RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

A Comprehensive Listing of What States Cover for Substance Use Disorder, including Medications

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

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March 2017— *The first edition of the 50-state review of Medicaid coverage for substance use-related services summarized information on each state from prior comprehensive reviews and provided current information on Medicaid eligibility, covered population, and enrollment by state, as well as covered substance use disorder treatment and recovery services. Updates include detailed information on coverage of MAT for opioid and alcohol use disorders is included from current state Medicaid preferred drug lists/formularies (e.g., preferred medications, prior authorization requirements and criteria, dosage and duration limitations, and Medicaid Managed Care coverage guidelines).*

February 2018— *Updates and revisions reflect relevant changes in coverage and preferred drug lists/formularies for various states. This edition reflects significant changes to prior authorization requirements, clinical criteria for medication-assisted treatments for opioid use disorders, and or Medicaid Managed Care guidelines in specific states. Other changes include Medicaid work requirements and specifics of coverage for opioid overdose antidotes (e.g., naloxone, Narcan). Overdose fatality rates for 2016 are based on available current information.[1] For a detailed introduction and discussion of changes see pages 12-13.*

September 2018— *Updates and revisions reflect changes in Medicaid coverage for relevant services and to preferred drug lists/formularies. In most cases, the trend is towards expanded coverage and access with fewer PA requirements. Changes to Medicaid Managed Care coverage guidelines, provisions of waiver applications and approved programs, and the implementation status of work requirements in various states have also been added. Overdose fatality rates for 2016 are based on Centers for Disease Control final mortality data,[2] and projected provisional drug overdose fatality rates for 2017, as of August 2018.[3] A summary of state prescription drug monitoring program (PDMP) mandates has been added. For a detailed discussion of changes and introduction see pages 14-16.*

[1] Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov

[2] Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov

[3] Ahmad FB, Rossen LM, Spencer MR, Warner M, Sutton P. Provisional drug overdose death counts. CDC, National Center for Health Statistics. 2018. Designed by LM Rossen, A Lipphardt, FB Ahmad, JM Keralis, and Y Chong: NCHS, last reviewed August 15, 2018.

Introduction (March 2017)

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 (OUDs).[4] ASAM engaged a contractor to conduct a 50 state Medicaid survey and to compile other data contained in the report. The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2014 review of state Medicaid coverage of medications for all substance use disorders [5] also added information on coverage of drugs approved for MAT of alcohol use disorders (AUDs). The 2017 update that follows builds on this foundational knowledge and provides additional current information. The following state profiles summarize the information from these prior reports and provide current updates. Current levels of coverage demonstrate that progress has been made, but also the challenges that remain in making all FDA approved medications that aid in the treatment of addictive disorders accessible to Medicaid beneficiaries. This information is important to all who work with individuals with opioid use disorders but particularly important to justice professionals. Investments in treatment for justice-involved populations are less likely to yield returns without access to follow-up care upon re-entry into the community. The re-entry population relies heavily on publicly-funded substance use disorder treatment programs and public healthcare coverage for continuing care and access to MAT for opioid use disorders.

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 agonist therapy (sometimes referred to as opioid replacement therapy): methadone and buprenorphine formulations. A third medication, long-acting injectable naltrexone, is approved for preventing relapse among individuals with opioid use disorders (OUDs). Other medications are sometimes used during detoxification to treat the symptoms of opioid withdrawal. Recently, lofexidine hydrochloride (brand name Lucemyra), which has been used off-label to relieve withdrawal symptoms, was approved by the FDA for such purposes.[6] Ensuring effective treatments are at least as accessible and affordable for Medicaid beneficiaries as continued opioid use is a critical component of a public health and public safety response to the current crises.

The 2013 ASAM report alluded to increases in drug overdose deaths attributable to opioids. Since that time, the situation has become more critical. There has been a dramatic rise in opioid overdose deaths, which is reflected in the overdose fatality data included in this review. It is also important to note the proportion of drug overdose deaths attributed to opioids is underestimated. A 2014 study demonstrated that at least one in five overdose deaths did not specify a drug or type of drug, and that many of those unspecified fatalities are attributable to opioids. The study

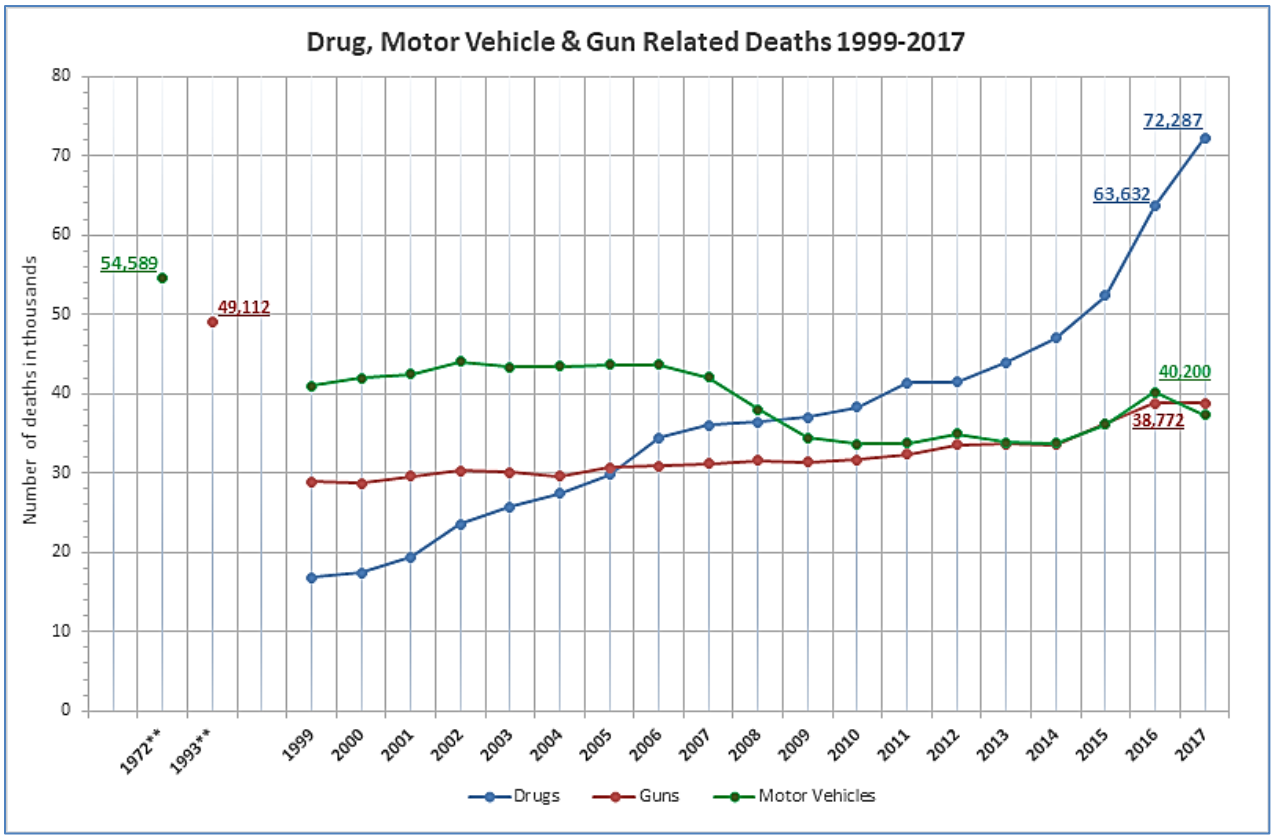
[4] *Advancing Access to Addictions Medications: A Project of ASAM.* (2013). Available online at: http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

[5] Substance Abuse and Mental Health Services Administration, *Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders*. HHS Publication No. SMA-14-4854.Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[6] FDA News Release (May 16, 2018). FDA approves the first non-opioid treatment for management of opioid withdrawal symptoms in adults. Available online at: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm607884.htm

estimated that deaths involving opioids were underreported by 24%. [7] Nationally, the underreported proportion of deaths attributable to opioids is likely to have decreased slightly since then.

Moreover, in 2015 the age-adjusted opioid-involved death rate increased 15.6%, driven largely by deaths involving heroin and synthetic opioids other than methadone (presumably illicitly fentanyl). [8] From 2014 to 2015 only four states reported decreases in overdose fatality rates of more than one per 100,000, while several states reported significant increases.[9] In 2016, the rate of drug overdose deaths in the U.S. increased 21.5%, while deaths involving opioids increased 27.9%.[10] Provisional drug overdose death counts for 2017 are also projected to increase, and to exceed 72,300. [11]



*2016 estimated number drug of overdose fatalities based on CDC provisional estimate of 63,600 in Drug Overdose Deaths in the US, 1999-2016. Provisional estimates are italicized. 2017 estimated number drug overdose fatalities based on provisional data for 12 month period ending May 2017; CDC indicates deaths are likely underreported due to incomplete data: www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

**1993 = Peak annual gun fatalities. Pew Research Center: www.pewresearch.org/fact-tank/2015/10/21/gun-homicides-steady-after-decline-in-90s-suicide-rate-edges-up/; 1972 = Peak annual motor vehicle fatalities. Source: Analysis of the Significant Decline in Motor Vehicle Traffic Fatalities in 2008.

***2016 motor vehicle fatality estimates from National Safety Council http://www.nsc.org/NewsDocuments/2017/12-month-estimates.pdf; 2016 gun deaths based on CDC estimate of 12 per 100,000 [(US population-323.1 mil/100,000 x 12=38,772]: www.cdc.gov/nchs/nvss/vsrr/mortality-dashboard.htm#

[7] Rudd RA, Seth P, David F, & Scholl L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. CDC *MMWR* 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1.

[8] CDC Drug Overdose Death data: https://www.cdc.gov/drugoverdose/data/statedeaths.html; *Increases in Drug and Opioid Overdose Deaths – United States, 2000 to 2014*; *Increases in Drug and Opioid Overdose Deaths – United States, 2010 to 2015*

[9] Rudd RA, Seth P, David F, & Scholl L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. CDC *MMWR* 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1

[10] Seth, P., Scholl, L., Rudd, R. A., & Bacon, S. (2018). Overdose deaths involving opioids, cocaine, and psychostimulants — United States, 2015–2016. *Mortality and Morbidity Weekly Report*, 2018;67:349–358. CDC;

[11] CDC National Center for Health Statistics, Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts (2018). Retrieved from: https://www.cdc.gov/nchs/vsrr/drug-overdose-data.htm

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 to have histories of heroin use. According to the CDC, more rural and impoverished counties tend to have higher prescription drug overdose death rates and higher abuse rates, especially among youth. The opioid epidemic has affected non-Hispanic whites and Native Americans/Alaska Natives between and 35 and 54 years old the hardest, but the most recent data indicates the age distribution of decedents is moving steadily downward, and that overdose deaths among diverse populations in urban centers are increasing. [12]

Despite the growing epidemic, a recent report for the Government Accounting Office estimated 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.[13] Passage of the Comprehensive Addiction Recovery Act (CARA) may increase treatment capacities with regard to buprenorphine by raising the maximum number of patients physicians can treat and allowing nurse practitioners and physicians' assistants to also prescribe buprenorphine for OUDs.[14]

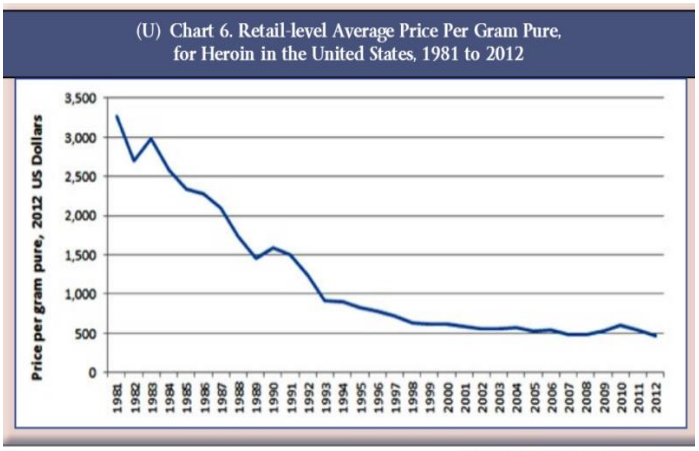
Medications that could help curtail the epidemic have been substantially underutilized by state Medicaid programs. They are also underutilized by community-based treatment providers, with documented disparities between publicly-funded and privately-funded treatment in access to pharmacotherapies, attributed to the scarcity of on-staff physicians in publicly-funded programs.[15] 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. [16]

The proportion of out of pocket expenditures for prescribed opioid drugs for both publicly and privately insured patients has decreased substantially since 1999 when 54% of total costs of a prescribed opioid medication were paid by patients to just 18% of costs by 2012.[17] Medicare spending on Central Nervous System (CNS) drugs comprises one of the largest categories of medication expenditures. Medicare paid a larger share of the cost of prescribed opioids for more than a decade, a larger share than private insurers or Medicaid. However, more recently the Medicaid population has been at greater risk for overdose. Studies show that Medicaid beneficiaries are prescribed opioids at higher rates and at higher doses than privately insured individuals, although risk mitigation steps taken in recent years have lowered dosage rates and curtailed opioid prescribing. The cost of MAT for individuals without coverage can range from

[12] Centers for Disease Control and Prevention, Prescription Drug Abuse and Overdose: Public Health Perspective, October 24, 2012.
[13] GAO, 2016 Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access Report to the Majority Leader, U.S. Senate.
[14] U.S. Congressional Record, 114th Congress, Second Session - H1119, Vol. 162, No. 35, Thursday March 3, 2016: Washington D.C.
[15] Abraham, A., Knudsen, H., Rieckmann, T. & Roman, P. (2013). Disparities in Access to Physicians and Medications for the Treatment of SUDs between Publicly and Privately Funded Treatment Programs in the US. *J.Stud. Alcohol Drug, 74, 258-265.*
[16] Knudsen, H. & Abraham, A. (2012). Perceptions of the State Policy Environment and Adoption Medications in the Treatment of Substance Use Disorders. *Psychiatric Services*, 2012, January; 63(1):19-25. DOI:10.1176/appi.ps.201 100034.
[17] Zhou, Florence & Powell. (2016) Payments For Opioids Shifted Substantially To Public And Private Insurers While Consumer Spending Declined, 1999-2012 *Health Affairs* 35(5):824-831, DOI: 10.1377/hlthaff.2015.1103

$750 to $1,200 a month or more. Out of pocket costs for covered individuals may include substantial co-pays for counseling, medications, physician visits and more.[18]

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 publicly-funded substance use disorder treatment or public health care coverage.



