dependence are listed as: buprenorphine/naloxone sublingual tablets\*; naltrexone (oral); Suboxone film,\* and Vivitrol injections\* (an asterisk indicates subject to utilization controls such as maximum units, prior authorization, or step-edits). Suboxone sublingual tablets \* and buprenorphine HCL sublingual tablets\* are listed as non-preferred drugs, which are subject to utilization controls and require documentation of "medical necessity.”

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 171,000 (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 1.4 billion; Medicaid spending on prescribed drugs: $29,029,728

**6. Drug overdose fatality rate** in 2014 was: 16.8 (per 100,000); rate of fatalities attributed to opioids: 10.6 (per 100,000).

**Notes:** Alaska Medicaid offers guidance on covered transportation to medical services.

Link to the Alaska Opioid Policy Taskforce: [http://dhss.alaska.gov/abada/Pages/default.aspx](http://dhss.alaska.gov/abada/Pages/default.aspx%20)

AK identified the following priority and pressing issue: *“For our prisoner and parole population, access to behavioral health care, including substance abuse treatment and mental health services, reduces offender recidivism.”*

**Arizona** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported**: according to the AZ Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse, Data Set &* ***Kaiser State Health Facts*** showed: Arizona Medicaid offered fee for service coverage for both categorically needy and medically needy beneficiaries with substance use disorders. Arizona has a CMS approved 1115 waiver under which it implemented the Arizona Health Care Cost Containment System (AHCCCS) in 2015. Providers are required to obtain prior approval for specified services for beneficiaries coved by fee for service and managed care plans.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**AHCCCS Covered Services Manual –** updated 2016**:** Covered services include: administration of prescribed opioid agonist drugs to a person in an office setting in order to reduce physical dependence on heroin and other opiate narcotics; methadone administration and/or services (from a licensed OTP) and administration of prescribed opioid agonist drugs for take home in order to reduce physical dependence on heroin and other opiate narcotics (coverage of allowable methadone take home doses). Detoxification (room and board–private, semi-private or ward) and Level I Residential treatment services are also covered services.

**Prescription Drugs: PDL Formulary (updated 2017)** Medications listed are: methadone HCL concentrates - Intensol (pre-approval required, quantity limited to 180 days with authorization every 30 days) and methadone HCL solution (pre-approval required, quantity limit -up to 500 days with authorization required every 30 days). Pre-approval requirements for buprenorphine products were recently added and coverage is subject to a maximum daily dosage of 24 mg. Reauthorization criteria and duration of coverage criteria must be met such as confirmation that the prescriber is evaluating random urine drug screens and assessment of the patient’s progress. As of October 2016, Vivitrol injections no longer require pre-approval. Naloxone vial & syringe and Narcan nasal spray are both preferred drugs that do not require pre-approval.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 1.7 million (children and adults = 25% of the state population). Total Medicaid spending for 2015: 10.4 billion; Medicaid spending on prescribed drugs: $8,023,533.

**6. Drug overdose fatality rate** in 2014 was: 18.2 (per 100,000); rate of fatalities attributed to opioids: 8.8 (per 100,000)

**Arkansas** has expanded Medicaid eligibility.

**1. In 2013** A**SAM reported:** according to the AR Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone (limited)

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated methadone and extended release injectable naltrexone were excluded from AR’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Arkansas Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders on fee for service basis, with prior approval required for specific services. SUD treatment required a mental health primary diagnosis. As of 2014, AR also had a CMS approved 1115 waiver under which it provided a safety net health benefit package called ARHealthNetworks (also called ARHealthNet). The plan limits covered services such as the number of prescriptions and physician office visits per month and hospital services per year. There is a $100 annual deductible, copayments are set at 15% of allowable charges for covered services, and there is a maximum annual benefit of $100,000. The maximum out of pocket cost per year is $1,000.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**Arkansas Division of Medical Services website, 2017:** For established beneficiaries, covered services for SUD treatment are: addiction assessment and treatment planning. The following services are covered when they are part of a treatment plan: care coordination; counseling (group, individual and family/marital), and medication management.

**Prescription Drugs - PDL Formulary (updated 2017):** Medicationslisted are:Suboxone film, buprenorphine HCL sublingual tablets (prior authorization required); Narcan nasal spray, and naloxone auto-injector (subject to pre-approval– can be over-ridden by calling MCO help desk).

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 931,000 (children and adults = 22% of the state population). Total Medicaid spending for 2015 was 5.5 billion; Medicaid spending on prescribed drugs: $154,097,994.

**6. Drug overdose fatality rate** in 2014 was: 12.6 (per 100,000); rate of fatalities attributed to opioids: 6.3 (per 100,000)

**California** has expanded Medicaid eligibility.

**1. In 2013** **ASAM reported:** CA responses to survey questions regarding Medicaid coverage for MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on the preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: California covered SUD treatment for both categorically needy and medically needy beneficiaries. Co-pays of $1.00 per visit were required. Specific services may require pre-approval. Residential treatment facilities are paid a standard per diem rate by facility bed size; substance abuse services paid a daily rate.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**California Department of Health Care Services website, 2/2017:** In 2015, the State’s SUD treatment continuum of care was overhauled to align with American Society of Addiction Medicine patient placement criteria, with a phased plan to roll it out in all counties. The plan includes: co-locating SUD counselors at mental health clinics, primary care settings and/or hospital ER’s; access to MAT at all programs and at MH and SUD facilities, and residential and intensive outpatient services.

**Prescription Drugs - PDL Formulary (as of 2017):** The flowing medications are listed:buprenorphine/naloxone sublingual tablets (2 mg/0.5 mg; 8 mg/2 mg; 1.4 mg/0.36 mg; 5.7 mg/1.4 mg & 11.4 mg/2.9 mg); buprenorphine/naloxone sublingual film (2 mg/0.5 mg; 4 mg/1 mg; 8 mg/2 mg & 12 mg/3 mg); buprenorphine/ naloxone buccal film (2.1 mg/0.3 mg; 4.2 mg/0.7 mg & 6.3 mg/1.0 mg, and buprenorphine HCL sublingual tablets (2 mg/8 mg). All of the above are restricted to a maximum of 120 dosage units and dispensed supplies of 30-days, subject to pre-approval and counseling documentation requirements. Naltrexone HCL tablets (50 mg) are also listed (restricted to maximums). Effective2015, coverage for Vivitrol 380 mg IM injections-every 28 days with up to 6 refills was extended to adult Medi-Cal beneficiaries that have *been charged with or convicted of a misdemeanor or felony and who are also under supervision by the county or state.*Methadone has been deleted and suspended from the 2017 PDL until further notice. However, methadone HCL concentrate (10 mg/ml) and methadone HCL solution (10 mg/5ml, 5 mg/5ml) are considered ‘carve out drugs’ covered through Medi-Cal as fee for service billing. Naloxone syringe & vial Narcan nasal Spray (4.0 mg/0.1 ml) are also preferred drugs.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 12.2 million (children and adults = 26% of the state population). Total Medicaid spending for 2015 was 85.4 billion; Medicaid spending on prescribed drugs: $1,587, 852,251.

**6. Drug overdose fatality rate** in 2014 was: 11.1(per 100,000); rate of fatalities attributed to opioids: 5.0 (per 100,000).

**Connecticut e**xpanded Medicaid eligibility.

**1. In 2013 ASAM reported:** CT responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from CT’s Medicaid preferred drug list. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed**:** Connecticut provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries at a prospective per diem or global rate. Ten days/per occurrence in an approved alcohol evaluation center for acute and evaluation phase of treatment was allowable.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**Connecticut Medicaid Summary of Services, 2017:** The following types of services are covered for beneficiaries with SUDs: inpatient services at a hospital; detoxification services at a hospital or detox facility; crisis services; day treatment programs; individual, group therapy and family therapy; methadone treatment services, and medication evaluation, prescription and management.

**Prescription Drugs - PDL Formulary (as of 2017):** The following medications are listed as preferred drugs for *Opiate Dependence:* Suboxone film; buprenorphine HCL sublingual tablets; naltrexone (oral) tablets; naloxone syringe & vial, and Narcan nasal spray. Methadone concentrate is listed on the PDL under analgesics. Methadone maintenance treatment is covered by fee for service Medicaid with documentation of counseling required. Vivitrol is covered under fee for service Medicaid and listed as a pharmacy benefit, but not included on the PDL.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 750,000 (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 7.9 billion; Medicaid spending on prescribed drugs: $ 616, 686,448.

**6. Drug overdose fatality rate** in 2014 was: 17.6 (per 100,000); rate of fatalities attributed to opioids: 15.2 (per 100,000).

**Colorado** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported**: according to the CO Medicaid website coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone (limited)

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated that only methadone was excluded from CO’s Medicaid preferred drug list. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***State Health Facts*** showed: Colorado Medicaid provided fee for service or prospective cost-based rate coverage for SUD treatment. Coverage is limited to 25 individual therapy sessions and 36 group therapy sessions per year with a co-pay of $2 per visit. Coverage of drug screening and monitoring is limited to 36 specimens per year.

**4. Verification Medicaid Covered Services-verified as of 3/2017:**

**Health First Colorado Member Handbook:** Lists the follow covered services: alcohol and drug screening; counseling; group counseling by a provider, targeted case management\*; behavioral health assessment\*; emergency and crisis services\*; medication-assisted treatment\*; outpatient day treatment, non-residential\*; family, group or individual psychotherapy \*; and social ambulatory detoxification\* (note: services with an \* may require pre-approval). Substance abuse treatment for pregnant women can extend up to 12 months postpartum if services were initiated prior to delivery.

**Prescription Drugs - PDL Formulary (updated as of 2017):** Buprenorphine-naloxone sublingual tablets (2-0.5 mg, 8-2 mg) are listed as preferred. Methadone Intensol oral concentrate (10mg/ml) and methadone oral solution (10 mg/5 ml, 5 mg/5 ml) are listed as non-preferred drug with a low co-pay. Buprenorphine HCL sublingual tablets (2 mg, 8 mg) available with pre-authorization and a low co-pay (quantities limited to up to 90 per 30 days). Probuphine implant is also covered under the medical benefit, but is listed as a non-preferred drug. Acamprosate (333 mg tablets) is non-preferred drug with a low co-pay; Antabuse oral tablets (250 mg, 500 mg) is a non-preferred drug, available with a higher co-pay.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization: 1.4 million (children and adults = 19% of the state population). Total Medicaid spending for 2015 as 7.4 billion; Medicaid spending on prescribed drugs: $316, 630, 448.

**6. Drug overdose fatality rate** in 2014 was: 16.3(per 100,000); rate of fatalities attributed to opioids: 9.4 (per 100,000).

**Delaware** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** according to the DE Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from DE’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Delaware Medicaid provided coverage for SUD treatment on a fee for service or prospective cost-based rate (limited to 30 days residential treatment per year - plus 2 days available for each unused inpatient psychiatric treatment day not used for outpatient treatment). Approved treatment includes a minimum of 1 hour per week clinical face to face contact.

**4. Current Medicaid Covered Services-verified as of 3/2017:**

**Delaware Department of Health and Human Services:** The 2015 covered services manual lists: substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), medication-assisted treatment, and licensed opioid treatment programs. Services provided in opioid treatment programs, including medication, medical monitoring/management, methadone dispensing, physical examinations, counseling, laboratory work (including urinalysis), and other assessment and treatment services provided by or required for admission to or continued stay in opiate treatment programs are included in the benefit package. In September of 2014, the Division of Substance Abuse and Mental Health (DSAMH), along with the Division of Medicaid and Medical Assistance (DMMA) obtained CMS approval of a 1115 waiver amendment for implementation of the PROMISE program (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) with the goal of improving behavioral health clinical and recovery outcomes through better care coordination. The program offers care coordination and other services for recovering individuals.

**Prescription Drugs – PDL Formulary (as of 1/2017):** The following are listed as preferred drugs for opiate dependence treatment: buprenorphine; naltrexone (oral); Suboxone film, and Vivitrol. Non-preferred agents with pre-approval required are listed as: Zubsolv; Bunavial, and buprenorphine/naloxone tablets. Naloxone and Narcan nasal spray are listed as preferred drugs.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 239,000 (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 1.9 billion. Spending on prescribed drugs was not available.

**6. Drug overdose fatality rate** in 2014 was: 20.4 (per 100,000); rate of fatalities attributed to opioids: 13.9 (per 100,000).

**District of Columbia - Washington DC** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** according to the DC Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage was limited for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from D.C.’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were included.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Washington D.C. covered SUD treatment for categorically and medically needy beneficiaries through fee for services reimbursement, with pre-approval required. Length of treatment covered at state-certified substance use disorder treatment programs was dependent on established level of acuity.

**4. Current Medicaid Covered Services - verified as of 2017:**

**Washington D.C. Department of Behavioral Health website:** Services include detoxification, treatment - including medication-assisted treatment, individual and group counseling, self-help and recovery activities, and (in some cases) residential treatment. Women can bring their children under 10 years old to live with them in certain residential programs. Recovery Support services are also available. As of 2014, a CMS approved 1115 waiver authorized the District to provide full Medicaid benefits to childless adults between the ages of 21 and 64 with income at or below 200% of the federal poverty level (FPL); individuals with income below 133 % of the FPL receive benefits through the District’s implementation of the childless adult coverage option available under the ACA. The benefit package, managed care delivery system, and cost sharing requirements are the same as for traditional Medicaid.

**Prescription Drugs – PDL Formulary (updated 12/2016):** Preferred medications for treatment of opiate dependence: naltrexone (oral) and Suboxone film. Naloxone syringe & vials and Narcan nasal spray are also preferred drugs. The following medications are listed as requiring pre-authorization: Bunavail, buprenorphine, buprenorphine/naloxone, and Zubsolv.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 262,000 (children and adults = 26% of the District population). Total Medicaid spending for 2015 was 2.4 billion. Spending on prescribed drugs was not available.

**6. Drug overdose fatality rate** in 2014 was 14.2 (per 100,000); rate attributed to opioids was: 9.4 (per 100,000).

**Florida** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** according to the FL Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated all medications used to treat SUDs were on Florida’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed:Florida Medicaid extended coverage for SUD treatment to both categorically and medically needy beneficiaries through both fee for service and capitated payment. Quantity and frequency limits vary by service and require a $2 per visit co-pay. In 2014, CMS approved a 1115 waiver under which some Medicaid eligible groups receive health care services though plans with a risk-adjusted premiums which are required to provide all mandatory and most optional Medicaid benefits, but coverage amount, duration and scope may vary.

**4. Current Medicaid Covered Services-verified as of 3/2017:**

**Florida Agency for Health Care Administration website:** The Medicaid Certified Match Substance Abuse Program allows counties to increase local public funds for substance abuse treatment for Medicaid recipients for the three approved substance abuse services: alcohol and/or drug intervention services; comprehensive community support services-peer recovery support, and comprehensive community support services-aftercare. Under this program, enrolled counties can contract with providers to offer these services and reimburse them directly. Then the county can submit claims to Medicaid for reimbursement of the federally-funded portion.

**Prescription Drugs – PDL Formulary ( updated 1/2017)**: The following are all listed as preferred drugs: Bunavial, buprenorphine/naloxone sublingual film & tablets, and buprenorphine sublingual tablets (limited to a maximum of 3 strips or tablets per day – minimum age 16); methadone tablets/ suspension/injectable and disket dispersible tablets - minimum age 18), and Vivitrol (380 mg ER suspension for injection-minimum age 18).

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 4.3 million, (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 21.5 billion. Medicaid spending on prescribed drugs: $103,732,365.

**6. Drug overdose fatality rate** in 2014 was: 13.2 (per 100,000); rate of fatalities attributed to opioids: 7.2 (per 100,000).

**Georgia** not expanded Medicaid eligibility.

**1. In 2013 ASAM reported** GA responses to a survey on Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on GA’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abused Data Set**&* ***State Health Facts*** showed: Georgia Medicaid covered treatment of SUDs for categorically and medically needy beneficiaries through fee for service reimbursement at almost 85% of the CMS approved rate.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**Understanding Medicaid-Georgia Medicaid Handbook: C**overed services listed include outpatient, inpatient and community support services as well as therapy/psychological counseling. The Georgia Department of Behavioral Health and Developmental Disabilities contracts with six regional providers to offer the following services: ambulatory substance abuse detoxification; residential substance abuse detoxification; crisis stabilization (medically monitored); residential services; opioid maintenance treatment; peer support services, and substance abuse intensive outpatient services.

**Prescription Drugs – PDL Formulary (updated 1/2017):** Buprenorphine-generic, Suboxone, and Vivitrol are all preferred medications (subject to pre-authorization; quantity limits may apply). Bunavial film, Zubsolv, and buprenorphine/naloxone sublingual tablets-generic are non-preferred medications with higher co-pays (subject to pre-authorization and quantity limits may apply). Naloxone injections & Narcan nasal spray are also preferred medications; nasal spray requires pre-authorization. Acamprosate and disulfiram (generic) are preferred medications (quantity limits may apply).

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.7 million, (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 9.8 billion. Medicaid spending on prescribed drugs: $369,096,102.

**6. Drug overdose fatality rate** in 2014 was: 11.9 (per 100,000); rate of fatalities attributed to opioids: 7.0 (per 100,000).

**Hawaii** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** according to the HI Medicaid website, coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage was limited for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from HI’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set**&* ***Kaiser State Health Facts*** showed: HI provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through a fee for service reimbursement or prospective payment system rate, with pre-approval required. As of 2014, a CMS approved 1115 waiver extended coverage to some previously uninsured groups through managed care delivery of services.

**4. Current Medicaid Covered Services - verified as of 3/2017:**

**Hawaii Department of Human Services website:** Medicaid plans list the following as covered services: substance abuse treatment programs; prescribed drugs including medication management and patient counseling, and methadone treatment services (includes provision of methadone or a suitable alternative).

**Prescription Drugs – PDL Formulary (updated 1/2017):** Preferred drugs that do not require pre-authorization are: disulfiram tablets (250 mg/ 500 mg); naltrexone HCL (50 mg) tablets; buprenorphine and buprenorphine/naloxone sublingual tablets (2-.05 mg/ 8-2 mg); Suboxone film (2-.05 mg/ 4-1 mg/ 8-2 mg/ 12-3 mg) and Narcan nasal spray. Acamprosate tablets (333 mg) require pre-authorization.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 345,000 (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 2 billion. Medicaid spending on prescribed drugs: $1,283, 880.

**6. Drug overdose fatality rate** in 2014 was: 10.9 (per 100,000); rate of fatalities attributed to opioids: 3.9 (per 100,000).

**Idaho** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** ID responses to a survey on Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone (limited)

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only methadone was excluded from ID’s Medicaid preferred drug list. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set* ***& Kaiser State Health Facts*** showed: Idaho covered SUD treatment for Medicaid beneficiaries through a fee for service reimbursement. Allowable service included psychosocial rehab-5 hours per week; individual sessions-12 per week, and group sessions-24 per week.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Idaho Department of Health and Welfare website:** lists substance abuse treatment as a service covered by Medicaid. The 2016 Benefits Guide for Idaho health plan lists behavioral health services delivered by network providers as a benefit covered by all plans. Outpatient behavioral health services covered by the Idaho Behavioral Health Plan program include: community-based treatment services to minimize symptoms of mental illness and substance use disorders such as assessment and planning; psychotherapy (individual, group, and family); pharmacologic management; community-based rehabilitation; substance use disorder treatment services; drug screening, and case management.

**Prescription Drugs – PDL Formulary (updated 1/2017):** Suboxone, Vivitrol and naltrexone (oral), plus naloxone vial & syringe and Narcan nasal spray are preferred medications. They all require pre-authorization. Total daily dose of buprenorphine cannot exceed 24 mg. Idaho Medicaid participants receiving Suboxone (buprenorphine/naloxone) or buprenorphine will be blocked by Idaho Medicaid for payment for any other opioids. Non-preferred medications are: Bunavial, Zubsolv and buccal buprenorphine. Idaho Medicaid does not list methadone as a preferred drug or a non-preferred drug, but it does have a process to request prior authorization for initial methadone and continuing methadone administration.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 298,000 (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 1.7 billion. Medicaid spending on prescribed drugs: $69,981, 599.

**6. Drug overdose fatality rate** in 2014 was: 13.7 (per 100,000); rate of fatalities attributed to opioids: 5.0 (per 100,000).

**Illinois** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** IL responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance with some SAPT Block grant funding
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from IL’s Medicaid preferred drug list. Other approved medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser:** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse, 2012 Data Set &* ***Kaiser State Health Facts*** showed**:** Illinois Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for services, cost based per diem, or certified cost reimbursement, with pre-approval required for residential-based services and active community treatments.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Illinois Division of Alcoholism and Substance Abuse website:** Several alcohol or other drug abuse treatment services are covered by the state's Medicaid program. Medicaid Managed Care Organizations (MCOs) are in place to assist qualified individuals and families with medical insurance coverage in Illinois and are responsible for assisting individuals in locating covered substance abuse services. **Illinois Department of Human Services Medicaid Manual:** Subacute medically necessary treatment services for alcoholism and other drug abuse provided in a setting besides an inpatient hospital are covered. Services must be a part of a treatment plan for the care of the client's drug or alcohol problem. Types of services covered are: outpatient treatment; intensive outpatient treatment; residential rehabilitation; subacute detoxification, and psychiatric diagnostic services. Inpatient hospitalization for detoxification is also covered.

**Prescription Drugs – PDL Formulary (updated 1/2017):** Buprenorphine (2 mg & 8 mg) sublingual tablets and buprenorphine/naloxone (2-0.5 mg, 2 mg & 8 mg) sublingual tablets require no pre-authorization as a generic, when prescribed for beneficiaries 16 or older. Suboxone film (2 mg-0.5 mg; 4 mg-1 mg; 8 mg-2 mg; 12 mg-3 mg) does not require pre-authorization for beneficiaries 16 or older. Vivitrol does not require pre-authorization for beneficiaries 12 or older. Disulfiram 250 & 500 mg tablets, Acamprosate 333 mg tablets, naltrexone 50 mg tablets, Narcan nasal spray, and naloxone vial & syringe are preferred medications with no pre-authorization required. Methadone 10 mg/ml solution and methadone 10 mg/ml oral concentrate require pre-authorization-alternatives are preferred.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 3.1 million (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 17 billion. Medicaid spending on prescribed drugs: $287,428,094.

**6. Drug overdose fatality rate** in 2014 was: 13.1 (per 100,000); rate of fatalities attributed to opioids: 9.4 (per 100,000).