As MAT utilization increases among justice programs, sustaining access to appropriate continuing care must be a major consideration. Increased vulnerability to overdose fatality among re-entering individuals during the immediate post-release period is well documented.[19] According to a June 2106 unclassified DEA Intelligence Report, heroin prices are decreasing as purity increases (see above figure). Seizures of cheap and potent illicitly manufactured fentanyl are also increasing.[20] These factors may elevate the fatality risk if access to continuing care 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 waiver applications; Medicaid brochures; memos pertaining to coverage for MAT; reports compiled by various states; and, Medicaid Managed Care plan reimbursement schedules and contracts. The Kaiser Family Foundation State Health Facts website and their Medicaid Benefits Data Collection was also a source of information on state Medicaid expansion status, spending and utilization. In some cases, Medicaid state plans, waiver applications submitted by states to the Center for Medicaid and Medicare Services, state opioid response plans, 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 available from 49 out of 50 states and the District of Columbia were reviewed in detail. Updated data on overdose fatalities is from CDC reports, primarily: *Increases in Drug and Opioid Overdose Deaths – United States, 2010 to 2015; Drug Overdose Deaths in the US, 1999-2016, and Provisional Estimates for 2017, based on data for 12 month period ending December 2017.*

[18] Baugh, D., Pine, P., Blackwell, S., et al. (2004): Medicaid Prescription Drug Spending in the 1990s: A Decade of Change. *Health Care Financing Review* 25(3):523, Fall 2004.

[19] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison – A high risk of death for former inmates. *New England Journal of Medicine, 365*, 157–165.

[20] Unclassified DEA Intelligence Report - Updated June, 2016, National Heroin Threat Assessment Summary: https://www.dea.gov/divisions/hq/2016/hq062716_attach.pdf

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. For this review, language was simplified when possible, but much of the terminology used by the verification source was retained to ensure the information was accurately represented. 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, making interpretation of coverage difficult for a health policy researcher. Presumably beneficiaries seeking care would find it even more difficult. The list that follows explains some of the terminology that appears in many of the state coverage summaries and in information on preferred and non-preferred drugs in simple language. It also explains the ways some of the rules that can affect access to clinically appropriate care.

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 the 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 tend to rely on drug company rebate programs. 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 left them as a fee-for-service or medical benefit.

***Categorically Needy and Medically Needy Populations*—**Federal Medicaid requirements designate categorically needy populations that state Medicaid programs are mandated to cover. The traditional Medicaid population has consisted largely of pregnant and parenting women, children living at or below poverty level and elderly and disabled individuals. States 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 (i.e., the expansion population). Most states that have expanded Medicaid eligibility opted to do so when the Affordable Care Act was implemented; but since that time several states have also done so through waiver programs (submitted to the Center for Medicare and Medicaid Services to amend existing state Medicaid plans and guide future reforms). A few states have allowed voters to decide on implementation of Medicaid expansion by referendum, and at least two more states will vote on the issue before the end of 2018.

***Medicaid Managed Care (MMC)*—**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 as many as eight different managed care plans that vary in the 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 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*—**State 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 fee,* and *cost-based or prospective cost rates*.

- ***Pre-approval or prior authorization (PA)*—**refers to needing approval for a specific service or cost to make sure the health plan will pay for it before the beneficiary can get care. Providers/prescribers usually submit PA 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, outpatient and residential treatment services. For example, counseling might be limited to 36 sessions per year or may limit 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 there is no research that has conclusively determined how long it can take, and the extent of the healing that takes place may be highly individualized. MAT is most likely to be effective when treatment duration is a minimum of 9 months to two years. Sometimes certain individuals function better when they remain on a reduced maintenance dose for an extended period. Recently research on justice-involved populations receiving MAT for opioid use disorders should significant reductions in criminal activity but only among individuals that received MAT for long-term treatment over an extended period. [21]

- ***Frequent reauthorization requirements*—**refers to needing permission to continue to get coverage for 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.

[21] Deck, D., Wiitala, W., McFarland, B., Campbell, K., Mulluly, J., Krupski, A., & McCarty, D. (2009). Medicaid coverage, methadone maintenance, and felony arrests: Outcomes of opiate treatment in two states. *Journal of Addictive Diseases*, *28*(2), 89–102. http://doi.org/10.1080/10550880902772373

- ***Prescription refill limits*—**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. They are sometimes only imposed when buprenorphine or methadone are prescribed to treat opioid addiction and are not limitations that apply to when they are prescribed for pain management.

- ***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. Sometimes details of counseling sessions or progress notes are demanded. Plans may offer limited coverage for the required counseling or wait lists and other capacity issues can delay access to treatment.

- ***Requiring documentation of having an OUD for a specified period of time*—**refers to having to document that an individual has had an OUD for a certain period, often for 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 of 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 with less effective approaches 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.

- ***Clinical criteria*—** are standards for medical necessity for procedures, treatments and for prescribed pharmacotherapies. State Medicaid plans often rely on accepted standards such as American Society of Addiction Medicine (ASAM) criteria. Reimbursement for MAT often requires physicians to document that patients with OUDs meet clinical criteria prior to authorizing treatments, while such requirements almost never apply to accepted treatment for other chronic conditions (e.g., asthma, arthritis, depression).

- ***Pharmacy lock-in*—** requires beneficiaries used one pharmacy to fill all prescriptions and is a surprisingly effective, simple utilization control for the dispensing of MAT drugs and other controlled substances.

***Preferred Drug List (PDL) and Formulary*—**Typically, preferred drugs lists are comprised of medications that health plans routinely cover without requiring prior authorization. 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 for non-preferred drugs. The ASAM report pointed out their review found PDL 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 universal formularies that listed preferred and non-preferred drugs and noted restrictions for non-preferred medications that applied to all benefit plans, including various managed care plans. In other

cases, managed care plans had their own drug lists. Some formularies provided an online look-up that allowed for checking the status of individual drugs. In such cases, each FDA approved medication for opioid and alcohol use disorders was entered into the online pharmacy database and the coverage information provided was 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). This waiver program offers wide latitude to states to select and achieve objectives that advance the overarching goals of the Medicaid program.

***Opioid Treatment Programs (OTP)*—**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 in addiction treatment services, 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 required in over 30 states. They guide the intensity and duration of initial levels of care as well as transfer/discharge and continuing care for patients with substance use disorders 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 publicly funded treatment and prevention programming. The amount of funding is based on a formula that accounts for state populations and other factors that influence the demand for services.

Note: Most of the 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 in the primary source. Corrections or requests for clarification should be directed to the appropriate state agency. Brand names of medications were used when relevant references appeared in PDLs or formularies.

Abbreviations used in state summaries that follow:

ASAM = American Society of Addiction Medicine

SUD = substance use disorder

AUD = alcohol use disorder

OUD = opioid use disorder

SL = sublingual

PA= pre-approval or prior authorization

MMC = Medicaid managed care

MCO = Managed care organization

SBIRT = screening, brief intervention and referral to treatment

OTP = opioid treatment program (meets federal and state requirements to dispense methadone for treatment of opioid use disorders

PDL = preferred drug list (often drugs listed are available without preauthorization, but in many cases preauthorization requirements are noted for both preferred and non-preferred drugs)

SSA= single state agency (for substance abuse services)

PDMP = prescription drug monitoring program (s)

CMS = the Center for Medicare and Medicaid Services is the federal agency that oversees state Medicaid programs and approves state plans and modifications or service delivery reforms under waiver programs.

OP, IOP = out patient, intensive out patient

Introduction to February 2018 Updates

All information has been re-verified and updated as of February 2018. Significant changes in Medicaid coverage since 2017 have been noted. Information on current preferred drug lists and formularies has also been verified, and current information is provided when available. The following is summary of the nature of these changes.

Medicaid coverage for methadone: Some states still do not cover methadone dispensed by qualified opioid treatment programs (OTPs); however, states such as West Virginia and a handful of others have added coverage for methadone maintenance treatments under waiver programs. A few other states that have not covered methadone treatment services under Medicaid in the past are now subsidizing some of these services through Federal State Response to the Opioid Crisis (STR) funding. Information on accessing these services is included where available. Many formularies have moved all methadone products from preferred to non-preferred status in response to high overdose rates among patients prescribed methadone for pain management. In some cases, but not all, states distinguish methadone products used for treatment of opioid use disorder (OUD) from the restrictions that govern prescribing methadone for pain.

Prior authorization requirements and quantity limits: Several states have lifted or loosened pre-approval or prior authorization requirements for prescribed drugs used for medication-assisted treatment of opioid use disorders. Most states still require pre-approval for buprenorphine formulations and apply dosage limitations of daily maximums from 24 to 32 mgs. In some cases, the maximum daily maintenance dose is 16 mgs or is reduced to 16 mgs after the initial months of treatment. Some state Medicaid programs require frequent re-authorization and or documentation of participation in counseling.

Prescribing guidelines for opioid medications: Many states have adopted the new CDC guideline for prescribing opioid medications for chronic pain, although adherence by prescribers is voluntary. The general trend regarding prescribing of opioid drugs for chronic and post-surgical pain has been to apply more controls, such as prior authorization requirements and quantity limits. Although this has made it more difficult to over-prescribe opioid analgesics, the process of securing coverage for medications to treat opioid addiction often remains more challenging than obtaining coverage for opioids prescribed for pain management.

New medications and formulations: Several states have added coverage for newly approved Probuphine buprenorphine implants with prior authorization required for beneficiaries to ensure they meet clinical criteria. The anticipated potential of long-acting formulations to reduce buprenorphine diversion has prompted a few states to also add Sublocade, a monthly buprenorphine depot injection in advance its availability.

Overdose antidotes: Most state Medicaid plans cover one or more forms of naloxone without prior authorization, including naloxone vails (injectable form) and Narcan (naloxone formulations for nasal administration), but many plans impose quantity limits. Many plans cover take-home prescriptions of these products for beneficiaries who may be at-risk for opioid overdose, and in some cases, for their friends, family members and caretakers.

Work requirements: Kentucky and Indiana are the first states to gain CMS approval to implement work requirements for certain Medicaid beneficiaries, but the earliest date Kentucky's

requirements are projected to take effect is June of 2018 (which could be delayed). Little information is available on the specifics of proposed implementation in KY. Information on Indiana's program, slated to become mandatory for some beneficiaries in 2019, proposes work requirements of 80 hours per month of work or other gainful activities (e.g., education, job training, volunteer work) with exceptions for caregivers of pre-school children, the re-entry population, youth and older adults). Work requirements are under consideration in at least seven other states, and more states are likely to consider adding them in the future.

Introduction to September 2018 Updates

All information has been re-verified and updated as of September 2018. Significant changes in Medicaid coverage since February 2018 have been noted. Current preferred drug lists and formularies have also been verified and updated. The following is summary of the nature of recent changes.

Medicaid coverage for methadone: Some states, including Kentucky, Arkansas, still do not cover methadone for treatment of OUDs. However, West Virginia, Illinois, Wyoming and other states have added provisions for coverage of methadone dispensed by qualified opioid treatment programs (OTPs) under Medicaid waiver programs. Other states, such as Idaho, are subsidizing methadone maintenance services with federal State Response to the Opioid Crisis (STR) grant funds. Information on accessing these services is included in state summaries where available. In many cases, coverage for methadone remains 'carved out' of managed care plans as a fee-for-service medical or pharmacy benefit; however, clarification of coverage for methadone often requires a deep dive into provider alerts, reimbursement manuals, or SSA websites.

Prior authorization (PA) requirements and quantity limits: More states have lifted or loosened PA requirements for buprenorphine formulations use to treat OUDs, and others are considering amending them. Many states still require PA and most apply dosage limits between 16 and 32 mgs daily. Frequent reauthorization and/or documentation of participation in counseling requirements are still quite complex in certain states. Extended release injectable naltrexone (Vivitrol) for alcohol and opioid use disorders is covered by many state plans, often without prior authorization. Recently a few plans have added treatment participation requirements for beneficiaries with OUDs. Research on extended release injectable naltrexone has demonstrated its effectiveness for OUDs in preventing relapse when used in conjunction with behavioral treatments, for which purposes it is approved by the FDA. However, research on opioid agonist therapies has demonstrated significant positive outcomes in the absence of participation in behavioral treatments, although these positive effects may diminish over time unless pharmacological interventions are combined with behavioral treatments and other recovery supports.

New medications and formulations: Several more states have added coverage for implants (Probuphine) that deliver a maintenance dose of buprenorphine for up to six months, with PA required PA to ensure beneficiaries meet clinical criteria. The number of state plans that have also added the approved buprenorphine depot injection (Sublocade) has also increased. At least one state Department of Corrections is piloting a program using the implants; another is planning to pilot use of monthly buprenorphine injections in two correctional facilities. A third long-acting injectable formulation (administered weekly or monthly) is projected to become available in 2019. In-custody treatment programs will likely be among the first to pilot use of such products because of their potential to reduce buprenorphine contraband and diversion.

Lofexidine, a medication originally approved for treating high blood pressure, recently gained FDA approval for treatment of opioid withdrawal symptoms (under the brand name Lycemyra). Like several other prescribed medications, lofexidine has been used off-label to treat opioid withdrawal symptoms. It has been added to Medicaid preferred drug lists in a handful of states.

Overdose antidotes: Most states list one or more naloxone formulations as covered without prior authorization, including naloxone vails and Narcan nasal formulations. A few states cover take home prescriptions of these products for beneficiaries and in some cases for friends or family members of beneficiaries. Quantity limits on several state formularies trigger an alert that requires documentation of consultation with the prescriber to ensures awareness that the patient has used naloxone to avoid more than one overdose event. Limits can usually be overridden once such requirements are met. The naloxone auto-injector or epi-pen has been dropped from most plans due to overpricing controversies and the manufacturer's (Envio) withdrawal from drug rebate programs.

Work requirements: The most controversial changes currently impacting state Medicaid programs are the addition of work requirements, which CMS authorizes under the Trump administration in January of 2018. Kentucky and Indiana were the first states to gain approval for implementation of work requirements for certain Medicaid beneficiaries under waiver programs, but several other states have followed suit and are in the process of obtaining CMS approval for similar programs. The first states to purpose work requirements targeted the Medicaid expansion population, largely consisting of childless adults with incomes at or below 138% of poverty level. However, Alabama and other states that have not expanded eligibility are now proposing work requirements that would apply to the traditional Medicaid population, which typically includes pregnant and parenting women, children, the elderly and, persons with disabilities. Opponents point out that many beneficiaries already work at low paying jobs that do not provide medical benefits and others experience significant barriers to employment. Legal challenges have been filed in more than one state and could delay or even prohibit implementation in other states.

Available information on approved state work requirements indicates that most allow for exceptions that typically include the re-entry population, elderly and young beneficiaries, pregnant, post-partum and parenting women, individuals in SUD treatment and others. Generally, participation in job training, education or community service qualifies as an employment activity. Arkansas, New Hampshire, Indiana and Kentucky have gained CMS approval for work requirements. However, litigation in Kentucky has halted implementation. Partial implementation of Arkansas' work requirements began in June of 2018. Almost a quarter of Arkansas beneficiaries required to register for work did not comply and could conceivably lose their coverage as a result. However, in mid-August 2018 a law suit was filed in Arkansas, but it is too early to determine the impact it will have on implementation efforts. Each state summary has information on approved or proposed work requirements. In several cases, work requirements have been proposed or discussed by state policy makers, but states have either formally declined to pursue such changes or have compiled reports that indicate low proportions of current beneficiaries could participate.

Prescription drug monitoring programs (PDMPs) are databases that contain information on medications prescribed and dispensed to patients. PDMPs are not new and have been primarily used by law enforcement to detect DEA registrants operating outside the law. However, advances in electronic health information have made have swift access to prescription-related data possible. Most states currently require pharmacies and other dispensers of controlled drugs to enter data, with varied requirements for how often they must update the information. PDMP databases that can be updated in real time are the most effective. Currently, 50 states, the District

of Columbia and two U.S. territories have PDMPs operating within their borders.[22] Although Missouri is the only state that has no PDMP legislation in place, St. Louis County recently implemented a PDMP open to other Missouri Counties, estimated to currently serve more than half the state population. There are no federal mandates that encourage high levels of PDMP utilization or linkages to connect individual state PDMP databases among neighboring states. [23] Fewer than half of U.S. states require prescribers to check PDMP database before prescribing a controlled substance to patients. Many states require prescribers to register, but only a small share of providers access PDMP data unless it is mandated.[24] The table that follows lists the 19 states that mandate prescribers consult PDMP databases and the conditions under which they required to consult or review information (as of July 2018).

Drug overdose fatality rates according 2017 CDC provisional overdose death counts, a handful of states show modest reductions in drug overdose fatalities (mostly between 2% and 5%) except for Wyoming where fatalities decreased more than 40% from the previous year. Other states that have achieved reductions include Hawaii, Massachusetts, Vermont, Rhode Island, North Dakota, Oklahoma and Utah. It should be noted that drug overdose deaths involving cocaine increased more than 50% in 2017, according to provisional CDC data. This trend has been significant in recent years, with DEA seizures of Columbian product reaching record levels in 2016.[25]

[22] Sacco, L., Duff, J. & Sarata, A. (2018). Prescription Drug Monitoring Programs. Congressional Research Service. May 2018.
[23] Prescription Drug Monitoring Program Training and Technical Assistance Center. (2018). History of Prescription Drug Monitoring Programs.
[24] Buchmueller, T. & Carey, C. (2018). The effect of prescription drug monitoring programs on opioid utilization in Medicare. *Am. Economic Journal: Economic Policy 2018, 10(1);77-122.*
[25] DEA Intelligence Brief (August 2017). Colombian cocaine production expansion contributes to rise in supply in the United States. U.S. Department of Justice, retrieved from https://ndews.umd.edu/sites/ndews.umd.edu/files/dea-colombian-cocaine-production_expansion-contributes-to-rise-in-us-supply2.pdf

States Mandating High-Levels of PDMP Utilization: States (19) that require pharmacies to enter data in PDMP databases ***and*** also require prescribers to consult them before prescribing a controlled drug are listed, along with conditions under which data must be checked or reviewed. Final 2016 drug overdose death rates, overdose fatality trends for prior years, and 2017 provisional death counts are included with relevant research studies.

State & Rates	Schedule drugs (1-5) report dispensers					Prescribers required to review data	Published studies on outcomes and cost-benefits
New Jersey 2016 OD death rate: 23 Number of fatalities: 2,056 42% increase 2015-16 16% increase 2014-15 2017 trending up 33%		II	III	IV		Initial prescription of schedule II and every 90 days	Drimalla, B.,agner, A., Volino, L., Feudo, D., & Toscani, M. (2015).
New Hampshire 2016 OD death rate: 39 Number of fatalities: 481 14% increase 2015-16 31% increase 2014-15 2017 trending up 5%		II	III	IV		Initial prescription of opioids and at least twice a year after	Ricco Jonas, M., & Shoemaker, J. (2016).
New York 2016 OD death rate: 18 Number of fatalities: 3,638 32% increase 2015-16 2017 rates are the same		II	III	IV		Each prescription of a schedule II-IV drug	Brown, R., Riley M., Ulrich, L., Jenkins, P., Krupa, N., & Gadomski, A. (2017); Rasubala, L., Penapati, L., Velazquez, X., Burk, J., & Ren, Y. (2015); Haffajee, R., Jena, A. & Weiner, S. (2015).
Rhode Island 2016 OD death rate: 31 Number of fatalities: 326 20% increase 2014-15 2017 trending down 4%		II	III	IV		Initial prescription of opioids and every 90 days	Green, T.C., Mann, M.R., Bowman, S.E, Zaller, N., Soto, X., Gadea, J.... Friedmann, P.D. (2012).
Vermont 2016 OD death rate: 22 Number of fatalities: 125 26% increase 2015-16 2017 trending down 5%		II	III	IV		Each prescription of schedule II-IV and at least annually	
Virginia 2016 OD death rate: 17 Number of fatalities: 1,405 35% increase 2015-16 2017 trending up 8%		II	III	IV		Initial prescription of opioid or benzodiazepine lasting for 7 days or more than 14 days after surgery	Mahon, W. (2012).
West Virginia 2016 OD death rate: 52 Number of fatalities: 884 25% increase 2015-16 17% up 14-15 2017 trending up 13%		II	III	IV		Each prescription of analgesics and at least annually	Xerox Outcomes Assessment. (2013)
Connecticut 2016 OD death rate: 27 Number of fatalities: 971 24% increase 2015-16 27% increase 2014-15 2017 trending up 8%		II	III	IV	V	Initial prescription of schedule II-V, every 90 days after, and annual review of a schedule V non-narcotic drugs	Green, T.C., Mann, M.R., Bowman, S.E, Zaller, N., Soto, X., Gadea, J.... Friedmann, P.D. (2012).

Indiana 2016 OD death rate: 24 Number of fatalities: 1,526 23% increase 2015-16 2017 trending up 15%		II	III	IV	V	Initial prescription opioids or benzodiazepines and every 90 days	
Kentucky 2016 OD death rate: 33 Number of fatalities: 1419 12% increase 2015-16 21% increase 2014-15 2017 trending up 9%		II	III	IV	V	Each prescription of a schedule II-III containing hydrocodone, all IV, and every 90 days	Goodin, A., Blumenschein, K., Freeman, P. & Talbert, J. (2012); Haffajee, R., Jena, A. & Weiner, S. (2015); Quesinberry, D., Bunn, T. & Slavova, S. (2015).
Massachusetts 2016 OD death rate: 33 Number of fatalities: 2,227 28% increase 2015-16 35% increase 2014-15 2017 trending down 2%		II	III	IV	V	Initial prescription of benzodiazepines; each opioid prescription	Poon S., Greenwood-Ericksen M., Gish R., Neri P., Takhar S., Weiner, S….. Landman, A. (2016).
New Mexico 2016 OD death rate: 25 Number of fatalities: 2,227 2015-17 rates are the same		II	III	IV	V	Initial prescription of opioids and every 90 days	
Nevada 2016 OD death rate: 22 Number of fatalities: 665 11% increase 2014-15 2017 trending up 7%		II	III	IV	V	Initial prescription of schedule II-V and every 90 days	
Ohio 2016 OD death rate: 39 Number of fatalities: 4,329 31% increase 2015-16 21% increase 2014-15 2017 trending up 19%		II	III	IV	V	Initial prescription of opioids, benzodiazepines and every 90 days	Penm, J., MacKinnon, N. J., Boone, J. M., Ciaccia, A., McNamee, C., & Winstanley, E. L. (2017); Haffajee, R., Jena, A. & Weiner, S. (2015).
Oklahoma 2016 OD death rate: 22 Number of fatalities: 831 15% increase 2015-16 2017 trending down 5%		II	III	IV	V	Initial of prescription of opioids, benzodiazepines, carisoprodol and every 180 days	
Tennessee 2016 OD death rate: 24 Number of fatalities: 1,630 10% increase 2015-16 14% increase 2014-15 2017 trending up 7%		II	III	IV	V	Each prescription of opioids, benzodiazepines, and at least annually or after suspected misuse	Haffajee, R., Jena, A. & Weiner, S. (2015).
Texas 2016 OD death rate: 10 Number of fatalities: 2831 9 % increase 2015-16 2017 trending up 5%		II	III	IV	V	Initial prescription of opioids, benzodiazepines, barbiturates, and carisoprodol (Soma)	

Louisiana 2016 OD death rate: 22 Number of fatalities: 996 15% increase 2015-16 12% increase 2014-15 2017 trending up 10%	I	II	III	IV	V	Initial prescription of opioids and every 90 days	
Pennsylvania 2016 OD death rate: 38 Number of fatalities: 4,627 44% increase 2015-16 20% increase 2014-15 2017 trending up 17%	I	II	III	IV	V	Initial prescription of controlled drug, each prescription of opioid or benzodiazepine, and after suspected misuse.	

Summaries of Medicaid Coverage by State

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 2018: Public comment period on Alabama's proposed 1115 waiver closed 8/30/18. It proposes the strictest work requirements in the nation including 35 hours per week for parents of minor children over age six and 20 hours for parents of children under six, with exceptions for beneficiaries in a GED or job training program. The proposed work requirements apply to the traditional Medicaid population, not the expansion population. Proposals have been widely criticized for requiring levels of employment that would result in loss of eligibility and are likely to be adjusted before they are finalized. ***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 as of July 2018: Suboxone strips are listed as preferred, not requiring prior approval with clinical criteria met. Other buprenorphine/naloxone formulations continue to require prior approval and documentation of failure with preferred agents. Generic methadone solutions (with prior approval required) are listed under opiate agonists. A search of the online drug look-up did not reveal information on any other medications, even when Narcan and naloxone were entered in the search window.