**Indiana** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported in 2013** that IN responses to a survey on Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2.** **In 2014 SAMHSA’s review of Medicaid policies:** indicated methadone and extended release injectable naltrexone were excluded from IN’s Medicaid preferred drug list. Other approved medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed **:** Indiana Medicaid covered treatment for substance use disorders through fee for service reimbursement with pre-authorization required. Limitations varied by service. As of 2014, Indiana had a CMS approved 1115 waiver under which the State offered two distinct health plans: one for the Medicaid eligible population and one for uninsured individuals that did not qualify for Medicaid. Co-pays are required under both programs for beneficiaries age 18 and older.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Indiana Medicaid 2015 Opioid Addiction Presentation:** indicates Indiana Medicaid covers inpatient detoxification services (including opiate withdrawal) and outpatient substance abuse treatment. Prior authorization is not required for Vivitrol, but is required for Suboxone. Methadone maintenance therapy is not currently covered.

**Prescription Drugs – PDL Formulary (updated 8/2016):** Suboxone and buprenorphine sublingual tablets are limited to a maximum of 24 mg per day (pre-authorization required). Naloxone injections and Narcan nasal spray are preferred drugs that do not require pre-authorization. Non-preferred medications include: Bunavail; buprenorphine/naloxone sublingual tablets and Zubsolv (subject to pre-approval criteria and quantity limits may apply.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.5 million (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 9.3 billion. Medicaid spending on prescribed drugs: $195,856,064.

**6. Drug overdose fatality rate** in 2014 was: 18.7 (per 100,000); rate of fatalities attributed to opioids: 7.3 (per 100,000).

**Iowa** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** IA responses to a survey on Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only methadone was excluded from IA’s Medicaid preferred drug list. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Iowa Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for service reimbursement with a $2 co-pay per visit. Pre-authorization of the initial treatment plan was required and at least annually thereafter. Iowa has an approved Section 1115 waiver under which it operates the IowaCare program, which covers a limited benefit package and restricts beneficiaries to selected providers for services. They are also subject to copayments.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Iowa Medicaid website:** indicates inpatient/outpatient services are covered for beneficiaries with substance use disorders.

**Prescription Drugs – PDL Formulary (updated 1/2017):** Acamprosate and disulfiram are listed as preferred medications for treatment of alcohol use disorders. Naloxone injections, Narcan nasal spray and oral naltrexone are listed as preferred opioid antagonists. Vivitrol is listed as a non-preferred opioid antagonist requiring pre-authorization. Suboxone, methadone HCL concentrate, methadone HCL solution, Methadose concentrate 10 mg/ml and Methadose SF concentrate 10 mg/ml are listed as preferred long-acting narcotics.

**5. State Medicaid Expenditures**: 2015 Medicaid Utilization was 624,000 (children and adults = 17% of the state population). Total Medicaid spending for 2015 was 4.6 billion. Medicaid spending on prescribed drugs: $176,102,829.

**6. Drug overdose fatality rate** in 2014 was: 8.8 (per 100,000); rate of fatalities attributed to opioids: 5.3 (per 100,000).

**Kansas** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** the KS Medicaid website indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage was limited for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated methadone and extended release injectable naltrexone were excluded from KS’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Kansas Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for service reimbursement or capitated payment, with pre-authorization required for specified substance abuse services. A co-pay of $2 per visit is required from certain beneficiaries.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Kansas Department for Aging and Disability Services website:** Substance use treatment services offered include: assessment and referral; acute detoxification; case management; crisis intervention: inpatient and outpatient treatment; opioid maintenance outpatient treatment which includes methadone; peer mentoring; social detox; specialized women’s treatment programs, and therapeutic communities which specifically address criminal activity/behavior. The site also indicates services funded by the SAPT prioritize individuals with SUDs who are not covered by Medicaid, Medicare or private insurance.

**Prescription Drug Coverage – PDL Formulary (updated 1/2017):** No medications approved for treating substance use disorders are included on the Kansas Medical Assistance Program PDL. However, the site has request forms for prior authorization of certain medications including long-acting opioids. Pre-authorization forms for buprenorphine formulations are available under the clinical step therapy category (may require documentation that other ‘first line’ medications or treatments have been attempted).

**5. State Medicaid Expenditures**: 2015 Medicaid Utilization was 416,000 (children and adults = 13% of the state population). Total Medicaid spending for 2015 was 3 billion. Spending on prescribed drugs was not available.

**6. Drug overdose fatality rate** in 2014 was: 11.7 (per 100,000); rate of fatalities attributed to opioids: 6.0 (per 100,000).

**Kentucky** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** KY responses to a survey on Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only methadone was excluded from KY’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Kentucky Medicaid covered treatment of substance use disorders as a primary diagnosis on a limited basis, primarily for pregnant women, through prospective cost based per diem. As of 2014, KY offered three plans with various levels of coverage and cost sharing in addition to traditional Medicaid benefits. All plans are subject to copayments for certain services and have both a medical and a pharmacy out of pocket maximum of $225 per year. Copays are applicable to beneficiaries age 18 and older and do not apply to preventive services; beneficiaries eligible for both Medicare and Medicaid are also exempt from cost sharing.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**The Kentucky Department for Medicaid Services website:** listedsubstance use disorder treatment covered services including: screening, brief intervention, referral to treatment; assessment; targeted case management; alcohol and/or substance abuse services treatment plan development; intensive outpatient services; peer support; individual, group and family psychotherapy, and inpatient treatment. Medicaid does not cover the use of methadone in medication-assisted treatment for substance use disorders and does not currently enroll narcotic treatment programs (methadone clinics). Vivitrol and Suboxone are covered by Medicaid for the use of medication-assisted substance use treatment.

**Prescription Drug Coverage - PDL Formulary (updated as of 2/2017):** lists methadone HCL oral solution 10 mg/5ml, 5 mg/5ml; buprenorphine HCL sublingual tablets (2 mg, 8 mg) and Zubsolv are listed with prior authorization required. Naltrexone HCL oral tablet (50 mg) and Narcan 4 mg/0.1 ml nasal spray were recently added to injectable naloxone products listed.

**5. State Medicaid Expenditures**: 2015 Medicaid Utilization was 1.2 million (children and adults = 22% of the state population). Total Medicaid spending for 2015 was 9.5 billion. Spending on prescribed drugs: $38,784,886.

**6. Drug overdose fatality rate** in 2014 was: 24.7 (per 100,000); rate of fatalities attributed to opioids: 16.8 (per 100,000).

**Louisiana** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** LA Medicaid website indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicted only methadone was excluded from LA’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***State Health Facts*** showed: Louisiana Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through capitated services reimbursement, with pre-approval required.

**4. Current Medicaid Covered Services – verified as of 3/2017**

**Medicaid Services Chart, 2017 - Louisiana Department of Health:** adult beneficiaries are eligible to receive mental health rehabilitation services including addiction services (outpatient and residential) under the State Medicaid Plan if they meet one of the following criteria: have a mental health diagnosis, assessed by a licensed mental health professional, and receive LOCUS score of 2. Medicaid eligible youth can access covered addiction services (outpatient and residential) if a qualified practitioner determines medical necessity. They can also receive services through the State’s Coordinated System of Care Program, designed to provide services and supports to children and youth who have significant behavioral challenges or co-occurring disorders and are in or at imminent risk of out-of-home placement. Narcotics prescribed only for narcotic addiction are listed as an exception to covered pharmacy benefits. **Louisiana Office of Behavioral Health** lists methadone maintenance and other medications for opioid addiction as covered services.

**Prescription Drug Coverage - PDL Formulary, 2017** – Suboxone, naltrexone tablets, Narcan nasal spray and naloxone syringe & vial are preferred drugs for opioid dependency that do not require pre-authorization. Bunavail, Zubsolv, buprenorphine tablets, Vivitrol and Probuphine implants require pre-authorization. In April of 2016, Louisiana amended the formulary to include the following limits: a maximum of 24 mg of buprenorphine (or equivalent) is allowed for initial 90 period, and a maximum of 16 mg is allowed after that. Methadone HCL solutions and concentrate are listed under analgesics (long-acting) that require prior authorization.

**5. State Medicaid Expenditures**: 2015 Medicaid Utilization was 416,000 (children and adults = 13% of the state population). Total Medicaid spending for 2015 was 3 billion. Spending on prescribed drugs: $198,511,241.

**6. Drug overdose fatality rate** in 2014 was: 11.7 (per 100,000); rate of fatalities attributed to opioids: 6.0 (per 100,000).

**Maine** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** ME responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: all medications used to treat SUDs were on Maine’s Medicaid preferred drug list including medications used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Maine Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for service or negotiated rate reimbursement. Services were limited to 30 weeks per year with co-pays from $.50-$2.00 per day, up to $20 per month depending on payment. As of 2014, CMS approved a 1115 waiver which extends Medicaid eligibility to childless adults with income at or below 100% of the Federal Poverty Level.

**4. Current Medicaid Covered Services – verified as of 3/2017**

**MaineCare (Medicaid) Rules regarding Substance Abuse:** As of 2016, medication-assisted treatment with methadone is covered for beneficiaries, subject to limitations and the provision that tapering/withdrawal from medication is discussed with the patient during the first sixty (60) days of treatment and quarterly thereafter if not prompted earlier by client or other circumstances.

**Prescription Drug Coverage - PDL Formulary, 2017** – Antabuse, disulfiram tablets and naltrexone HCL tablets are preferred medications for alcohol use disorders; Acamprosate is non-preferred (treatment with preferred medication must be attempted). Suboxone film, Vivitrol, oral naltrexone, and Narcan nasal spray are preferred medications for opioid use disorders. Suboxone tablets, Bunavail, Zubslov and buprenorphine tablets (limited to use for pregnant women) are non-preferred medications. Effective 1/1/2013, MaineCare implemented a 24-month lifetime limit for Suboxone. Prior authorization is needed to restart treatment to assess risk of relapsing or evidence of relapse. Maximum dose is 32 mg for the first 60 days and 16 mg thereafter. Methadone and Methadose are listed as non-preferred medications. Established users must have a trial and failure of at least 2 preferred drugs for at least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred medication.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 296,000 (children and adults = 23% of the state population). Total Medicaid spending for 2015 was 2.6 billion. Spending on prescribed drugs was $95,884,099.

**6. Drug overdose fatality rate** in 2014 was: 16.8 (per 100,000); rate of fatalities attributed to opioids: 13.7 (per 100,000).

**Maryland** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MD responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated all medications used to treat SUDs on Medicaid preferred drug list including those approved to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***State Health Facts*** showed: Maryland Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for service reimbursement, with pre-authorization. As of 2014, CMS approved a 1115 managed care waiver under which the State extends Medicaid eligibility to a number of different populations not otherwise eligible for Medicaid in a program called HealthChoice. Services for HealthChoice members are provided primarily through managed care organizations.

**4. Current Medicaid Covered Services – verifies as of 3/2017:**

**Maryland Medicaid Summary of Mental Health and Substance Abuse Benefits:** Services paid for by the MCO (providers do not need to be in MCO network) include: physician management of buprenorphine/naloxone medications; comprehensive substance abuse assessment; individual, family, or group counseling; intensive outpatient treatment; methadone maintenance, and hospital and community-based detoxification. Buprenorphine and other medications are covered as allowed on MCO formularies. Some do not cover treatment services rendered in hospitals or HSCRC rate regulated hospital outpatient clinics. Medicare Part A and B, and Medicare general hospital services pay for a portion of substance abuse treatment services from a hospital clinic or outpatient department; methadone may be covered if provided to hospital inpatients, but not as an outpatient service.