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 for 2016 was 16.2 (per 100,000) with the rate of fatalities attributed to opioids at 7.5 (per 100,000). Rates have increased from the previous year by 3% and 23%, respectively. 2017 provisional CDC data show the number of drug overdose deaths increased slightly, from 794 in 2016 to 805 projected for 2017.

Alaska: has expanded 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 8/2018: ***Alaska Medicaid Recipient Services Handbook, revised June 2018:*** "Community Behavioral Health Services are only provided within the state. If needed services are not available in your community…the provider will contact the state to request a service authorization for travel…" Clinical and rehabilitation services are available for adults or children experiencing a substance use disorder. Covered services include assessments; case management; medication administration; comprehensive community support services for adults; substance use disorder treatment (outpatient, detoxification, residential treatment), and peer support. The Alaska Division of Behavioral Health listed only 19 MAT providers in the state, as of 12/2017. Nine of the providers accept Medicaid and only two of them offer methadone. In January 2018, Alaska submitted a 1115 waiver to CMS with service enhancement for adults and adolescents with SUDs as one of three priority objectives.

Prescription Drugs - PDL Formulary as of 2018: As of 4/2017 buprenorphine-based products for treatment of OUDs do not require prior approval for the initial 28-day supply. Preferred medications still apply and are listed as: Suboxone film, with a maximum dose of 24 mg daily. Subutex is also listed as not to be prescribed to males and requiring documentation of "medical necessity." Narcan nasal spray take home prescriptions are covered, limited to two per 365 days, but the limit can be overridden if consultation with prescriber alerting them of patient's Narcan use is documented. Oral naltrexone and Vivitrol are listed as preferred drugs; methadone from OTPs is covered but only available in Fairbanks or Anchorage.

5. State Medicaid Expenditures: As of December 2016 Medicaid, Utilization: 173,312 (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 for 2016 was 16.8 (per 100,000); rate of fatalities attributed to opioids at 12.5 (per 100,000). Rates increased from the previous year by 5% and 14%, respectively. 2017 provisional CDC data show the number of drug overdose deaths increased nearly 9% from 127 in 2016 to 138 projected for 2017.

Note: Alaska Medicaid website offers guidance on covered transportation to medical services. The state identified the following as a 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."* Link to the Alaska Opioid Policy Taskforce report: http://dhss.alaska.gov/abada/Pages/default.aspx

Arizona has expanded Medicaid eligibility through its Section 1115 Waiver program.

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 8/2018: Arizona submitted a proposed 1115 waiver plan to CMS in 2017 which includes a work requirement with exceptions for beneficiaries under age 16 and over 54, fulltime students, domestic violence victims, and beneficiaries who are homeless, pregnant or caring for minor children. The AZ Medicaid website lists seven different managed care plans, indicating they all provide the same coverage. Some plans are only available in specified counties and others (including the 'American Indian Health Plan') are available statewide. ***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. Level I Residential treatment services are also covered and includes detoxification.

Prescription Drugs: PDL Formulary (updated July 2018) Preferred medications for OUDs that do not require pre-approval: methadone oral concentrate (only through OTPs), Suboxone, Vivitrol, naloxone vial & syringe and Narcan nasal spray. As of July 2018, prior approval for Subutex for pregnant women is no longer required. Non-preferred buprenorphine formulations require prior approval. Acamprosate and disulfiram are listed on the formulary without information on their status or clinical criteria for coverage.

5. State Medicaid Expenditures: As of October 2017 Medicaid, Utilization: exceeds 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 for 2016 was 20.3 (per 100,000); rate of fatalities attributed to opioids at 11.4 (per 100,000); Rates increased from the previous year by 7% and 12%, respectively. 2017 provisional CDC data show the number of drug overdose deaths increased more than 4% from 1573 in 2016 to 1641 projected for 2017.

Arkansas has expanded Medicaid eligibility through its Section 1115 Waiver program.

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***: Arkansas Medicaid covers 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 safety net health benefit package called ARHealthNetworks (also called ARHealthNet) authorized under a 1115 waiver. The plan limited covered services with a $100 annual deductible, copayments set at 15% of allowable charges for covered services (not to exceed $1,000 per year and a maximum annual benefit of $100,000).

4. Current Medicaid Covered Services - verified as of 8/2018: ***Arkansas Division of Medical Services website:*** covered services for SUD treatment include addiction assessment and treatment planning, outpatient care, specialized women's services and early intervention. The following services are covered when they are part of a treatment plan: care coordination; counseling (group, individual and family/marital) and medication management. In March 2018, AR gained approval to impose work requirements of 80 hours with some exemptions (e.g., beneficiaries caring for dependent children, over age 54 or under age 19, in school or volunteering, etc.). The program was slated to be phased-in for the age group from 30-49 years in June of 2018 and for the age group from 19-29 years in 2019. More than a quarter of those required to enroll in the work program have not complied and could lose coverage in September 2018. ***A law suit specific to the AZ work requirement was filed in mid-August, but it is not yet clear what impact it will have on implementation.***

Prescription Drugs - PDL Formulary (updated 8/2018): The required prior authorization criteria for buprenorphine formulations involve ***detailed*** documentation of counseling (offered at only 8 approved locations throughout the state at costs dependent on income-driven eligibility). Documentation of AA or NA attendance may substitute if beneficiaries are unable to access an authorized SUD counseling provider. Re-certification is required monthly, initially with documentation of negative drug screens (UAs); coverage for periods ranging from 2-7 months may be authorized as treatment continues. Preferred medications: Suboxone film and buprenorphine mono formula SL tablets. Bunavail, Zubsolv and generic buprenorphine/naloxone tables are non-preferred, along with Vivitrol, Probuphine and Sublocade. Narcan nasal spray and naloxone do not require pre-approval, but there is a limit of 4 doses per 90-day period, after which a consultation with the prescriber is required. Methadone products were moved to non-preferred status in 2016. AR Medicaid does not cover methadone for OUD treatment.

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 for 2016 was 14.1 (per 100,000); rate of fatalities attributed to opioids: 5.9 (per 100,000); 2017 provisional CDC data show the number of drug overdose deaths increased more than 10% from 387 in 2016 to 428 projected for 2017.

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 8/2018: 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 primary care, MH and SUD facilities; and, residential and intensive outpatient services. As of August 2018, a total of 19 counties comprising 75% of the Medi-Cal population, are operating as pilot sites of the Drug Medi-Cal Organized Delivery System (DMC—ODS) to expand and improve SUD treatment under a 1115 waiver approved in 2017. SUD services are delivered to meet standards for quality and access, coordinating treatment (including MAT), and physical, and mental health services. Non-residential services do not require prior authorization and must be accessible 24 hours a day/7 days a week through a toll-free number. The waiver also overrides the IMD exclusion of Medicaid coverage for residential treatment in facilities with more than 16 beds.

Prescription Drugs - PDL Formulary (as of 8/2018): The flowing medications are listed as preferred on the Medi-Cal formulary as of 2/2018: buprenorphine/naloxone SL tablets-up to four 11.4 mg. tablets per day; Suboxone-up to four 12 mg strips per day; Bunavail buccal-up to four 6.3 mg films per day; and, buprenorphine mono formula SL-up to four 8 mg tablets per day. All are restricted to a maximum of 120 dosage units dispensed as a 30-day supply, subject to clinical criteria requirements. Disulfiram is a preferred drug, as is oral naltrexone (for relapse prevention of opioid or alcohol use disorders to be prescribed only by providers experienced in SUD treatment). Effective 2015, coverage for Vivitrol injections every 28 days with up to 6 refills was extended to adult Medi-Cal beneficiaries even if they have been '*charged with or convicted of a misdemeanor or felony and who are also under supervision by the county or state.'* Methadone oral solution is considered a 'carve out drug' covered through the Medi-Cal medical benefit. Naloxone vials and Narcan nasal spray are also preferred drugs that do not require preauthorization.

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 for 2016 was 11.2 (per 100,000); rate of fatalities attributed to opioids: 4.6 (per 100,000). 2017 provisional CDC data show the number of drug overdose deaths increased nearly 6% from 5,058 in 2016 to 5,357 projected for 2017.

Connecticut expanded 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 9/2018: ***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. Effective 2/1/18 new CMS approved guidelines for covered services and reimbursement rate for methadone maintenance from appropriately certified OTPs are available online at: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/Chemical-Maintenance-providers/CTSPA18_016_Chemical_Maintenance_Clinics_FINAL_APPROVED.pdf?la=en

Prescription Drugs - PDL Formulary (as of 8/2018): Suboxone film is listed on the PDL as the preferred brand drug that does not require PA. The following medications are also listed as preferred drugs but may require pre-authorization: buprenorphine mono formula SL 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 as a pharmacy benefit with new billing guidelines issued as of 2/2018 (see above). Vivitrol long-acting injections are covered under a pharmacy benefit and have recently been added to the PDL. **Note:** CT requires prescribers to consult prescription drug monitoring data before prescribing schedule II-V medications, every 90 days thereafter and to review schedule V non-narcotic medications annually. In June 2017 the Drug Utilization Review board issued a notice to providers to encourage naloxone distribution, which is available without a prescription from pharmacists, to prevent opioid overdose events among priority populations: *Using opioids after a period of abstinence (post-incarceration, post-addiction treatment, relapse).*

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 for 2016 was 27.4 (per 100,000); rate of fatalities attributed to opioids: 24.5 (per 100,000). Rates have increased from the previous year by 24% and 28%, respectively. 2017 provisional CDC data show the number of drug overdose deaths increased nearly 8% from 985 in 2016 to 1,060 projected for 2017.

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 2018: *Health First Colorado Website - Mental Health, Substance Use Disorder, or Behavioral Health Services:* Lists the follow covered services, mostly without limits or co-pays, although pre-authorization is sometimes required: alcohol and drug screening; counseling - group and individual, targeted case management, emergency and crisis services, medication-assisted treatment (in the case of certain non-preferred drugs); outpatient day treatment, detoxification services and inpatient/residential services. Colorado begin covering methadone treatment for opioid use disorders in 2014.

Prescription Drugs - PDL Formulary (updated as of 7/2018): Oral naltrexone is a preferred drug and does not require pre-authorization; Suboxone strips and generic buprenorphine/ naloxone tablets are preferred, with PA of required clinical criteria, at a maximum dosage of 24 mg daily. Non-preferred drugs: Acamprosate and Antabuse; Subutex, Bunavail, and Zubsolv SL tablets at a maximum dosage of 24 mg., all require prior authorization and annual re-authorization. Initial PA for non-preferred drugs may require verification of failure with preferred formulations, intolerance to naloxone or pregnancy (for buprenorphine mono formulations). Vivitrol injections administered in a provider's office require prior approval and are billed as a medical benefit. Methadone oral concentrate is listed as a non-preferred drug with low co-pays but may also require PA documenting patients meet clinical criteria. Narcan nasal spray and naloxone vials do not require PA and are limited to 15 doses per year. Sublocade buprenorphine depot injections have been added with specific criteria required for PA.

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 for 2016 was projected at: 16.6 (per 100,000); rate of fatalities attributed to opioids: 9.5 (per 100,000). Both rates increased from the previous year by less than 10%. 2017 provisional CDC data show the number of drug overdose deaths increased nearly 8% from 977 in 2016 to 1,052 projected for 2017.

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 2018: ***Delaware Department of Health and Human Services:*** In 2014, Delaware obtained CMS approval of a 1115 waiver amendment to implement the PROMISE program (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) to improve behavioral health clinical and recovery outcomes through better care coordination. The following services are provided: screening and evaluation; outpatient counseling; opioid treatment (including methadone maintenance); continuous treatment team programs for individuals with long-term, disabling alcohol and drug dependence disorders; less intensive case management services offered through the outpatient counseling agencies; detoxification; and residential services. The residential services include short-term/variable length-of-stay treatment (30 days or less), long-term treatment, and halfway houses. Care coordination and services for recovering individuals, services provided in opioid treatment programs include medications, medical monitoring/management, methadone dispensing, physical exams, counseling, lab work, and other assessment and treatment services are included in the benefit package.

Prescription Drugs – PDL Formulary (revised 7/2018): In July 2017**,** DE Medicaid lifted pre-authorization requirements for preferred drugs for treatment of OUDs. The current PDL lists the following as preferred medications: buprenorphine mono formula, oral naltrexone tablets; Suboxone film, Zubsolv and Sublocade and Vivitrol (which requires preauthorization for OUDs or AUDs). Non-preferred agents with pre-approval required: Bunavial, generic buprenorphine/naloxone SL tablets. Methadone provided by OTPs is also covered. Naloxone vials and Narcan nasal spray do not require pre-authorization or prescription from a physician under a standing order issued by the Division of Public Health; as of 7/2018 co-pays are no longer required.

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 for 2016 was: 30.8 (per 100,000); rate of fatalities attributed to opioids: 16.9 (per 100,000). Rates increased from the previous year by 40% and 14%, respectively. Provisional 2017 CDC data show the number of drug overdose deaths increased nearly 7% from 309 in 2016 to 330 projected for 2017.

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 8/2018: ***Washington D.C. Department of Behavioral Health website:*** 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 already receive benefits through the District's implementation of the expansion option under the ACA. The benefit package, managed care delivery system, and cost sharing requirements are the same as for traditional Medicaid. Substance abuse services can be accessed through the Assessment and Referral Center (ARC), which provides same day assessment and referral for individuals seeking treatment. As of 4/2018, MCOs are responsible for care coordination unless beneficiaries are enrolled in one of the Districts Health Home programs. Services include detoxification, treatment (including coverage for drugs used for MAT) individual and group counseling, self-help, risk reduction interventions and recovery support, as well as residential treatment in cases where clinical criteria are met. Women can bring their children under 10 years old to live with them in certain residential programs. Recovery Support services are also available.

Prescription Drugs – PDL Formulary (updated 2018): Preferred medications for treatment of opiate dependence that list no preauthorization requirements: naltrexone (oral), Suboxone film and naloxone syringe & vials and Narcan nasal spray. The following medications are listed as non-preferred, requiring pre-authorization: Bunavail, buprenorphine mono formula, buprenorphine/naloxone, Zubsolv, and Lycemyra (lofexidine for withdrawal). Methadone provided by OTPs is covered.

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 for 2016 was: 38.8 (per 100,000); rate attributed to opioids was: 30.0 (per 100,000). Both rates increased from the previous year by more than 100%. 2017 provisional CDC data show the number of drug overdose deaths increased just over 2% from 325 in 2016 to 332 projected for 2017.

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 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 8/2018: ***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. **Note:** As of 2018 additional opioid response funding subsidizes naloxone distribution and selected SUD treatment services.

Prescription Drugs – PDL Formulary (updated 8/2018): Sublocade was added to the PDL, with pre-authorization required. All buprenorphine formulations require pre-authorization and re-authorization every six months. The following are listed as preferred drugs: buprenorphine mono formula SL tablets, Suboxone strips (limited to a maximum of 3 strips or tablets per day – minimum age 16); methadone suspension - minimum age 18, and Vivitrol (380 mg ER suspension for injection-minimum age 18). Methadone provided by OTPs is covered. Acamprosate, oral naltrexone, naloxone vials, Narcan nasal products and disulfiram are preferred drugs that do not require prior authorization.

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 for 2016 was: 23.7 (per 100,000); rate of fatalities attributed to opioids at 14.4 (per 100,000). Rates increased from the previous year by 46% and 53%, respectively. 2017 provisional CDC data show the number of drug overdose deaths increased more than 5% from 5,196 in 2016 to 5,484 projected for 2017.

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 2018: ***Understanding Medicaid-Georgia Medicaid Handbook:*** Covered 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 IOP programs.

Prescription Drugs – PDL Formulary (updated 8/2018): PDL lists buprenorphine mono formula SL tablets, Suboxone, and Vivitrol as preferred medications (subject to pre-authorization; quantity limits apply). Naloxone vials and Narcan nasal spray are also preferred medications; Narcan requires pre-authorization. Acamprosate, disulfiram (generic) are preferred medications (quantity limits may apply). Methadone provided by OTPs is covered.

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 for 2016 was: 13.3 (per 100,000); rate of fatalities attributed to opioids: 8.8 (per 100,000). Both rates increased 5% over the previous year. 2017 provisional CDC data show the number of drug overdose deaths increased nearly 6% from 1,411 in 2016 to 1,491 projected for 2017.

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 2018: ***Hawaii Department of Human Services website:*** Medicaid plans list the following as covered services: substance abuse treatment programs (both inpatient and outpatient), prescribed drugs including medication management and patient counseling, and methadone treatment services.

Prescription Drugs – PDL Formulary (updated 2018): Medicaid managed care plans each have preferred drug lists. Most do not require preauthorization for the following: disulfiram; naltrexone tablets; buprenorphine mono formula, buprenorphine/naloxone SL tablets and Suboxone – with quantity limits of up to 24 mg per day. Naloxone vails are preferred and Narcan nasal spray is covered by some plans, subject to quantity limits. Acamprosate tablets are listed as preferred but require pre-authorization on some plans; Vivitrol is listed as a non-preferred drug. Methadone provided by OTPs is covered.

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 for 2016 was: 12.8 (per 100,000); rate of fatalities attributed to opioids: 5.2 (per 100,000). Rates increased from the previous year by 13% and 27%, respectively. Provisional 2017 CDC data show the number of drug overdose deaths decreased more than 5% from 214 in 2016 to 203 projected for 2017.

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 2018: ***Idaho Department of Health and Welfare website*** lists substance abuse treatment as a service covered by Medicaid. Services are available by a limited network of providers listed by region. The 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 2018): Suboxone, Vivitrol and naltrexone (oral), plus naloxone vial & syringe and Narcan nasal spray are preferred medications, but all require pre-authorization. Maximum daily dose of buprenorphine is 24 mg and can only be overridden with a request and justification by a physician. Non-preferred medications listed: Bunavial, Zubsolv, Probuphine implants, Sublocade buprenorphine extended release injections and buccal buprenorphine. Idaho Medicaid does not cover methadone for OUD detoxification or maintenance treatment.

Note: The Idaho's Response to the Opioid Crisis (IROC) program is supported by Federal State Target Response to the Opioid Crisis funding and supports MAT with methadone. It also provides recovery support to individuals reentering from jails and prisons. **To check eligibility call (800) 922-3406**.

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 for 2016 is projected at: 15.2 (per 100,000); rate of fatalities attributed to opioids: 7.4 (per 100,000). Rates increased from the previous year by 7% and 23%, respectively. Provisional 2017 CDC data show the number of drug overdose deaths at 226, which was the same as in 2016.

*Voters in Idaho will consider adoption of Medicaid expansion for individuals with incomes at up to 138% of Federal Poverty Level on the 2018 ballot.

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 2018: *Illinois Division of Alcoholism and Substance Abuse website:* Medicaid Managed Care Organizations (MCOs) are responsible for assisting individuals in locating covered substance abuse services. *Medicaid Managed Care Plans:* those qualifying for Medicaid or Medicare are offered six plan choices that all cover 'subacute medically necessary treatment services for alcoholism and other drug abuse provided in a setting besides an inpatient hospital.' Services must be a part of a treatment plan and include OP; IOP; residential rehabilitation; subacute detoxification, and psychiatric diagnostic services. Inpatient hospitalization for detoxification is also covered. A compare plans tool shows that two of the plans are rated highest on behavioral health services (Meridian and Illini-Care). The *DASA Policy Manual for Participants Covered Under the Department of Healthcare and Family Services Medical Programs, 2018* lists methadone as an adjunct to treatment as a covered service.

Prescription Drugs – PDL Formularies (updated 2018): All six MMC plans have PDLs available online. All of them offer coverage of preferred drugs available without pre-approval for alcohol and opioid use disorders, as well as naloxone agents. However, plans differ in the number of preferred products they cover, copay amounts and in some of the quantity limitations they apply. The most generous plan covers all opioid antagonists, including Vivitrol, without preauthorization requirements, as well as disulfiram and acamprosate. Most plans cover buprenorphine combination and mono formulations as preferred drugs with dosage limitations (24 mg maximum). Methadone oral solutions and concentrates were also listed as preferred drugs (quantity limits may apply). This information should be considered when selecting a Medicaid managed care plan.

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 for 2016 is project at: 18.9 (per 100,000); rate of fatalities attributed to opioids: 15.3 (per 100,000). Both rates increased from the previous year by 34% and 43%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,758 which is a 9% increase over the 2,524 reported in 2016.

Indiana has expanded Medicaid eligibility though its Section 1115 Waiver program.

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 9/2018: Indiana Medicaid website indicates a fee-for-service plan and one managed care plan cover the traditional Medicaid-eligible population, and the Health Indiana Plan (HIP) covers most of the adult expansion population under the state's 1115 waiver. All plans cover SUD treatment services including required inpatient detoxification services (and opiate withdrawal) and outpatient substance abuse treatment. *Medical Policy Manual, 2018*: *As of March 2018, most HIP plans now cover bundled payments to OTPs that include daily methadone for beneficiaries over age 18 addicted to opioids for 12 months, and for those under 18 who have two failed attempts at drug-free treatments.* Coverage for inpatient stays of up to 15 days per calendar month has also been added. The Medicaid website information listed information early in 2018 on the ***'Gateway to work'*** component, to be implemented in 2019 for some non-working HIP members with exceptions (medically frail, pregnant, in substance abuse treatment, primary caregiver for a pre-school age child or re-entering from a period in custody). Requirements are up to 20 hours a week of work activities for 8 out of 12 months per year (training, school, work readiness and job search and placement), but legal challenges in other states could affect implementation.

Prescription Drugs – PDL Formulary (updated 8/2018): Indiana has a comprehensive formulary for all Medicaid plans. Generic buprenorphine/naloxone and buprenorphine SL tablets are preferred, requiring minimal copays and no preauthorization. Maximum dose is 24 mg per day for up to 90 days and 16 mg thereafter. Vivitrol requires pre-authorization and higher co-pays. Naloxone vials and Narcan nasal spray are preferred drugs that do not require pre-authorization, but quantity limits may apply to naloxone (2 per day 90 days). Non-preferred medications include: Bunavail; buprenorphine/naloxone sublingual tablets and Zubsolv (subject to pre-approval criteria; quantity limits may apply). Methadone oral concentrate is listed with prior authorization required, subject to quantity limits.

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 for 2016 is projected at: 24.0 (per 100,000); rate of fatalities attributed to opioids: 12.6 (per 100,000). Rates increased from the previous year by 23% and 48%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,803 which is nearly a 15% increase over the 1,576 reported in 2016.

Iowa has expanded Medicaid eligibility through its Section 1115 Waiver program.

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 9/2018: ***Iowa Medicaid website*** programs include fee for service Medicaid and IA Health Link, which offers a selection of managed care plans to its expansion population, with coverage that varies according to qualifying income levels. Inpatient/residential SUD treatment services are covered by traditional fee for service Medicaid and by one of the managed care plans. Outpatient treatment is covered by all plans. Extent of covered services and copay requirements for beneficiaries with substance use disorders may vary across plans.

Prescription Drugs – PDL Formulary (updated 9/2018): Preferred medications that do not require preauthorization are: Acamprosate, disulfiram, Narcan nasal spray, naloxone vials, and oral naltrexone. All buprenorphine formulations require pre-authorization that documents clinical criteria and participation in counseling. Suboxone strips are preferred, with a maximum dose of 24 mg for up to 90 days and 16 mg after that. Renewal authorization requires an updated treatment plan. In October of 2017, Iowa Medicaid issued a letter clarifying that methadone dispensed by an authorized OTP is covered as a medical benefit without preauthorization. Non-preferred medications that require pre-authorization and documentation of medical necessity include: Vivitrol, Zubsolv, generic buprenorphine/naloxone and buprenorphine mono formula (with documentation of pregnancy or intolerance of naltrexone).

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 for 2016 is projected at: 10.6 (per 100,000); rate of fatalities attributed to opioids: 6.2 (per 100,000). Both rates increased slightly from previous years. Provisional 2017 CDC data show the number of reported drug overdose deaths at 336 which is nearly a 4% increase over the 325 reported in 2016.

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 9/2018: ***Kansas Department for Aging and Disability Services website:*** SUD treatment services are offered through three managed care plans under KanCare, the state's privatized program for the traditional Medicaid population: United Health Care Midwest, Sunflower State Health Plan, and until 12/31/18, Amerigroup. In 2019, Aetna Better Health of Kansas will replace Amerigroup. Services provided may include assessment and referral; acute detoxification; case management; crisis intervention: inpatient and outpatient treatment; opioid maintenance outpatient treatment (OBOT) with buprenorphine formulations; 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 block grant prioritize individuals with SUDs who are not covered by Medicaid, Medicare or private insurance. Coverage under United Health Care plans appears to offer the best coverage of MAT drugs for opioid and alcohol use disorders including naloxone and Narcan without PA requirements. However, Aetna policies generally support MAT and details of plan coverage will be available in 2019. Kansas is a non-expansion state that is proposing a work requirement as part of a 1115 waiver application under review. Kansas may consider expanding Medicaid eligibility with inclusion of a work requirement.

Prescription Drug Coverage – PDL Formulary (updated 9/2018): None of the medications approved for treating substance use disorders are listed on the Kansas Medical Assistance PDL. However, United Health Care lists prior authorization requirements for buprenorphine formulations (as if 4/2017), which require documentation of clinical criteria and participation behavioral treatment. Maximum dosage is 24 mg per day or equivalent for Suboxone film or SL tablets, Zubsolv, and Bunavail film, with Subutex requiring documentation of pregnancy or intolerance to naloxone. Re-authorization is required every 90 days. As of 10/2016, pre-authorization for up to 4 Probuphine implants (one every 6 months) is available for members meeting clinical criteria; additional requirements may apply. As of 2017, Kansas Medicaid included methadone maintenance in their credentialing application for behavioral health service providers. Kansas fee-for-service Medicaid and MMC plans may cover services at some OTPs.

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 for 2016 is projected at: 11.1 (per 100,000); rate of fatalities attributed to opioids: 5.1 (per 100,000). Both rates declined slightly from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 323 which is nearly a 3% increase from the 313 reported in 2016.