**Prescription Drug Coverage - PDL Formulary, 2017:** Vivitrol injections every 28 days with diagnosis of opioid or alcohol use disorder; no opioid claim in the past 7 days; negative for opioids or documentation of successful naloxone challenge in the past 7 days; negative for alcohol in the past 7 days (for alcohol use disorder only) with patients enrolled in a comprehensive management program including psychosocial support. Buprenorphine/ Naloxone combination therapies covered include: Bunavail, Zubsolv and Suboxone- up to 2 film/tablets per day (exception: Suboxone 2 mg/0.5 mg tablet allows 6 tablets/daily). Subutex - no clinical criteria applied to first prescription, but refills require diagnosis of opioid use disorder, pregnant, breastfeeding or intolerance to naloxone. Naltrexone (oral) for diagnosis of opioid or alcohol use disorder is listed - with history of 90 days of therapy; pre-authorization may be required. Campral- up to 6 tablets per day with diagnosis of alcohol use disorder; negative test result for alcohol in the past 7 days; history of naltrexone or disulfiram therapy and patient enrolled in a comprehensive management program including psychosocial support.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.3 million (children and adults = 15% of the state population). Total Medicaid spending for 2015 was 9.6 billion. Spending on prescribed medications was $243,031,799.

**6. Drug overdose fatality rate** in 2014 was: 17.4 (per 100,000); rate of fatalities attributed to opioids: 15.0 (per 100,000).

**Massachusetts** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MA responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only Acamprosate was excluded from MA’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Massachusetts Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for service or negotiated rate reimbursement. Massachusetts operates many coverage types under an approved 1115 Waiver from CMS that includes expansion populations. MassHealth members including – Standard, CommonHealth, Family Assistance, Basic, Essential, Limited and others are limited to annual co-payment maximums of $250 for prescription drugs and $36 for non-pharmacy services per beneficiary.

**4. Current Medicaid Covered Services – verified as of 3/2017**

**MassHealth Substance Use Treatment Manual, 6/2016:** The following services provided by freestanding opioid treatment service centers are covered: the administration and dispensing of FDA-approved medications for opioid use disorders; individual, group, and family/couples counseling; services provided by acute inpatient treatment providers. Covered outpatient counseling services: individual, group, and family/couples counseling; case consultation; and acupuncture detoxification, which includes acupuncture treatments and motivational and supportive services; and the following special substance use disorder treatment services for pregnant members - intensive outpatient program services; day treatment; enhanced acute inpatient substance use disorder treatment services. The following coverage limitations apply: oral opioid agonist medication is limited to one dose per member per day with take homes limited to amounts and frequency set forth in by regulations. Opioid partial agonist medication is limited to one dose per member per day. Take-home supply is limited to 30 days. Administering opioid antagonist medication is limited to one dose per member per month. Counseling is limited to four sessions (individual, group, or family/couple) per member per week.

**Prescription Drug Coverage - PDL Formulary, 2017:** The following buprenorphine formulations are preferred medications, requiring pre-authorization: buprenorphine / naloxone film ≤ 16 mg/day; buprenorphine / naloxone film > 180 days (> 16 mg/day and ≤ 24 mg/day); buprenorphine / naloxone film > 32 mg/day; buprenorphine / naloxone film > 90 days (> 24 mg/day and ≤ 32 mg/day).  Non-preferred medications that also require pre-authorization: Zubsolv; buprenorphine buccal film; buprenorphine implant, and Bunavial. Preferred medications without pre-authorization required: Vivitrol, Acamprosate, disulfiram, Narcan nasal spray, naloxone vial & syringe and naltrexone tablets.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.7 million (children and adults = 23% of the state population). Total Medicaid spending for 2015 was 15.6 billion. Spending on prescribed medications was $ 343,720, 986.

**6. Drug overdose fatality rate** in 2014 was: 19.0 (per 100,000); rate of fatalities attributed to opioids: 17.0 (per 100,000).

**Michigan** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MI responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(requires documentation of counseling)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2.** **In 2014** **SAMHSA’s review of Medicaid policies**: all medications used to treat SUDs on Michigan’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Michigan Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through capitated payment reimbursement. As of 2014, CMS approved a 1115 waiver under which it extends Medicaid coverage for a limited package of benefits to non-pregnant childless adults between the ages of 19 and 64 called the Adult Benefits Waiver. Copayments for selected services are required and are higher than for the traditional Medicaid population.

**4. Verification Medicaid Covered Services as of 2017:**

**Michigan Department of Community Health: Medicaid Mental Health and Substance Abuse Services** – Covered services include: Access Assessment and Referral Services; Outpatient Treatment; Intensive Outpatient Treatment; Methadone as an adjunct to therapy; sub-Acute Detoxification; Residential Treatment.

**Prescription Drug Coverage - PDL Formulary, 2017:** The following are included on the PDL Bunavail film (2.1-0.3 mg; 4.2-0.7 mg; 6.3-1 mg); buprenorphine sublingual tablets (4 mg; 8 mg); buprenorphine-naloxone sublingual tablets (8-2 mg; 2-0.5 mg); Suboxone (2 mg-3 mg; 2 mg-0.5 mg; 4 mg-1 mg; 8 mg-2 mg) Zubsolv (1.4-0.36 mg; 5.7-1.4 mg; 8.6-2.1 mg).

Acamprosate 333 mg tablets; Vivitrol 380 mg injections; Antabuse 250 & 500 mg tablets; Disulfiram 250 & 500 mg tablets. Methadone 10 mg/5 ml solution and methadone 10 mg/ml oral concentrate are listed as subject to quantity limitations.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 2.3 million (children and adults = 19 % of the state population). Total Medicaid spending for 2015 was 15.9 billion. Spending on prescribed drugs was $387,016.416.

**6. Drug overdose fatality rate** in 2014 was: 18.0 (per 100,000); rate of fatalities attributed to opioids: 10.9 (per 100,000).

**Minnesota** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MN responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only Acamprosate was excluded from MN’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Minnesota Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for service or negotiated rates reimbursement. Minnesota’s traditional Medicaid population, disabled adults covered by the optional Medicaid buy-in, childless adults with income at or below 75 percent of the federal poverty level (FPL), and children and pregnant women are covered under the MinnesotaCare program. They all receive the same full Medicaid benefits through a CMS approved 1115 waiver. There is a cap on copays equal to 5% of family income for all individuals with income at or below 100 percent of the FPL. Caretakers and parents with incomes up to 215% of the FPL generally receive a lesser benefit package and may be subject to additional co-pays.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Minnesota Department of Health and Human Services website:** Alcohol and Drug Services (revised 9/2015) lists the following covered services: nonresidential treatment; residential treatment; hospital-based inpatient treatment; service coordination, and room and board (when treatment is currently authorized and used). Methadone and all medication-assisted therapies must be contracted for, authorized and billed using daily units. Recipients who get their MinnesotaCare services through an MCO must work with their MCO to obtain prior authorization for services.

**Prescription Drug Coverage - PDL Formulary, 2017:** Preferred medications listed are: Suboxone film and naloxone prefilled syringe with nasal atomizer. Non-preferred medications requiring pre-authorization are listed as: buprenorphine/naloxone sublingual tablets, buprenorphine (4 mg and 8 mg) sublingual tablets, and Zubsolv. No pre-authorization is required for Vivitrol, methadone HCL oral concentrate, naltrexone oral (50 mg) tablets, Acamprosate 333 mg tablets, Antabuse and disulfiram (250 mg and 500 mg) tablets.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1 million (children and adults = 14% of the state population). Total Medicaid spending for 2015 was 10.9 billion. Spending on prescribed drugs was $15,855,356.

**6. Drug overdose fatality rate** in 2014 was: 9.6 (per 100,000); rate of fatalities attributed to opioids: 6.0 (per 100,000).

**Mississippi** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MS responses to a survey on coverage of MAT for beneficiaries with substance use disorders were as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone

**2**. **In 2014** **SAMHSA’s review of Medicaid policies:** indicated Acamprosate, methadone and extended release injectable naltrexone were excluded from MS’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Mississippi Medicaid covered approved substance abuse drugs for a maximum of 24 months, subject to prescription drug co-pays and limits. Reimbursements for drugs are paid in accordance with prescription drug methodologies; therapies paid on a fee for service basis.

**4. Verification Medicaid Covered Services as of 2017:**

### **Mississippi Division of Medicaid website-**Covered mental health services listed: inpatient psychiatric care; outpatient hospital mental health services; psychiatric residential treatment facilities, and therapeutic and evaluative mental health services. The Special Mental Health Initiatives page lists inpatient detox for chemical dependency as one of its programs. MS Medicaid does not cover alcohol and drug treatment; however, with a primary mental health diagnosis rules for psychiatric care apply. On the Managed Care webpage - a 2015 comparison chart of benefits covered by each MCO indicates that the two CHIP managed care programs, Magnolia Care and United Health cover substance abuse services for beneficiaries under 21, with prior authorization.

**Prescription Drug Coverage - PDL Formulary, 2017:** Naltrexone tablets, Suboxone, Narcan nasal spray and naloxone vial & syringe are listed as preferred medications. Detailed rules apply to prescribing buprenorphine: Induction period (up to 60 days) maximum dose is 24 mg; for month 3 and beyond – maximum dose is 16 mg. Non-preferred medications listed which require pre-authorization include: buprenorphine tablets (only for pregnant women); buprenorphine/ naloxone tablets, Bunavail; Zubslov, and Probuphine implant. Such Medicaid claims are electronically reviewed for opiate use. In 2014, Vivitrol was included on some of the managed care plan PDLs, but does not currently appear on the 2017 universal PDL.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 677,000 (children and adults = 23 % of the state population). Total Medicaid spending for 2015 was 5.2 billion. Spending on prescribed drugs was $103,774, 346.

**6. Drug overdose fatality rate** in 2014 was: 11.6 (per 100,000); rate of fatalities attributed to opioids: 3.9 (per 100,000).

**Missouri** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Missouri responses to survey questions regarding Medicaid coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only Acamprosate was excluded from MO’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Missouri Medicaid covered treatment for beneficiaries with substance use disorders though fee for service reimbursement. Adult coverage for some program benefits is limited to pregnant women and those beneficiaries who are blind or are residing in an institutional setting such as a nursing facility. Copayment requirements are mostly applicable to beneficiaries age 19 and older. Dual eligible beneficiaries are exempt from cost sharing if program payment is limited to coinsurance or deductible amounts. The copayment requirement for physician and related services is applicable to and in addition to any amount payable to hospitals or laboratories for services.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Missouri Division of Behavioral Health website**: The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs are funded by Missouri’s Medicaid program through a purchase-of-service system. Primary Recovery Plus offers a full continuum of services within multiple levels of care for the general population. CSTAR Women and Children Priority serves women who are pregnant, postpartum, or have children in their care and custody. CSTAR Adolescent is early intervention, comprehensive treatment, academic education, and multiple levels of care designed for children 12 to 17 years in age. CSTAR Opioid are medication-assisted treatment programs designed for medically supervised withdrawal from heroin and other opiate drugs, followed by ongoing treatment.

**Prescription Drug Coverage - PDL Formulary, 2017:** As of 6/2015, Suboxone film and naltrexone are listed as preferred medications. Non-preferred medications are available with pre-authorization based on specific criteria: Bunavail; buprenorphine sublingual tablets and Subutex (for pregnant women); buprenorphine/naloxone tablets; Suboxone sublingual tablets; Zubsolv; Revia (oral naltrexone); Vivitrol; naloxone syringe & vial. Methadone oral solution 5mg/5ml and methadone orals solution 10mg/5ml are also listed as medications that can be used to treat opioid addiction. Dosing maximums for buprenorphine products are outlined for the first 180 days of treatment and thereafter.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 977, 000 (children and adults = 28 % of the state population). Total Medicaid spending for 2015 was 9.6 billion. Spending on prescribed drugs was $704,718,571.

**6. Drug overdose fatality rate** in 2014 was: 18.2 (per 100,000); rate of fatalities attributed to opioids: 12.0 (per 100,000).

**Montana** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** MT Medicaid responses to a survey on coverage of MAT for beneficiaries with substance use disorders as follows:

* No public funded coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated Acamprosate, methadone and extended release injectable naltrexone were excluded from MT’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Montana Medicaid covers substance abuse services in state approved facilities, with prior authorization required for specific services, through fee for services reimbursement. Traditional Medicaid population and an optional buy-in program for disabled adults have a full benefits package. The State extends Medicaid benefits as well as a limited package of optional services to adults between the ages of 21 and 64 who are parents and caretaker relatives of dependent children.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Montana Medicaid Member Guide:** Effective 2016, pre-authorization is no longer required for inpatient and outpatient day treatment services. Treatment must be medically necessary. Covered services include: hospital Inpatient; day treatment; non-hospital inpatient treatment; and non-hospital outpatient treatment. The following outpatient services are covered: screening and assessment; individual, group or family counseling; and targeted case management for youth. Services are subject to coverage limits. Methadone maintenance is not covered.

**Prescription Drug Coverage - PDL Formulary, 2017:** Preferred medications for treatment of opioid use disorders are listed as: oral naltrexone and Suboxone. Clinical criteria apply. Narcan nasal spray and naloxone vial and syringe are also preferred.  Non-preferred medications are listed as: Bunavail; buprenorphine/naloxone sublingual tablets; buprenorphine sublingual tablets; Vivitrol and Zubsolv, all require additional pre-authorization criteria.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 241,000 (children and adults = 16 % of the state population). Total Medicaid spending for 2015 was 1.1 billion. Spending on prescribed drugs was $1, 033,111.

**6. Drug overdose fatality rate** in 2014 was: 12.4 (per 100,000); rate of fatalities attributed to opioids: 5.4 (per 100,000).

**Nebraska** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Nebraska Medicaid website indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance with some SAPT Block grant funding
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated methadone and extended release injectable naltrexone were excluded from NE’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Nebraska Medicaid provided coverage for substance use disorder treatment for categorically and medically needy beneficiaries through fee for service reimbursement with required $2 co-pay per visit for specified services. Any identified copayment requirements are applicable to beneficiaries age 19 and older.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Nebraska Medicaid Mental Health and Substance Abuse Provider Handbook:** Covered services include:medically necessary psychotherapy and substance abuse counseling: individual psychotherapy or substance abuse counseling; group psychotherapy or substance abuse counseling, and family psychotherapy or substance abuse counseling. Medically Necessary Pharmaceutical Services: if medications are dispensed by the program, pharmacy services must be provided under the supervision of a registered pharmacy consultant or the program may contract for these services through an outside facility or provider.

**Prescription Drug Coverage - PDL Formulary, 2017:** Naltrexone 50 mg tablets,Antabuse 250 mg & 500 mg tablets, disulfiram 250 mg tablets, and Acamprosate 333 mg tablets are covered and do not require pre-authorization.Suboxone (12 mg/3 mg; 8 mg/3 mg; 4 mg/1.mg; 2 mg/.5 mg) is listed as a preferred drug that requires pre-authorization and is subject to some limitations. Buprenorphine 2 mg/ 8 mg sublingual tablets, Methadose 10 mg/ml oral concentrate are non-preferred drugs that require pre-authorization and are subject to limitations. Vivitrol is not as covered.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 237,000 (children and adults = 13% of the state population). Total Medicaid spending for 2015 was 1.9 billion. Spending on prescribed medications was $87,754,501.

**6. Drug overdose fatality rate** in 2014 was: 7.2 (per 100,000); rate of fatalities attributed to opioids: 3.2 (per 100,000).

**Nevada** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Nevada Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from NV’s Medicaid preferred drug list. Other approved medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Nevada Medicaid covered treatment for beneficiaries with substance use disorders through fee for services reimbursement.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Nevada Medicaid Informational Bulletin on Medications and Services for Substance Use Disorder,** 9/2016:Medicaid and all managed care plans cover the following services with clinical pre-authorization within allowable quantity limits: individual therapy; family therapy; group therapy; therapy in home or community setting; skills training & development; psychosocial rehabilitation, and self-help/peer support. Screening, brief intervention and referral to treatment is covered without pre-approval. Inpatient and outpatient detoxification is covered within quantity limits with clinical pre-authorization. Medication-assisted treatment including direct observation of oral medications to treat opioid dependence/withdrawal given at methadone clinics requires pre-authorization and is covered within quantity limits.

**Prescription Drug Coverage - PDL Formulary, 2017:** Dolophine is a preferred drug for methadone maintenance. Suboxone, Revia (oral naltrexone), Vivitrol, disulfiram and Subutex are preferred drugs. Acamprosate, Bunavail and Zubsolv are non-preferred, but are covered by all plans with pre-authorization criteria. Narcan nasal spray and naloxone vial and syringe are also preferred drugs.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 620,000 (children and adults = 17% of the state population). Total Medicaid spending for 2015 was 3.1 billion. Spending on prescribed medications was $124,424,038.

**6. Drug overdose fatality rate** in 2014 was: 18.4 (per 100,000); rate of fatalities attributed to opioids: 12.7 (per 100,000).

**New Hampshire** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** New Hampshire Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated all medications used to treat SUDs were on the NH Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: NH Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. Ambulatory detox services were not covered. The prescription copayment requirement applies to beneficiaries age 18 and older.

**4. Current Medicaid Covered Services – verified as of 2017:**

**NH Department of Health and Human Services Issue Brief:** NH Substance Use Disorder Treatment System - Services may be covered through the New Hampshire Health Protection Program, NH’s alternative managed care plan that covers the expansion population, or traditional Medicaid. Plans cover a continuum of care that includes: screening; evaluation (assessment); withdrawal management (detoxification) within acute care settings; treatment with methadone in Opioid Treatment Programs; individual, group and family counseling; crisis intervention; screening, brief intervention and referral to treatment (SBIRT); treatment with buprenorphine in Opioid Treatment Programs and office-based, medication-assisted treatment with a primary care provider; intensive outpatient; partial hospitalization; residential rehabilitation; medically-monitored withdrawal management (residential and ambulatory); individual and group peer and non-peer recovery supports, and continuous recovery monitoring.

**Prescription Drug Coverage - PDL Formulary, 2017:** Suboxone is listed as preferred. Non- preferred medications listed are: Bunavail, buprenorphine (generic tablets); buprenorphine/naloxone (generic tablets) and Zubsolv. Both preferred and non-preferred require pre-authorization. Vivitrol, Acamprosate tablets, Antabuse and oral naltrexone tablets are covered with co-pays. Methadose 10 mg/ml oral concentrate is covered with pre-authorization and co-pays apply.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 186,000 (children and adults = 13% of the state population). Total Medicaid spending for 2015 was 1.7 billion. Spending on prescribed drugs is not available for 2015.

**6. Drug overdose fatality rate** in 2014 was: 26.2 (per 100,000); rate of fatalities attributed to opioids: 23.4 (per 100,000).

**New Jersey** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** New Jersey Medicaid website indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone was limited

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from NJ’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: New Jersey Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. Under a CMS approved 1115 waiver the state offers NJ FamilyCare, which covers parents and caretaker relatives of Medicaid and CHIP-eligible children with income at or below 200% of the federal poverty level (FPL) and also extends coverage to pregnant women with income between 185% and 200% of the FPL. Under the waiver, pregnant women receive full Medicaid benefits. Children in families with income between 200% and 350% of the FPL as well as parents and caretakers with income above 150 % of the FPL can buy in to the program.

**4. Current Medicaid Covered Services – verified as of 2017:**

**NJ Department of Human Service website:** New Jersey's substance abuse treatment services and continuum of care network is structured around four major phases of treatment: Inpatient Treatment, Outpatient Treatment, Pre-Treatment Recovery Support, and Post-Treatment Recovery Support. The State also has a Medication Assisted Treatment Initiative (MATI). In 2016 the State began to transition from fee for service to weekly bundled rates, specific to methadone and buprenorphine delivered in an OTP which cover the medication and the following services: case management, medication dispensing, counseling, and medication monitoring. Naltrexone, Revia and Vivitrol continues to be reimbursed by Medicaid and through the state fee for services initiatives. The new alternative benefit plan includes: intensive outpatient, outpatient, partial care, short term residential, detox, and opioid treatment.

**Prescription Drug Coverage - PDL Formulary, 2017:**  Preferred medications include: methadone HCL oral solution (10 mg/5ml, 5 mg/5ml); Acamprosate 333 mg tablets; disulfiram oral tablets (250 mg & 500 mg), and naltrexone oral 50 mg tablets. Buprenorphine HCL sublingual tablets (2 mg, 8 mg) and Zubslov are also preferred but require pre-authorization.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.8 million (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 14.2 billion. Spending on prescribed drugs was $28,840,824.

**6. Drug overdose fatality rate** in 2014 was: 14.0 (per 100,000); rate of fatalities attributed to opioids: 8.2 (per 100,000).

**New Mexico** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** New Mexico Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated both methadone and extended release injectable naltrexone were excluded from NM’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were included.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: New Mexico Medicaid covered treatment for beneficiaries with substance use disorders through fee for services reimbursement with pre-authorization required after seven visits and co-pays ranging from $ 0-7.00 per visit. The State’s 1115 waiver program covers parents of Medicaid and CHIP eligible children as well as childless adults between the ages of 19 and 64. These adults receive a benefit package similar to basic commercial coverage, which is more limited than the traditional Medicaid package, with copayments for some services.There is an optional Medicaid buy-in group for disabled adults.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**NM Department of Human Services website:** As of 2014, Medicaid covered medication-assisted treatment for opioid addiction at certified OTP and the initial medical examination for beneficiaries meeting the DSM criteria. If the recipient is requesting maintenance treatment, he or she must have been addicted for at least 12 months prior to starting MAT, unless pregnant, released from a penal institution within the last six months, was treated for opioid dependence within the last 24 months, or meets other specified criteria. Recipients with two or more unsuccessful opioid withdrawal treatment episodes within a 12-month period requesting long-term or short-term opioid withdrawal treatment must be assessed by the agency’s medical director or physician to determine if other forms of treatment may be more appropriate. Reimbursement includes the cost of methadone, administering and dispensing methadone or other narcotic replacement or agonist drug items, and substance abuse and HIV counseling and other services performed by the agency, unless otherwise described as separate.

**Prescription Drug Coverage - PDL Formulary, 2017:**  Preferred drugs (coverage subject to quantity limits) include: disulfiram and Antabuse; naloxone injections and Narcan nasal spray (maximum of 2 administrations per year); naltrexone tablets; buprenorphine and buprenorphine/ naloxone sublingual tablets, buprenorphine/naloxone buccal film. Bunavail, Suboxone, and Zubsolv are also included on preferred lists for NM managed care contractors. Dolophine and methadone generics, Acamprosate, and Vivitrol are covered with pre-authorization, subject to quantity limits.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 772,000 (children and adults = 27% of the state population). Total Medicaid spending for 2015 was 4.9 billion. Spending on prescribed drugs was $8,839,998.

**6. Drug overdose fatality rate** in 2014 was: 27.3 (per 100,000); rate of fatalities attributed to opioids: 20.2 (per 100,000).

**New York** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** New York Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated methadone and extended release injectable naltrexone were excluded from NY’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: New York Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. In 2014, CMS approved a 1115 waiver which extends health care coverage to low-income adults covered under the former state-funded cash assistance safety net program and moved most Medicaid beneficiaries from a primarily fee for service delivery system to a mandatory managed care environment.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**NY Office of Alcohol and Substance Abuse Services website:** As of 2016, new fee for service and managed care plans cover: withdrawal and stabilization services; inpatient rehabilitation; outpatient clinic/rehab and OTPs; residential rehabilitation for youth, and medication-assisted treatment (specifically with methadone, buprenorphine, and Vivitrol).