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 9/2018: Note: In January 2018, the state announced approval of work requirements of 80 hours per month with various rules for work activities and exceptions for Medicaid recipients, slated to roll out in July 2018. *However, a federal ruling in June of 2018 has blocked implementation of the state Medicaid work requirements.* The state website offers legal notices for providers and beneficiaries that announce the work program is on hold and invoices for premium payments should be ignored. Covered substance use disorder treatment services include: SBIRT; assessment; targeted case management; treatment plan development; IOP; peer support; individual, group and family psychotherapy, and inpatient treatment. Vivitrol and Suboxone are covered by Medicaid for medication-assisted treatment.

Prescription Drug Coverage – PDL and Formularies (updated as of 9/2018): KY Medicaid list links to preferred drug lists for five Medicaid Managed Care plans and for other Medicaid plans, which all have slight differences in preauthorization requirements. Suboxone is generally a preferred drug that requires PA verifying clinical criteria, subject to quantity limits. The following are listed on at least one PDL as not requiring pre-authorization: naltrexone tablets and Vivitrol. Acamprosate, disulfiram, naloxone vials and Narcan nasal solution are also covered but may require PA (some quality limits may apply). Buprenorphine mono formula SL and Zubsolv are listed as preferred, but with prior authorization required. MAT coverage should be a considered when selecting a managed care plan. Currently, KY Medicaid does not cover MAT with methadone.

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 was: $38,784,886.

6. Drug overdose fatality rate for 2016 is projected at: 33.5 (per 100,000); rate of fatalities attributed to opioids: 26.3 (per 100,000); both rates increased 12% from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,566 which is a 9% increase over the 1,437 reported in 2016.

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 2018: ***Medicaid Services - Louisiana Department of Health:*** adult beneficiaries are eligible to receive mental health rehabilitation services including addiction services (outpatient and residential) 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 (with pre-approval required for some services). 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 at risk for out-of-home placement. Medications 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; however, methadone may be subsidized by federal block grant and State Targeted Response to the Opioid Crisis funding.

Prescription Drug Coverage - PDL Formulary, July 2018 – Suboxone, naltrexone tablets, Narcan nasal spray and naloxone syringe & vial are preferred drugs for opioid dependency that do not require pre-authorization. As of 2018, naloxone limits apply (2 covered administrations per 90-day period for most types) but can be overridden in emergency cases. Pre-authorization required for non-preferred drugs: Bunavail, Zubsolv, buprenorphine tablets, Vivitrol (covered for beneficiaries over 18 meeting clinical criteria) and Probuphine implants (age 16 and up only with no renewals). In April of 2016, Louisiana amended the formulary to include the following limits: a maximum of 24 mg of buprenorphine (or equivalent) for initial 90-day period, and 16 mg after that. Methadone is only covered for treatment of chronic pain, but according to the 2017 report of the Louisiana Commission on Preventing Opioid Abuse, expanding Medicaid coverage for methadone is under consideration and it is anticipated to go into effect in 1-2 years. Effective September 2018, Sublocade buprenorphine injections may be covered for beneficiaries meeting clinical criteria.

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: $198,511,241.

6. Drug overdose fatality rate for 2016 is projected at: 21.8 (per 100,000); rate of fatalities attributed to opioids: 7.7 (per 100,000). Both rates increased from the previous year by 15% and 2%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,103 which is nearly a 10% increase over the 1,004 reported in 2016.

Maine voters a passed referendum to expand Medicaid eligibility in November 2017, but the governor refuse to fund its implementation. In August of 2018 the Maine Supreme court rejected the governor's request to delay Medicaid implementation, but the state needs to prepare and file its plan with CMS. The original ballot question, as written, gave DHHS 90 days to submit a plan to the federal government and 180 days to cover to adults with incomes below or equal 138% of FPL.

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 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. A 2017, CMS approved a 1115 waiver that extended Medicaid eligibility to childless adults with income at or below 100% of the Federal Poverty Level.

4. Current Medicaid Covered Services – verified as of 2/2018: ***MaineCare (Medicaid) Rules regarding Substance Abuse:*** As of 2016, medication-assisted treatment with methadone is covered for beneficiaries, subject to 24-month limitation and requirements that tapering/withdrawal from medication is discussed with the patient during the first 60 days of treatment and quarterly thereafter if not earlier. Suboxone is subject to the same duration limits and other clinical criteria. No information is available on the Maine Medicaid website re: the expansion referendum. Maine's 1115 waiver, submitted to CMS in 2017 is still under review, and includes work requirements, asset testing and monthly premiums. It could be affected be legal challenges to work requirements in other states. that has not yet been approved but could be affected by legal challenges. Maine Opioid Health Homes for people receiving buprenorphine or naltrexone is an initiative partially funded by federal STR Opioid Response grant monies.

Prescription Drug Coverage - PDL Formulary, July 2018 – Antabuse, disulfiram and oral naltrexone tablets are preferred medications for alcohol use disorders; Acamprosate is non-preferred (step therapy with preferred medications required). Suboxone film, Vivitrol, and Narcan nasal spray are preferred medications for opioid use disorders. A 24-month limited applies to Suboxone, with PA and recertification requirements that include a titration plan. Suboxone tablets, Bunavail, Zubslov and buprenorphine mono formula tablets (limited to use for pregnant women), Probuphine implants and Sublocade are non-preferred medications that require pre-approval, step therapy or documentation of adverse reactions to preferred drugs. Prior authorization is needed to restart treatment after a prior 24 month-period to assess risk of relapsing or evidence of relapse. Maximum buprenorphine dose is 32 mg for the first 60 days and 16 mg thereafter. Methadone is listed as non-preferred. Established opioid users must have a trial and failure of at least 2 preferred drugs for at least 2 weeks to gain approval for methadone treatment. 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 for 2016 is projected at: 28.7 (per 100,000); rate of fatalities attributed to opioids: 25.2 (per 100,000). Both rates increased from the previous year 55% and 31%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 409 which is nearly a 15% increase over the 357 reported in 2016.

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 Medicaid managed care 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 in accordance MCO formularies. Some do not cover treatment services rendered in hospitals or certain hospital outpatient clinics.

Prescription Drug Coverage - PDL Formulary, July 2018: Pre-authorization of clinical criteria required for Vivitrol injections with diagnosis of opioid or alcohol use disorder and enrollment in a comprehensive management program including psychosocial support. Requirements for Acamprosate are similar, but also require a history of treatment failure with naltrexone or disulfiram. Preferred buprenorphine/ naloxone combination therapies without preauthorization requirements include: Zubsolv and Suboxone. Bunavail requires clinical criteria and is subject to quantity limits equivalent to a maximum of 16 mg. For Subutex no preauthorization or clinical criteria applies 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 pre-authorization required. Narcan and naloxone vials do not require preauthorization. Methadone dispensed provided by OTPs is covered.

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 for 2016 is projected at: 33.2 (per 100,000); rate of fatalities attributed to opioids: 29.7 (per 100,000). Rates increased from the previous year 59% and 68%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,282 which is a 10% increase over the 2,074 reported in 2016.

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: administration/dispensing of FDA-approved medications for opioid use disorders; individual, group, and family/couples counseling; services provided by acute inpatient treatment providers. Counseling is limited to four sessions (individual, group, or family/couple) per member per week. Covered outpatient counseling services are individual, group, and family/couples counseling; case consultation; and acupuncture detoxification/acupuncture treatments, supportive motivational services; and special substance use disorder treatment services for pregnant members (intensive outpatient program services; day treatment; enhanced acute inpatient treatment). Coverage limitations: oral opioid agonist medication is limited to amounts and frequency set forth in by regulations.

Prescription Drug Coverage - PDL Formulary, September 2018: The MassHealth PDL is 750 pages with complex criteria, summarized as follows: No preauthorization required for Vivitrol, disulfiram, Acamprosate, naltrexone tablets, oral methadone formulations dispensed by OTP's or for any form of naloxone. Preferred buprenorphine formulations include Suboxone and generic buprenorphine SL tablets, prescribed at doses less than or equal to 16 mg per day for clients meeting clinical criteria. However, when doses exceed standard MassHealth limits or are prescribed for periods longer than higher doses are permitted, prior authorization criteria are more extensive. For example, preauthorization is required, even for the preferred drugs, under the following conditions: dosage exceeds 32 mg per day; dosage exceeds 24 mg for longer than a 90-day period, or dosage exceeds 16 mg for longer than 180 days. All non-preferred medications require preauthorization including Zubsolv, Bunavail, Probuphine implants, Subutex or generic mono-formulas as well as generic buprenorphine/naloxone products.

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 for 2016 is projected at: 33.0 (per 100,000); rate of fatalities attributed to opioids: 29.7 (per 100,000). Both rates increased by more than 25% from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,138 which is just over a 2% decrease from the 2,198 reported in 2016.

Michigan has expanded Medicaid eligibility through its 1115 Waiver program.

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; mat and residential treatment. In *June 2018, the Michigan governor signed a bill requiring able-bodied Medicaid beneficiaries to work up to 80 hours a month, for nine months out of the year, with some exceptions.* The provisions are slated to go into effect in 2020 but could be affected by litigation that is underway in other states, especially some the provisions that may require beneficiaries to pay premiums.

Prescription Drug Coverage - PDL Formulary, September 2018; Treatment for Opioid Dependence Memo 6/2018: Methadone oral solutions are carved out of pharmacy benefits but are covered (quantity limitations may apply). Disulfiram, Acamprosate, oral naltrexone, Vivitrol, naloxone vails and Narcan (also covered for family members and others) are preferred medications available without PA. The following can be pre-authorized for up to 12 months at a maximum dosage of 24 mg: Bunavail film; Subutex; buprenorphine mono formula SL tablets; buprenorphine/naloxone SL tablets; Suboxone strips and Zubslov, with counseling required for treatment naïve patients. Sublocade has also been added. No limits on duration, but after one year, renewal requests are reviewed on a case by case basis and should include an ongoing treatment plan, a report of compliance, attendance and counseling participation etc. Methadone dispensed by OTPs is covered.

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 for 2016 is projected at: 24.4 (per 100,000); rate of fatalities attributed to opioids: 18.5 (per 100,000). Rates increased from the previous year by 20% and 38%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,665 which is nearly a 14% increase over the 2,342 reported in 2016.

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 7/2018: ***Minnesota Department of Health and Human Services website:*** Alcohol and Drug Services lists the following covered services: non-residential 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 are covered by contracted providers at daily rates and are required to co-ordinate care. 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, July 2018: No pre-authorization is required for Vivitrol, methadone oral concentrate, oral naltrexone, Acamprosate, disulfiram tablets or naloxone and Narcan. Suboxone film is a preferred medication that requires preauthorization with a maximum dosage of 24 mgs. Non-preferred medications also require prior authorization: buprenorphine/naloxone SL tablets, buprenorphine mono formula SL tablets, Zubsolv, Probuphine implants and Sublocade buprenorphine depot injections.

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 for 2016 is projected at: 12.5 (per 100,000); rate of fatalities attributed to opioids: 7.4 (per 100,000). Both rates increased almost 20% from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 728 which is a 10% increase over the 664 reported in 2016.

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 September 2018: ***Mississippi Division of Medicaid website*** lists covered mental health services on the Special Mental Health Initiatives page as including inpatient detox for chemical dependency. MS Medicaid does not cover alcohol and drug treatment; however, rules for psychiatric care apply if there is a primary mental health diagnosis. 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. MS is also one of the non-expansion states proposing work requirements through a waiver program. Because eligibility for Medicaid is restricted to those with incomes at only 27% of poverty level or less, the proposed 20 hour per week work requirement would put the annual income for individuals making minimum wage over the $4,444 limit, but under the income level required to purchase insurance on the exchange and qualify for tax credits. Legal challenges may impact MS's plans.

Prescription Drug Coverage - PDL Formulary, 2018: Oral naltrexone, Narcan nasal spray and naloxone vials are listed as preferred medications that do not require preauthorization. Suboxone is preferred with pre-authorization and maximum dose of 24 mg (up to 60 days) and then 16 mg. Non-preferred medications which require pre-authorization include: buprenorphine mono formula tablets (only for pregnant women), buprenorphine/naloxone tablets, Bunavail and Zubslov. Vivitrol was included on some of the managed care plan PDLs but does not currently appear on the 2018 universal PDL. Medicaid may cover some the of costs for methadone treatment at OTPs for some beneficiaries.

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 for 2016 is projected at: 12.1 (per 100,000); rate of fatalities attributed to opioids: 6.3 (per 100,000). The rate of opioid deaths increased 17% from the previous year. Provisional 2017 CDC data show the number of project number of drug overdose deaths at 340, which is the same as for 2016.

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. Services for youth are covered. 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 copay for physician and related services is applicable and any other amounts may payable to hospitals or laboratories for services.

4. Current Medicaid Covered Services – verified as of 2018: ***Missouri Division of Behavioral Health website****:* provides information on 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; 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. CSTAR Opioid-consists of MAT programs designed for medically supervised withdrawal from heroin and other opiate drugs, followed by ongoing treatment. Missouri Division of Behavioral Health 2018 listing of Opioid Treatment Programs includes five that accept Medicaid. Missouri has had at least legislative bill under consideration that proposes work requirements, but several policy papers examining the impact of such requirements have shown most of the traditional Medicaid-eligible population (incomes at or less than at 24% of poverty level) are in poor health or living rural areas.

Prescription Drug Coverage - PDL Formulary, 2018: The revised PDL for opiate dependence agents list Suboxone film (maximum 24 mg dose), oral naltrexone and Vivitrol as preferred medications, with one 14-day supply of Suboxone or naltrexone covered without diagnosis. Non-preferred medications are available with pre-authorization criteria including buprenorphine mono formula SL tablets and Subutex (for pregnant women); Bunavail; buprenorphine/naloxone tablets; Zubsolv and Probuphine. Methadone oral solutions are generally covered when provided by OTPs. Preauthorization for Narcan has been eliminated.

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 for 2016 was projected at: 23.6: 18.2 (per 100,000); rate of fatalities attributed to opioids: 15.9 (per 100,000). Both rates increased by about a third from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,398 which is a slight increase over the 1,386 reported in 2016.

Montana has expanded Medicaid eligibility through its 1115 Waiver program.

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 2018: ***Montana Medicaid Member Guide:*** Effective May 2018, a new Addictive and Mental Health Services guide for providers lists pre-authorization as only required for medically necessary inpatient services; not required for outpatient and day treatment services. The following outpatient services are covered: screening and assessment; intensive OP and day hospitalization, individual, group or family counseling; and targeted case management. Services are subject to coverage limits. According to a 2017 report by the Montana Health Care Foundation, the state has only four OTPs that dispense methadone and have just begun to bill Medicaid for some of their services, excluding services on the SUD fee schedule that may only be billed by State-approved facilities. As of 2018, MT Medicaid offers fee-for-service and at least one managed care plan, which covers most of the expansion population (Blue Cross/Blue Shield, MT).

5. Prescription Drug Coverage - PDL Formulary, August 2018: Preferred medications for treatment of opioid use disorders are listed as: oral naltrexone, Suboxone and buprenorphine mono formula SL tablets (clinical criteria and quantity limits apply). The MMC formulary does not list prior authorization requirements for preferred medications. Maximum buprenorphine dose is 24 mg for the first 6 months with participation in counseling required. Additional 6-month approvals are for 16 mg maximum dosage. Narcan nasal spray and naloxone vial and syringe are also preferred and do not require preauthorization. Non-preferred medications are listed as: Bunavail; buprenorphine/naloxone sublingual tablets, Zubsolv, Vivitrol and Lycemyra - all require PA. Montana has only four OTPs that have only just begun to bill Medicaid for some of their services, excluding those on the SUD fee schedule that may only be billed by State-approved facilities.

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 for 2016 is projected at: 11.7 (per 100,000); rate of fatalities attributed to opioids: 4.2 (per 100,000). Both rates decreased by about 15%. Provisional 2017 CDC data show the number of reported drug overdose deaths at 118 which is a slight increase over the 114 reported in 2016.

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, group and family psychotherapy or substance abuse counseling. Services are generally covered for only for Medicaid eligible groups such as youth and pregnant women. 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. Most Medicaid SUD services are contracted to an MCO (Magellan).

Prescription Drug Coverage - PDL Formulary, September 2018: Oral naltrexone, Antabuse, disulfiram and Acamprosate are covered naloxone products and Narcan nasal spray are covered without preauthorization. Suboxone is listed as a preferred drug that does not requires pre-authorization and is subject to some limitations. Buprenorphine mono formula SL tablets, methadone oral concentrates are non-preferred drugs that require pre-authorization and are subject to limitations. Vivitrol is not listed, but non-preferred agents may be covered with prior authorization.

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 for 2016 is projected at: 6.4 (per 100,000); rate of fatalities attributed to opioids: 2.4 (per 100,000). Both rates have decreased from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 157 which is a 39% increase over the 113 reported in 2016.

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, family and group therapy; therapy in home or community settings; skills training & development; psychosocial rehabilitation and self-help/peer support. SBIRT is covered without pre-approval. Inpatient and outpatient detoxification is covered within limits with clinical pre-authorization. Medication-assisted treatment including direct observation of oral medications (including methadone) to treat opioid dependence/withdrawal given at OTPs, requires pre-authorization and is covered within quantity limits.

Prescription Drug Coverage - PDL Formulary, September 2018: Suboxone, Bunavail, Zubsolv, oral naltrexone, Vivitrol, and disulfiram are preferred drugs, but all require preauthorization. Acamprosate and methadone are non-preferred but are covered by all plans with pre-authorization criteria. Narcan nasal spray and naloxone vial and syringe are preferred drugs that do not require pre-authorization. Note: Nevada DOC and Behavioral Health is participating in a pilot with Titan Pharmaceuticals of Probuphine buprenorphine implants; however, the implants are not included on the most recent Medicaid formulary.

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 for 2016 is projected 21.7: 18.4 (per 100,000); rate of fatalities attributed to opioids: 13.3 (per 100,000). Drug overdose death rates increased slightly from the previous year, while opioid deaths decreased slightly. Provisional 2017 CDC data show the number of reported drug overdose deaths at 754 which is a nearly a 7% increase over the 707 reported in 2016.

New Hampshire has expanded Medicaid eligibility through its 1115 Waiver program.

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 September 2018: ***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 at OTPs; individual, group and family counseling; crisis intervention; SBIRT; treatment with buprenorphine at OTPs or office-based MAT from 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. In May of 2018 CMS approved a work Medicaid requirement. Re-authorization of the Medicaid expansion program by the NH state legislature was contingent on this approval. Requirements for beneficiaries ages 19-64 are 100 hours of 'community engagement activities including work, job training or community service, with exceptions for people with children up age 12, drug court participants, and those with disabilities, to take effect in 2019. It is not clear if the plan will open the state up to legal challenges.

Prescription Drug Coverage - PDL Formulary, 2018: Both preferred and non-preferred medications for OUDs require pre-authorization. Suboxone and generic buprenorphine mono formula SL tablets and generic buprenorphine/naloxone SL tablets are listed as preferred medications (quantity limits and copays apply). Non-preferred medications are: Bunavail and Zubsolv. Two MMC plans that cover most of the expansion population have formularies that list Acamprosate, Antabuse, oral naltrexone tablets and naloxone vials as preferred, not requiring pre-authorization, but and Narcan nasal spray is limited to one kit per month. Vivitrol is covered subject to quantity limits but requires PA and 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 for 2016 is projected at: 39.0 (per 100,000); rate of fatalities attributed to opioids: 35.8 (per 100,000). Both rates have increased 14% since the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 478 which is a nearly a 5% increase over the 458 reported in 2016.

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 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 – as of October 2018: ***NJ Department of Human Service website:*** New Jersey's substance abuse treatment services announced additional SUD services including MAT, IOP and partial hospitalization programs as well as hospital-based acute treatment and residential treatment. 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 at OTPs, which cover medication and the following services: case management, medication dispensing, counseling and medication monitoring. Oral naltrexone and Vivitrol continues to be reimbursed by Medicaid through fee for services initiatives. The new alternative benefit plan includes intensive outpatient, outpatient, partial care, short term residential, detox, and opioid treatment, as well as the new additional services listed above.

Prescription Drug Coverage - PDL Formulary, 2018: Medicaid managed care plans have formularies/PDLs that may differ slightly, and coverage should be considered when selecting plans. Methadone oral solution is listed as covered subject to quantity limits but may require prior authorization. Generally, preferred medications not requiring pre-authorization are listed as: Acamprosate, disulfiram, oral naltrexone and naloxone and Narcan (quantity limits may apply). Buprenorphine mono formula SL tablets are preferred and may not require prior authorization, but quantity limits may apply. Suboxone and generic buprenorphine/naloxone SL tablets 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 for 2016 is projected at: 23.3 (per 100,000); rate of fatalities attributed to opioids: 16.0 (per 100,000); rates increased from the previous year by 42% and 63%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,621 which is a nearly a 33% increase over the 1,971 reported in 2016.

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 2/2018: NM Department of Human Services website: As of 2014, Medicaid covered medication-assisted treatment for opioid addiction at certified OTPs and the initial medical examination for beneficiaries meeting the DSM criteria. Specified criteria for maintenance treatment include: addicted for at least 12 months prior to starting MAT (unless pregnant, released from a penal institution within the last six months or prior treatment for opioid dependence within the last 24 months). 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 provider'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, substance abuse and HIV counseling and other services performed by the agency, unless otherwise described as separate. In July of 2017, Medicaid expanded coverage of prescribed Narcan kits for people at-risk for opioid overdose.

Prescription Drug Coverage - PDL Formulary, July 2018: Preferred drugs (coverage subject to quantity limits) include disulfiram and Antabuse; naloxone and Narcan nasal spray; oral naltrexone. All buprenorphine formulations require prior authorization according to the MCC formulary and are subject to quantity limits and clinical criteria including buprenorphine mono and buprenorphine/ naloxone SL tablets, Bunavail, Suboxone, and Zubsolv. Methadone concentrate 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 for 2016 is projected at: 25.2 (per 100,000); rate of fatalities attributed to opioids: 17.5 (per 100,000). Rates are stable or have decreased slightly from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 495, the same as reported in 2016.

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 3/2018: ***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, July 2018: In 8/2016, the state enacted changes to Social Services Law section 364-j, and Public Health Law section 273. Medicaid Fee-for-Service and Medicaid Managed Care cannot require prior authorization for initial or renewal prescriptions for preferred or formulary buprenorphine or injectable naltrexone when used for detoxification or maintenance treatment of opioid addiction. Suboxone and buprenorphine are listed as preferred agents with Zubsolv and Bunavail listed as non-preferred; all are subject to quantity limits. Methadone oral concentrate; disulfiram and Acamprosate, and oral naltrexone are available with pre-authorization. Narcan nasal spray, naloxone vials, and oral naltrexone are listed as preferred without pre-authorization required. The state has several MMC plans, but pharmacy benefits should be provided as outlined above. An online look-up is available to verify drug coverage across plans.

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 for 2016 projected at: 18.0; rate of fatalities attributed to opioids: 15.1 (per 100,000). Rates have increased by more than a third from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,444 which is nearly the same as for 2016.

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 – as of 2018: ***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). The state has considered work requirements for the traditional Medicaid eligible population, but none have been proposed. Analysis of the current covered population does not indicate many beneficiaries would be able to participate in work activities.

Prescription Drug Coverage - PDL Formulary, August 2018: Preferred list includes: Vivitrol, naltrexone (oral), and naloxone syringe & vial and Narcan nasal spray. All buprenorphine formulations require documentation of clinical criteria: Suboxone and Sublocade are preferred. Non-preferred medications that require pre-approval (criteria may require failure of two preferred agents) are: Bunavail; buprenorphine mono and buprenorphine-naloxone SL tablets, and Zubsolv. Formulary indicates that not all covered drugs are listed. Methadone provided by OTPs is covered.

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 for 2016 is project at: 19.7 (per 100,000); rate of fatalities attributed to opioids: 15.4 (per 100,000). Both rates increased from the previous year by 25% and 29%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,366 which is a nearly a 22% increase over the 1,931 reported in 2016.

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, the state updated its standards for OTP's to ensure appropriate access to all FDA approved mediations for treating addiction 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) with minimal co-pays. Inpatient services require pre-authorization and a co-pay of $75 per stay. Benefit limited only to certain facilities.

Prescription Drug Coverage - PDL Formulary, 2018: For Vivitrol is preferred for treatment of alcohol and opioid use disorders without pre-authorization required. Zubslov is preferred with clinical pre-authorization requirements. Other buprenorphine formulations may be pre-authorized after a 30-day trial of preferred drug except mono formulas during pregnancy. Acamprosate and disulfiram are preferred drugs that do not require pre-authorization. Oral naltrexone and methadone are covered but require pre-authorization and minimal co-pays.

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 for 2016 is projected at: 10.6 (per 100,000); rate of fatalities attributed to opioids: 7.6 (per 100,000). Both rates increased from the previous year 23% and 58%, respectively. Provisional 2017 CDC data show the number of reported drug overdose deaths at 76 which is a slight decrease from the 80 reported in 2016.

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 Services webpage, Medicaid coverage for methadone administration, buprenorphine induction, and injections of naltrexone are all explicitly listed. Reimbursement guidelines for naloxone kits and administration are also provided.

Prescription Drug Coverage - PDL, September 2018: Preferred agents can be dispensed for 7 days without pre-authorization: Suboxone and Zubsolv require preauthorization for the next 30 days and then every 6 months, with dosage maximums at 16 mgs. and 11.4 mgs., respectively. Vivitrol does not require pre-authorization. Methadone oral concentrate/solutions are listed as non-preferred drugs that require pre-authorization. Buprenorphine mono formula SL; Bunavail, and buprenorphine/naloxone SL tablets are non-preferred medications, also requiring pre-authorization. Methadone provided by OTPs is covered.

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 for 2016 was 39.1 (per 100,000); rate of fatalities attributed to opioids: 32.9 (per 100,000). Both rates increased by nearly a third from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 5,138 which is nearly a 19% increase over the 4,326 reported in 2016.