**Prescription Drug Coverage - PDL Formulary, 2017:**  Includes: Vivitrol; Zubsolv; methadone HCL oral concentrate; disulfiram, Acamprosate, and naltrexone HCL oral (with pre-authorization). Narcan nasal spray and naloxone injections are also listed as preferred.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 64 million (children and adults = 24% of the state population). Total Medicaid spending for 2015 was 59.8 billion. Spending on prescribed drugs was $1,059,011,459.

**6. Drug overdose fatality rate** in 2014 was: 11.3 (per 100,000); rate of fatalities attributed to opioids: 8.6 (per 100,000).

**North Carolina** has not expanded Medicaid eligibility.

**1. In ASAM reported in 2013:** North Carolina Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone was limited

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated **o**nly extended release injectable naltrexone was excluded from NC’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. In 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: North Carolina Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services and capitated rate reimbursement, with a limit of eight ambulatory visits.

**4. Current Medicaid Covered Services – verified as of 2017:**

**NC Division of Medical Assistance:** Medicaid and Health Choice Enhanced Mental Health

Clinical Coverage and Substance Abuse Services,October, 2016: covered services were expanded to include: substance abuse comprehensive outpatient and intensive outpatient services; medically monitored community residential treatment, and non-medical community residential treatment. Also covered are: ambulatory detoxification; non-hospital medical detoxification; medically supervised detoxification/crisis stabilization, and outpatient opioid treatment (includes methadone or buprenorphine administration for treatment or maintenance).

**Prescription Drug Coverage - PDL Formulary, 2017:**  The 11/2016 preferred list includes: Vivitrol, naltrexone (oral), Suboxone, and naloxone syringe & vial and Narcan nasal spray. Non-preferred medications that require pre-approval (criteria may require failure of two preferred agents) are: Bunavail; buprenorphine sublingual tablets; buprenorphine-naloxone sublingual tablets, and Zubsolv. Formulary indicates that not all covered drugs are listed.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 2 million (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 13.5 billion. Spending on prescribed drugs was $ 737,864,919.

**6. Drug overdose fatality rate** in 2014 was: 13.8 (per 100,000); rate of fatalities attributed to opioids: 10.6 (per 100,000).

**North Dakota** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** North Dakota Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No public funding or Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2**. **In 2014** **SAMHSA’s review of Medicaid policies**: indicated both methadone and extended release injectable naltrexone were excluded from ND’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: North Dakota Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services. In 2014, the State began to offer managed care program coverage with full benefits to the ‘expansion’ population in addition to tradition Medicaid.

**4. Current Medicaid Covered Services – verified as of 3/ 2017:**

**North Dakota Department of Human Services website**: In 2014, ND updated its standards for OTP’s to ensure appropriate access to all FDA approved mediations for an indeterminate length of time, as long as the physician deems it clinically appropriate and patient is compliant. **Medicaid Member Handbook:** Mental Health and Substance Use Disorder Services covered by Medicaid managed care include: office visits to physicians, nurse practitioners, physician assistants, clinical psychologists, licensed clinical social workers, licensed chemical dependency counselors and intensive outpatient/partial hospitalization programs (day treatment). A $2 co-pay per office visit and $2 per course of treatment applied to all other services including partial hospitalization/intensive outpatient programs (co-pays applicable to beneficiaries 21 and over). Inpatient services require pre-authorization and a co-pay of $75 per stay. Benefit limited only to certain facilities.

**Prescription Drug Coverage - PDL Formulary, 2017:** For all managed care plans covering the expansion population, the formulary lists: Acamprosate, disulfiram, naltrexone, methadone, and buprenorphine & buprenorphine/naloxone sublingual tablets – all as first tier generic medications with minimal co-pays. Suboxone is listed as a brand name medication with higher co-pays. Vivitrol is not listed, specifically, only naltrexone without forms delineated and no mention of the injectable form. Although methadone products are not specifically listed for opioid treatment, the drug appears on the formulary; it is not clear whether coverage only applies to its use as an analgesic.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 83,000 (children and adults = 10% of the state population). Total Medicaid spending for 2015 was 1.1 billion. Spending on prescribed drugs was $ 23,719,713.

**6. Drug overdose fatality rate** in 2014 was:6.3 (per 100,000); rate of fatalities attributed to opioids: 4.5 (per 100,000).

**Ohio** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Ohio Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on Ohio’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Ohio Medicaid covered treatment for beneficiaries with substance use disorders through cost-based payment reimbursement.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Ohio Department of Medicaid website**: Effective 2012, the Ohio Department of Alcohol and Drug Addiction Services revised its administrative rules governing Medicaid reimbursement for substance use disorder treatment to include the following services: ambulatory detoxification, assessment, case management; laboratory testing, medical services, rehabilitative services such as individual, group and family counseling, and opioid agonist administration (services limited to 30 hours a week to include case management, counseling and medical/somatic services). On the Alcohol and Drug Service webpage, Medicaid coverage for methadone administration, buprenorphine induction, and injections of naltrexone are all explicitly listed.

**Prescription Drug Coverage - PDL Formulary, 2017**: Suboxone, Vivitrol, Zubsolv, methadone HCL oral concentrate (10mg/ml; 5mg/5ml) and methadone Intensol (10mg/ml; 10mg/5ml) are listed as preferred drugs that require pre-authorization. Buprenorphine HCL sublingual tablets; Bunavail, and buprenorphine/naloxone HCL sublingual tablets are non-preferred medications, also requiring pre-authorization.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 3 million (children and adults = 21% of the state population). Total Medicaid spending for 2015 was 21.6 billion. Spending on prescribed drugs was $ 108,617,284.

**6. Drug overdose fatality rate** in 2014 was:24.6 (per 100,000); rate of fatalities attributed to opioids: 19.1 (per 100,000).

**Oklahoma** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Oklahoma Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only methadone was excluded from OK’s Medicaid preferred drug list. Medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Oklahoma Medicaid covered treatment for beneficiaries with substance use disorders through a fee for services or all-inclusive daily rate. Service limitations vary by type of treatment. As of 2014, a CMS approved 1115 waiver authorized the State’s SoonerCare program, which currently delivers enhanced primary care case management through a Patient-Centered Medical Home model. Members receive full benefits with cost sharing required, except from pregnant beneficiaries. It also authorizes the Insure Oklahoma program which expanded coverage by providing premium assistance to uninsured adults and college students and direct coverage to select uninsured adults. Medical benefits under the Insure Oklahoma program are more limited with higher co-pays.

**4. Current Medicaid Covered Services – verified as of 2017:**

**OK Health Care Authority website:** Contracted substance abuse **s**ervices are provided by the Department of Mental Health Substance Abuse Services (ODMHSAS). Their webpage on substance abuse services has very little information about treatment. It specifies the following services are available: peer support services (for MH & SUDs), drug courts, and DUI classes. However, the site has a list of contracted MH and SUD services providers including some that deliver: outpatient services; residential treatment; halfway treatment programs; outpatient and medically managed detoxification services; and residential treatment for women, pregnant women, and adolescents. There is no mention of opioid treatment programs.

**Prescription Drug Coverage - PDL Formulary, 2017**: Suboxone is listed as a preferred medication available without pre-approval within quantity limits and a maximum dose of 24 mg. (requests for higher doses approved on a case by case basis for 30 days with taper schedule documentation). Subutex is a non-preferred drug requiring pre-approval – for use with pregnant women or patients with a documented naloxone allergy. Zubsolv and Bunavail are non-preferred medications – approval may be requested for up to 90 days. Probuphine implants are listed as non-preferred with the following approval criteria: stable on buprenorphine dose 8 mg per day or less for three months or longer without supplemental or adjustments; **AND** no positive urine toxicology results or paid claims for opioids for the last three months. Prescribers must enroll in Probuphine Risk Evaluation and Mitigation Strategy (REMS) to receive approval for one kit.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 803,000 (children and adults = 17% of the state population). Total Medicaid spending for 2015 was 5 billion. Spending on prescribed drugs was $ 366,694,843.

**6. Drug overdose fatality rate** in 2014 was: 20.3 (per 100,000); rate of fatalities attributed to opioids: 13.0 (per 100,000).

**Oregon** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Oregon Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated extended release injectable naltrexone was excluded from OR’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Oregon Medicaid covered treatment for beneficiaries with substance use disorders through fee for service or negotiated rate reimbursement. Specific procedures may require pre-approval and co-pay of $3 per visit. The State offers expanded coverage at a variety of levels through the Oregon Health Plan under a CMS approved 1115 waiver.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Medication-Assisted Treatment and Recovery (U MATR) webpage:** Opioid Treatment Program services are covered with pre-authorized after review of documentation. Criteria may include: one year history continuous physical dependence on narcotics or opiates and documentation that medically supervised withdrawal has proven ineffective (except for people released from custody in the last 6 months, those with a documented history of narcotic addiction in danger of relapse, and pregnant women). Required services include counseling, medical care, and transitional care for patients tapering off opioid agonist medications. Transitional treatment should help prepare the patient to begin a reduction in opioid agonist medication dosage and shall be continued while the patient undergoes reduction in doses. The treatment shall continue following the final dose of opioid agonist medication, consistent with clinical needs.

**Prescription Drug Coverage - PDL Formulary, 2017**: Preferred medications include: Acamprosate, buprenorphine and buprenorphine/naloxone HCL tablets, Suboxone; naltrexone (oral), and naloxone vial & syringes. Probuphine implants may be covered by the Oregon Health Plan, but not by all managed care plans offer it. Vivitrol is covered by all plans.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 981,000 (children and adults = 24% of the state population). Total Medicaid spending for 2015 was 8.1 billion. Spending on prescribed drugs was $ 85,383,325.

**6. Drug overdose fatality rate** in 2014 was: 12.8 (per 100,000); rate of fatalities attributed to opioids: 8.3 (per 100,000).

**Pennsylvania** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Pennsylvania Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on PA’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: PA Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. Most SUD treatment services are provided by Medicaid Managed Care contracted organizations. Some limitations apply for certain services and may require co-pays ranging from $.50-$3.80. An optional Medicaid buy-in group of disabled/formerly disabled adults is covered, but benefit plans may differ. Copays apply to beneficiaries age 18 and older.

**4. Current Medicaid Covered Services – verifies as of 3/2017:**

**PA Behavioral Health Services Contract Standards and Requirements for Medicaid MCOs:** Required services include: diagnostic, assessment, referral, and treatment (patient placement according ASAM criteria). Medicaid benefits for non-hospital detox and a full continuum of treatment are mandated by law in PA. **Prior Authorization of Opiate Dependence Treatments, Oral Buprenorphine Agents-**2015 Memo: Oral buprenorphine can be dispensed without prior authorization for 5-days (once during a six month period). Documentation for approval of ongoing treatment includes: history of opioid dependence and active withdrawal as documented by a Clinical Opiate Withdrawal Scale (COWS) score greater than or equal to 9. For a non-preferred opiate dependence treatment, a documented history of therapeutic failure, contraindication, or intolerance of preferred opiate dependence is required. Vivitrol approval requires referral to a substance abuse treatment program, or counseling at appropriate levels for alcohol or opioid dependency, plus a negative test for recent opioid use.

**Prescription Drug Coverage - PDL Formulary, 2017**: Preferred medications include: Suboxone; buprenorphine HCL tablets, naltrexone tablets, methadone oral solutions/concentrates and Vivitrol. Prior authorization is required for ongoing treatment with most medications, but not for naloxone syringe &vials or Narcan nasal spray. The following are listed as non-preferred drugs with additional pre-approval criteria: Acamprosate, disulfiram, buprenorphine/naloxone HCL tablets, Bunavail, Zubsolv and Probuphine implant.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 2.9 million (children and adults = 18% of the state population). Total Medicaid spending for 2015 was 23.4 billion. Spending on prescribed drugs was $ 23,593,005.

**6. Drug overdose fatality rate** in 2014 was: 21.9 (per 100,000); rate of fatalities attributed to opioids: 9.0 (per 100,000).

**Rhode Island** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported: a**ccording to Rhode Island’sMedicaid website coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only extended release injectable naltrexone was excluded from RI’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: RI Medicaid covered substance use disorder treatment services through a negotiated rate reimbursement. Rhode Island has a CMS approved 1115 waiver under which the State extended Medicaid eligibility to a number of previously uninsured individuals in its Rhode Island RIte Care and RIte Share programs, each with several benefit components for different groups at different income levels.

**4. Current Medicaid Covered Services – verified as of 2017:**

**According to the RI Medicaid website: C**overed alcohol and/or drug services include: methadone administration and/or service (1 unit per week) with no co-pays required for services. Managed care plans list the following covered services: substance abuse outpatient; substance abuse inpatient, and community-based narcotic treatment; community-based detoxification, and residential substance abuse treatment.

**Prescription Drug Coverage - PDL Formulary, 2017**: No pre-authorization is required for up to 1 year of treatment for opioid dependence with preferred medications including: Suboxone film, naltrexone (oral), or buprenorphine HCL tablets. Naloxone syringe & vial and Narcan nasal spray are also preferred. Pre-authorization is required for Vivitrol, Zubsolv, buprenorphine/ naloxone HCL tablets, and Probuphine implant.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 290,000 (children and adults = 17% of the state population). Total Medicaid spending for 2015 was 2.6 billion. Spending on prescribed drugs was $1,693,248.

**6. Drug overdose fatality rate** in 2014 was: 23.4 (per 100,000); rate of fatalities attributed to opioids: 19.8 (per 100,000).

**South Carolina** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** South CarolinaMedicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated both methadone and extended release injectable naltrexone were excluded from SC’s Medicaid preferred drug list.

**3. For 2012 Kaiser** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: SC Medicaid covered treatment for beneficiaries with substance use disorders at approved centers through fee for services reimbursement. Qualifying beneficiaries receive services through contracted managed care organizations, most of which offer additional services and do not charge copayments.

**4. Current Medicaid Covered Services –verified as of 2017:**

**SC Department of Alcohol and other Drug Abuse Services website**: “The primary source of funding for prevention and treatment programs managed by the department is the Substance Abuse Prevention and Treatment Block Grant.” Listed services are: outpatient and intensive outpatient treatment services, halfway houses, social detoxification, freestanding medical detoxification, residential treatment, inpatient treatment, and day treatment. Prior authorization for all alcohol and other drug abuse rehabilitative services for the state's Medicaid-eligible population is provided by the department. SC also has county-level alcohol and drug abuse authorities. Methadone treatment does not appear to be covered.

**Prescription Drug Coverage - PDL Formulary, 2017**: Narcan nasal spray and naloxone vial & syringe are the only relevant medications listed on the PDL; however, a search of the SC Medicaid online prescription drug look up (indicates inclusion of a medication is not a reflection of coverage) listed Vivitrol injections; Suboxone; buprenorphine sublingual tablets (2 mg & 8 mg); methadone oral concentrate (10 mg/10 ml); Acamprosate 333 mg tablets; and disulfiram (500 & 250 mg) tablets all as covered without pre-approval required.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 998,000 (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 6 billion. Spending on prescribed drugs was $ 49,347,911.

**6. Drug overdose fatality rate** in 2014 was: 14.4 (per 100,000); rate of fatalities attributed to opioids: 10.7 (per 100,000).

**South Dakota** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** South DakotaMedicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only methadone was excluded from SD’s Medicaid preferred drug list. Medicaid covered drugs used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: SD Medicaid covered treatment for beneficiaries with substance use disorders through a prospective cost-based rate, with substance abuse services reimbursement for pregnant women only.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**South Dakota Medicaid Professional Services Billing Manual,** January 2017: Covered telemedicine services listed are: alcohol/substance abuse structured assessment and brief intervention - 15 to 30 minutes; alcohol/substance abuse structured assessment and intervention - greater than 30 minutes; annual alcohol misuse screening -15 minutes, and brief alcohol misuse counseling -15 minutes. The Managed Care Medicaid program lists the following chemical dependency treatment services as covered with pre-authorization within coverage limits: clinically managed low intensity residential treatment for pregnant adolescents or adolescents with dependent children (9 months during a 12 month period); short term relapse program for

adolescents (18 Days); substance use disorder psychiatric residential treatment for adolescents (45 Days); day treatment for adolescents (30 Days); intensive inpatient treatment for pregnant women (45 Days), and day treatment for pregnant women (30 Days).

**Prescription Drug Coverage - PDL Formulary, 2017**: The South Dakota Medicaid Pharmacy Billing Manual, 2015 is available online, but it does not contain a listing of medications. On a phone call placed to the South Dakota Medicaid Office on 2/15/2017 staff indicated an actual listing of preferred drugs could be found on the “Medicare Crosswalk” publication. This publication was not on the list of South Dakota’s Department of Social Services publications and it could not be located by an internet search.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 119,000 (children and adults = 14% of the state population). Total Medicaid spending for 2015 was 813.1 million. Spending on prescribed drugs was $ 31,545,451.

**6. Drug overdose fatality rate** in 2014 was: 7.8 (per 100,000); rate of fatalities attributed to opioids: 4.1 (per 100,000).

**Tennessee** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Oklahoma Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only methadone was excluded from TN’s Medicaid preferred drug list. Medicaid covered drugs used to treat alcohol use disorders.

**3. For 2012 Kaiser** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: As of 2014, a CMS approved 1115 waiver under which the State operates the TennCare program offered plans with different reimbursement methodologies and co-pay requirements. The traditional Medicaid-eligible population has a comprehensive package of covered services with some limitations for adults (nominal copayment requirements and exemptions prescription drugs). TennCare Standard provides a similar package for certain adults and children who do not meet eligibility criteria for Medicaid but who meet eligibility criteria established by the State. TennCare CHOICES provides both nursing facility and home and community-based services to eligible persons.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**TN Division of Health Care Finance & Administration - TennCare webpage:** All TennCare plans cover medically necessary inpatient and outpatient substance abuse services (for some groups it only covers services not covered by Medicare). Medically necessary methadone clinic services are covered only for beneficiaries under 21. **The Tennessee Department of Mental Health and Substance website:** OTPs: “There are currently twelve licensed clinics in Tennessee where individuals can receive treatment to reduce cravings and lessen withdrawal symptoms caused by quitting the abused drug. The two most common medicines used in Tennessee opioid treatment programs are Methadone and Buprenorphine.” There is also information on oral and injectable naltrexone. Most services are funded by the SAPT block grant for persons with no medical coverage or for Medicaid recipients who have exhausted coverage or are not covered for a specific service.

**Prescription Drug Coverage - PDL Formulary, 2017**: Narcan nasal spray, Bunavail and naltrexone (oral) are listed as preferred drugs, requiring pre-authorization, with Bunavail subject to quantity limits. Methadone, Methadose, buprenorphine, Suboxone film, buprenorphine/ naloxone tablets, and Zubsolv are non-preferred drugs requiring pre-authorization and subject to quantity limits. Notes indicate drugs not listed can be assumed not to be covered.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.9 million (children and adults = 19% of the state population). Total Medicaid spending for 2015 was 9.1 billion. Spending on prescribed drugs was $ 423,593,486.

**6. Drug overdose fatality rate** in 2014 was: 19.5 (per 100,000); rate of fatalities attributed to opioids: 13.4 per 100,000.

**Texas** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Texas Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated only extended release injectable naltrexone was excluded from TX’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: TX Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through cost-based payment reimbursement, with pre-approval required for residential detox and treatment and for ambulatory detox. Coverage limit are: 126 hours for group services or 26 hours for individual services; 35 days for residential treatment, and 21 days for detox.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Texas Department of State Health Services website:** “…comprehensive Medicaid substance use disorder treatment services include outpatient services (assessment, ambulatory detox, individual and group outpatient counseling, medication-assisted therapy, and residential services (treatment and detoxification). Medication-Assisted Treatment (MAT) is a form of pharmacotherapy and refers to any treatment for a substance use disorder that includes a pharmacologic intervention as part of comprehensive substance abuse treatment. The ultimate goal is for the client to achieve recovery with the ability to live life with full social functioning. MAT is not just limited to narcotic treatment programs. Any level of treatment for SUD services can offer MAT as a treatment modality.”

**Prescription Drug Coverage - PDL Formulary, 2017**: Effective 2016 preferred medications listed are: Suboxone film; buprenorphine; naltrexone (oral); naloxone syringe & vial. Non-preferred medications with pre-authorization requirements include: Bunavail, Vivtrol and Zubsolv. Criteria for pre-approval includes: treatment failure with preferred drugs within any subclass or contraindication or allergic reaction to preferred drugs.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 4.8 million (children and adults = 16% of the state population). Total Medicaid spending for 2015 was 35.8 billion. Spending on prescribed drugs was $ 230,038,121.

**6. Drug overdose fatality rate** in 2014 was: 9.7 (per 100,000); rate of fatalities attributed to opioids: 4.3 (per 100,000).

**Utah:** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Utah Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only Acamprosate was excluded from UT’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. For 2012 Kaisers** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set & Kaiser State Health Facts*: UT Medicaid covered treatment for beneficiaries with substance use disorders through fee for services or capitated payment reimbursement. Ambulatory detox is not covered. As of 2014, a CMS approved 1115 waiver authorized the State to provide three different packages of services for Medicaid beneficiaries. Traditional Medicaid provides a comprehensive package of covered services primarily to children, pregnant women, and the aged, blind and disabled, with some limitations and nominal copayments with an optional buy-in for disabled adults. A smaller package of covered services for certain adults receiving or previously receiving cash assistance is available, with some limitations and copays up to an annual maximum of $500. A very limited package of services is available for parents of Medicaid-eligible children and other adults with income below 150 % of the federal poverty level, which has higher co-pays with an annual maximum of $1,000.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Utah Medicaid Member Guide:** Alcohol and Drug Services: “If you need in-patient drug or alcohol detoxification services and have a health plan, call your health plan. If you do not have a health plan, the hospital will bill Medicaid for detoxification services.” Only authorized providers are reimbursed for services. Only outpatient services provided by Utah County Department of Drug and Alcohol Prevention and Treatment are covered without pre-approval, except for American Indians or Alaska Natives. Methadone maintenance is not covered through primary care providers. Medicaid pays for these services directly. Beneficiaries already receiving other MAT services from a private doctor can keep seeing their doctor.

**Prescription Drug Coverage - PDL Formulary, 2017**: Suboxone is listed as preferred; Bunavail, Zubsolv, and buprenorphine/naloxone tablets require clinical pre-authorization and may be subject to quantity limits. Other medications not listed require submission of a preferred drug override request and approval.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 304,000 (children and adults = 12% of the state population). Total Medicaid spending for 2015 was 2.2 billion. Spending on prescribed drugs was $ 62,785026.

**6. Drug overdose fatality rate** in 2014 was: 22.4 (per 100,000); rate of fatalities attributed to opioids: 16.8 (per 100,000).

**Vermont** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Vermont Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies**: indicated all medications used to treat SUDs were on VT’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: VT Medicaid covered treatment for beneficiaries with substance use disorders through fee for services reimbursement. Vermont has a CMS approved 1115 waiver under which The Department of Vermont Health Access, as a managed care entity, administers Vermont’s public health coverage programs, including Medicaid and Vermont Health Access Plan (VHAP). Medicaid and VHAP services are delivered on a fee for service basis or through the State’s Primary Care Case Management model of managed care called Primary Care Plus.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Department of Vermont Health Access Medicaid Covered Services Rules**: Chemical dependency services require pre-authorization, but at least one visit is allowed without authorization for all plans; self-referral for chemical dependency visits is covered up to $500 per year. A 2014 memo outlining the Medicaid State Plan amendment that authorized Vermont’s ‘Hub and Spokes’ program for treatment of opioid use disorders states: “Methadone and buprenorphine are the primary pharmacological treatments for opioid addiction. Methadone treatment for opioid addiction is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTPs), of which Vermont currently has five. Approximately 150 physicians can prescribe buprenorphine in Vermont.”

**Prescription Drug Coverage - PDL Formulary, 2017**: Suboxone, naltrexone (oral), Acamprosate tablets, disulfiram (250 & 500 mg) tablets, methadone oral concentrate (10 mg/ml) and as well as Vivitrol (for prevention relapse) are preferred drugs that are approved once clinical criteria are met, with a maximum dose of 16 mg for buprenorphine products and a maximum prescribed supply of 14 days. Buprenorphine/naloxone or buprenorphine tablets, Probuphine implant, Zubsolv, Bunavail and Antabuse are non-preferred drugs and may be subject to additional pre-authorization criteria and quantity limits.

**5. State on state Medicaid Expenditures:** 2015 Medicaid Utilization was 166,000 (children and adults = 27% of the state population). Total Medicaid spending for 2015 was 1.6 billion.

**6. Drug overdose fatality rate** in 2014 was: 13.9 (per 100,000); rate of fatalities attributed to opioids: 11.1 (per 100,000).

**Virginia** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Virginia Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicted only acamprosate was excluded from VA’s Medicaid preferred drug list. Other medications used to treat alcohol use disorders were covered.

**3. In 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: Virginia Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement, with pre-authorization and a co-pay of $3 per visit. Limits varied by service.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Virginia’s Addiction and Recovery Treatment Services Delivery System Transformation, 2016:** This CMS approved 1115 waiver expanded coverage of inpatient detox and treatment for up to 15 days for all Medicaid members. It expands coverage of residential detox and treatment and increases reimbursement rates for substance abuse treatment services currently covered by Medicaid such as case management; partial hospitalization/intensive outpatient, and counseling components of opioid treatment. It also adds coverage for peer support services.

**Prescription Drug Coverage - PDL Formulary, 2017**: As of 2015, preferred methadone products include: methadone 10mg/ml Intensol oral concentrate, Methadose 10 mg/ml solution (approved ONLY for detoxification and maintenance treatment of narcotic addiction) for patients enrolled in certified and registered methadone treatment programs (OTP). Buprenorphine sublingual tablets, naltrexone tablets, and Suboxone film are also preferred (with a 16 mg maximum dose). Bunavail, Zubsolv, and buprenorphine/naloxone sublingual tablets are non- preferred drugs, subject to additional pre-authorization criteria.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 976,000 (children and adults = 11% of the state population). Total Medicaid spending for 2015 was 8.1 billion. Spending on prescribed drugs was $ 76,703,282.

**6. Drug overdose fatality rate** in 2014 was: 11.7 (per 100,000); rate of fatalities attributed to opioids: 9.1 (per 100,000).

**Washington:** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** Washington Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on WA’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: WA Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services or percentage of charge reimbursement. Ambulatory detox was not covered and pre-approval was required for specified services.

**4. Current Medicaid Covered Services – verified as of 2017:**

**Division of Behavioral Health and Recovery webpage:**WA Medicaid covers a continuum of substance use disorder services including: assessment; brief intervention and referral to treatment; withdrawal management (detoxification); outpatient treatment; inpatient residential treatment; opiate substitution treatment services, and case management.

**Prescription Drug Coverage - PDL Formulary, 2017:** Acamprosate, disulfiram/Antabuse, naltrexone oral tablets, methadone and Vivitrol are on the preferred list, but Vivitrol and naltrexone require pre-authorization if used for beneficiaries under 18. Suboxone, Subutex, Bunavail, Zubsolv and generic buprenorphine/naloxone sublingual tablets are on the preferred list, but require pre-authorization for use with beneficiaries under 16. Naloxone vial & syringe and Narcan nasal spray are also listed. Quantity limitations apply to most of these medications.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1.8 million (children and adults = 22% of the state population). Total Medicaid spending for 2015 was 10.6 billion. Spending on prescribed drugs was $ 169,973,118.

**6. Drug overdose fatality rate** in 2014 was: 13.3 (per 100,000); rate of fatalities attributed to opioids: 9.2 (per 100,000).

**West Virginia** has expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** West Virginia Medicaid responses to a survey indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated only methadone was excluded from WV’s Medicaid preferred drug list. Medicaid covered drugs used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: WV Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. West Virginia has a CMS approved 1115 waiver under which the State implements a Medicaid reform program called Mountain Health Choices. The program has a Basic and an Enhanced plan, as well as a traditional Medicaid Plan. The Basic plan includes all state and federal mandatory services; the Enhanced plan offers additional services to members voluntarily signing a health care responsibility agreement.

**4. Current Medicaid Covered Services – verified as of 2017:**

WV Medicaid currently provides coverage for buprenorphine/naloxone formulations, mono-buprenorphine, and Vivitrol. As of 2/2017, Page Content

​The WV Bureau for Medical Services webpage has an update announcement for their Behavioral Health Rehabilitation Services Manual that includes information on coverage of methadone (Chapter 503). On 11/2016, West Virginia proposed a program to CMSunder a new 1115 waiver: **Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders.** Itaims to increase the availability of community-based and outpatient SUD treatment services, make residential treatment available to Medicaid beneficiaries, build MAT capacities by including access to methadone treatment, and widely distribute naloxone and Narcan. As of 3/1/2017 approval is pending.

**Prescription Drug Coverage - PDL Formulary, 2017:** Preferred medications are listed as naloxone, Narcan nasal spray, Suboxone film and Vivitrol. They require clinical pre-authorization. Non-preferred pre-authorization criteria are available online for: buprenorphine tablets, buprenorphine/naloxone tablets, Bunavail, and Zubsolv. Methadone is listed as a non-preferred drug with pre-authorization criteria that require attempts at treatment with preferred agents.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 596,000 (children and adults = 29% of the state population). Total Medicaid spending for 2015 was 3.7 billion. Spending on prescribed drugs was $ 188,456,455.

**6. Drug overdose fatality rate** in 2014 was: 35.5 (per 100,000); rate of fatalities attributed to opioids: 31.6 (per 100,000).

**Wisconsin** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** The Wisconsin Medicaid website indicated coverage of MAT for beneficiaries with substance use disorders was as follows:

* Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone
* Medicaid coverage for long-acting injectable naltrexone

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicated all medications used to treat SUDs were on WI’s Medicaid preferred drug list including those used to treat alcohol use disorders.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: WI Medicaid covered treatment for categorically and medically needy beneficiaries with substance use disorders through fee for services reimbursement. Co-pays are between $.50 and $3 depending on the service. The Statehas a CMS approved Section 1115 waiver under which it extends Medicaid eligibility to families and caretaker relatives with net income up to 200% of the federal poverty level (FPL). They have full Medicaid benefits either directly or as a wrap-around for services included in an employer’s insurance package through the State’s BadgerCare Plus Standard Plan. A limited benefit package with higher copayments called the BadgerCare Plus Benchmark Plan is available for children and pregnant women with income between 200% and 300% of the FPL. A BadgerCare Plus Core Plan is available for childless adults with income at or below 200% FPL with fewer benefits.

**4. Current Medicaid Covered Services – verified as of 3/2017:**

**Wisconsin Department of Health Services website:** Opioid treatment page explicitly addresses the MAT choices available: methadone, buprenorphine, and naltrexone. “Methadone to treat addiction is dispensed only at specially licensed treatment centers. Buprenorphine and naltrexone are dispensed at treatment centers or prescribed by doctors. A doctor must have special approval to prescribe buprenorphine.” A continuum of services is also covered, including assessment, detox, inpatient and outpatient treatment, counseling, and recovery coaching.

**Prescription Drug Coverage - PDL Formulary, 2017**: Methadone, Suboxone film, buprenorphine and buprenorphine/naloxone tablets, naltrexone tablets, Vivitrol, naloxone vial & syringes, Narcan nasal spray, Bunavail, and Zubsolv are on the preferred drug list. Narcan and naloxone require no pre-authorization, but the remainder has diagnostic criteria and other requirements for pre-authorization.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 1 million (children and adults = 17% of the state population). Total Medicaid spending for 2015 was 8 billion. Spending on prescribed drugs was $496,284,152.

**6. Drug overdose fatality rate** in 2014 was: 15.1 (per 100,000); rate of fatalities attributed to opioids: 11.1 (per 100,000).

**Wyoming** has not expanded Medicaid eligibility.

**1. In 2013 ASAM reported:** the Wyoming Medicaid website indicates coverage of MAT for beneficiaries with substance use disorders was as follows:

* No Medicaid coverage for methadone maintenance
* Medicaid coverage for buprenorphine/naloxone *(documentation of counseling required)*
* Medicaid coverage for long-acting injectable naltrexone for opioid use disorders

**2. In 2014 SAMHSA’s review of Medicaid policies:** indicatedboth methadone and Acamprosate were excluded from WY’s Medicaid preferred drug list.

**3. For 2012 Kaiser’s** *Medicaid Benefits: Rehabilitation Services-Mental Health and Substance Abuse Data Set &* ***Kaiser State Health Facts*** showed: WY Medicaid covered treatment for beneficiaries with substance use disorders through fee for services reimbursement.

**4. Current Medicaid Covered Services – verified as of 2017:**

**WY Medicaid Community Mental Health & Substance Use Treatment Services Manual, r**evised 3/2016, lists the following reimbursable services: clinical assessment; peer specialist services; agency/based individual/family therapy; comprehensive medication services; substance use intensive outpatient treatment services – with “structured program of group treatment which may include education about role functioning, illness, and medications; group therapy and problem solving, and similar treatment to implement each enrolled client’s treatment plan.”

**Prescription Drug Coverage - PDL Formulary, 2017**: Suboxone is listed as a preferred medication requiring clinical criteria and pre-authorization with dosage limits of 16 mg for the first two years and 8 mg after that. Oral buprenorphine can be pre-authorized for pregnant or nursing women and those with a documented allergy to naltrexone. Vivitrol is also listed as a preferred medication, requiring clinical criteria and pre-authorization. Bunavail, Zubsolv, buprenorphine and buprenorphine/naloxone HCL tablets are listed as non-preferred, but the latter is recommended under a mandatory generic policy. Methadone is listed as non-preferred with quantity and dosage limitations.

**5. State Medicaid Expenditures:** 2015 Medicaid Utilization was 60,000 (children and adults = 10% of the state population). Total Medicaid spending for 2015 was 566.4 million. Spending on prescribed drugs was $23,028,792.

**6. Drug overdose fatality rate** in 2014 was: 19.4 (per 100,000); rate of fatalities attributed to opioids: 9.3 (per 100,000).

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