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 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 2018: ***OK Health Care Authority website*** states that 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 OK Healthcare Authority lists SUD services and providers that deliver inpatient acute care, 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, 2018: Suboxone is listed as a preferred medication available with documentation of clinical criteria at a maximum dose of 24 mgs daily. Request for higher dosages are considered on a case by case basis for 30 days with taper schedule). Subutex is a non-preferred drug requiring pre-approval for 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. Medicaid fee-for-service does not cover methadone through opioid treatment programs.

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 for 2016 is projected at: 21.5 (per 100,000); rate of fatalities attributed to opioids: 11.6 (per 100,000). Rates increased slightly since the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 769 which is a nearly a 5% decrease over the 808 reported in 2016.

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 2018: ***Medication-Assisted Treatment and Recovery (MATR) webpage:*** Opioid Treatment Program services are covered with pre-authorization after review of documentation. Clinical 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 – Oregon Fee for Service Enforceable Physical Health PDL Formulary, 2018: Preferred medications that do not require pre-authorization include: Acamprosate, buprenorphine mono and buprenorphine/naloxone SL tablets (Zubsolv), Suboxone; Vivitrol, oral naltrexone and naloxone spray, vial & syringes. Dosages of buprenorphine formulation that exceed 24 mgs and Probuphine implants require PA but may be covered by the Oregon Health Plan. Not by all managed care plans offer them, which may be a consideration in plan selection. Methadone provided by OTPs is covered.

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: 11.9 (per 100,000); rate of fatalities attributed to opioids: 7.6 (per 100,000). Rates have decreased slightly from previous 2 years. Provisional 2017 CDC data show the number of reported drug overdose deaths at 534 which is nearly an 8% increase over the 496 reported in 2016.

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. 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 – as of 2018: ***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 state law. Buprenorphine formulations 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 and a documented history of therapeutic failure. 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. The Governor of Pennsylvania announced as of March 2018, Medicaid pre-certification requirements for medications that are FDA-approved and considered "evidence-based" treatments for opioid addiction will be lifted and pledged to ask private insurers to do the same.

Prescription Drug Coverage - PDL Formulary, July 2018: Preferred medications include: Suboxone; buprenorphine mono formula SL tablets, oral naltrexone, methadone oral solutions/concentrates and Vivitrol. Prior authorization is no longer required, as of 4/10/18; however, documentation of medical necessity is required for buprenorphine mono formula, dosages that exceed quantity limits, patients also prescribed benzodiazepines and for any non-oral buprenorphine product (Probuphine implants and Sublocade depot injections. Quantity limits are listed for each product, but 16 mgs. appears to be the maximum dose for Suboxone. Naloxone syringe & vials, oral naltrexone and Narcan nasal spray do not require prior authorization. The following are listed as non-preferred drugs with additional pre-approval criteria: Acamprosate, disulfiram, buprenorphine/naloxone SL tablets, Bunavail, Zubsolv, Sublocade depot injections and Probuphine implants. Methadone provided by OTPs is covered.

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 is projected for 2016 at: 37.9 (per 100,000); rate of fatalities attributed to opioids: 18.5 (per 100,000). Rates increased 44% and 65% from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 5,430 which is just over a 17% increase from the 4,648 reported in 2016.

Rhode Island has expanded Medicaid eligibility.

1. In 2013 ASAM reported: according to Rhode Island's 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 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:*** Covered 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, June 2018: 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 mono formula SL tablets. Naloxone syringe & vial and Narcan nasal spray are also preferred. Pre-authorization is required for Vivitrol, Zubsolv, buprenorphine/ naloxone SL tablets, Sublocade buprenorphine depot injections and Probuphine implants. Methadone provided by OTPs is covered.

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: 30.8 (per 100,000); rate of fatalities attributed to opioids: 26.7 (per 100,000). Both rates were up 9% and 14%, respectively from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 332 which is just over a 4% decrease from the 346 reported in 2016.

South Carolina has not expanded Medicaid eligibility.

1. In 2013 ASAM reported: South Carolina 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 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 2018: ***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. Effective January 2018, selected medication-assisted treatment services via telemedicine will be covered by Medicaid. Methadone treatment does not appear to be covered. Early in 2018, the governor of the state directed Medicaid to seek permission to impose work requirements. However, an estimated 83% of the state's Medicaid beneficiaries are elderly, disabled of children.

Prescription Drug Coverage - PDL August 2018: Buprenorphine mono formula SL tablet, buprenorphine/naloxone SL tablets, Suboxone and Sublocade are list as preferred for MAT on the most recent PDL, along with Narcan and naloxone for emergency treatment. A search of the SC Medicaid online prescription drug look-up (inclusion of a medication is not a reflection of coverage) lists Vivitrol as a preferred drug along with oral naltrexone, disulfiram, (some are subject to quantity and age limits). Methadone oral concentrate, acamprosate and Suboxone were not included.

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 for 2016 is projected at: 13.1 (per 100,000); rate of fatalities attributed to opioids: 18.1 (per 100,000); both rates increased 15% over the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,001 which is a 15% increase over the 871 reported in 2016.

South Dakota has not expanded Medicaid eligibility.

1. In 2013 ASAM reported: South Dakota 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 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; alcohol/substance abuse structured assessment and intervention and brief alcohol misuse counseling. 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, effective 11/2017, the state Medicaid website indicates it will use OpturnRx to process pharmacy claims and Pas. OptunRs PA requirements for buprenorphine formulations (Bunavail, Suboxone, generic mono formula and combination SL tabs and Zubsolv requires clinical criteria are met and approval of the requested starting dosage, as well as verification that the patient is not prescribed other opioids or certain other medications. 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 for 2016 is projected at: 8.4 (per 100,000); rate of fatalities attributed to opioids: 5.0 (per 100,000). All overdose death rate was flat, but a 43% increase in opioid deaths from the previous year was reported. Provisional 2017 CDC data show the number of reported drug overdose deaths at 75 which is just over a 6% increase from the 69 reported in 2016.

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, the TennCare program has 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 3/2018: ***TN Division of Health Care Finance & Administration - TennCare webpage:*** All TennCare plans cover medically necessary inpatient and outpatient substance abuse services. Medically necessary methadone clinic services are covered only for beneficiaries under 21. A note on the 2018 formulary indicates methadone for treatment of opioid use disorders is not paid for by TennCare. Most treatment other 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. TennCare has added an Opioid Strategy guide effective 2018. All three MMC plans adhere to standard that encourage timely prior authorization when required and referral to counseling.

Prescription Drug Coverage - PDL Formulary, 2018: Narcan nasal spray, Bunavail, naltrexone tablets are listed as preferred drugs, requiring PA and subject to quantity limits. Buprenorphine mono formula, Suboxone, 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. Narcan is listed subject to PA and quantity limits.

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 for 2016 is projected at: 24.5 (per 100,000); rate of fatalities attributed to opioids: 18.1 per 100,000. Rates increased 10 % and 13 % respectively since the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,784 which is nearly a 9% increase over the 1,643 reported in 2016.

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 2018: no changes to the information provided below were noted. *Texas Department of State Health Services website*: Medicaid substance use disorder treatment services include outpatient services (assessment, ambulatory detox, individual and group outpatient counseling, medication-assisted therapy, and residential services. "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, update 3/2018: Preferred medications listed are: Suboxone film; buprenorphine mono formula; naltrexone (oral); naloxone syringe & vial and Narcan. 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. Methadone provided by OTPs is only covered for pregnant women and under certain circumstances for adolescents and others by fee for service Medicaid. There is no billing provider type in Texas Medicaid for an OTP or narcotic treatment clinic. OTPs must either submit claims using the physicians' provider identifier, or as a Department of State Health Services (DSHS) licensed chemical dependency treatment facility.

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 for 2016 is projected at: 10.1 (per 100,000); rate of fatalities attributed to opioids: 4.9 (per 100,000); rates increased only slightly from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 2,950 which is a 5% increase over the 2,812 reported in 2016.

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 with some limitations and copays and 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 2018: In January 2018, implementation of limited eligibility expansion under Utah's 1115 waiver program is projected to cover up to 6,000 additional childless adults. **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. Utah also has submitted a waiver plan for CMS approval that would expand Medicaid eligibility and include a work requirement.

Prescription Drug Coverage - PDL Formulary, August 2018: Suboxone, Vivitrol and naltrexone tablets are listed as preferred, with PA of clinical criteria. Bunavail, Zubsolv, buprenorphine mono formula SL tablets and buprenorphine/naloxone SL tablets may also be coverage with prior authorization of an override of preferred agents and may be subject to quantity limits. Sublocade and Vivitrol must be dispensed by the prescriber.

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 2016 is projected to be: 22.4 (per 100,000); rate of fatalities attributed to opioids: 16.4 (per 100,000); rates have been fairly stable from the previous year. Provisional 2017 CDC data show the projected number of drug overdose deaths at 671 which is a nearly a 14% decrease from the 771 projected for 2016. However, it should be noted data is still incomplete for both years.

*Voters in Utah will consider adoption of Medicaid expansion for individuals with incomes at up to 138% of Federal Poverty Level on the November 2018 ballot.

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 2018: ***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 OTPs, of which Vermont currently has five. Approximately 150 physicians can prescribe buprenorphine in Vermont."

Prescription Drug Coverage – PDL, August 2018: Suboxone, naltrexone (oral), Acamprosate, disulfiram, methadone oral concentrate (10 mg/ml) and naloxone vials and Narcan are preferred drugs that do not require pre-approval (clinical criteria apply to some). Maximum maintenance dose is 16 mg for buprenorphine products and a maximum prescribed supply of 14 days. Buprenorphine/naloxone or buprenorphine mono formula SL tablets, Probuphine implants, Sublocade depot injections, Zubsolv, Bunavail and Antabuse are non-preferred drugs and may be subject to additional pre-authorization criteria and quantity limits. Methadone for treatment of opioid use disorders is available through VT's certified OTPs. Vivitrol is approved for prevention of relapse for OUDs without prior authorization and for AUDs once clinical criteria are met.

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 for 2016 is projected to be: 22.2 (per 100,000); rate of fatalities attributed to opioids: 18.4 (per 100,000); rates increased by more than a third over the previous year. Provisional 2017 CDC data show the reported number of drug overdose deaths at 128 which is just over a 5% decrease from the 136 reported in 2016.

Virginia General Assembly voted to approve expanded Medicaid eligibility on 5/30/18.

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 2018: The law expanding Medicaid eligibility to families and individuals with income at or below 138% of poverty level was signed into the 2019-2020 budget law by the governor on 6/7/2018 and is slated to take effect in January 1, 2019. Applications are being accepted. The plan includes work opportunity referrals and incentive. Discussion of work requirements is also underway, but no formal plan has been submitted for CMS approval. In 2016, CMS approved 1115 waiver that expanded VA's SUD treatment coverage – includes inpatient detox and treatment for up to 15 days, 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, July 2018 applies to Medicaid FFS and some managed care plans: Preferred methadone products include oral concentrate and solution (for detoxification and maintenance treatment of narcotic addiction only) for patients enrolled in certified/registered OTP's, services approved with documentation of clinical criterion. Preferred buprenorphine formulations include Suboxone and mono formula SL tablets with PA of clinical criteria are covered up to 16 mgs maximum; higher dose must obtain approval of medical justification. Non-preferred agents requiring PA include Bunavail, Zubsolv, and buprenorphine/naloxone. No PA is required for Vivitrol, naltrexone tablets and Narcan nasal spray and naloxone.

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 2016 is projected at 16.7 (per 100,000); rate of fatalities attributed to opioids: 13.5 (per 100,000). Both rates have increases by more than a third over the prior year. Provisional 2017 CDC data show the reported number of drug overdose deaths at 1,455 which is a nearly an 8% increase over the 1,356 reported in 2016.

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 2018: ***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. New MAT guidelines apply to fee for service and all contracted MMC providers for all prescribed medications for alcohol and opioid use disorders became effective in 2017. The link take you to guidelines updated as of January 2018 that do away with most precertification requirements, only require recertification every 12 months and loosen requirements for documentation of counseling: https://www.hca.wa.gov/assets/billers-and-providers/Clinical-guidelines-coverage-limitations.pdf

Prescription Drug Coverage – PDL July 2018: applies to for Medicaid Fee for Service and all Managed Care contractors: Naloxone vials and Narcan nasal spray, as well as Acamprosate, disulfiram/Antabuse, naltrexone oral tablets, buprenorphine/naloxone generic SL tablet, Suboxone and Vivitrol are on the preferred list and do not require pre-authorization. Non-preferred drugs listed include buprenorphine mono formula SL tablets, Bunavail, Zubsolv, Probuphine implants and Sublocade depot injections require pre-authorization. More detail available in clinical guidelines above. Methadone provided by OTPs is covered, and may require PA.

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 2016 is projected at: 14.5 (per 100,000); rate of fatalities attributed to opioids: 9.4 (per 100,000); rates remained stable since the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,168 which is nearly a 5% increase over the 1,117 reported for 2016.

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 – *Note: Effective as of January 2018* - WV Medicaid now provides coverage for buprenorphine/naloxone formulations, mono-buprenorphine, Vivitrol and methadone from OTPs under a CMS approved 1115 waiver, which increases coverage of community-based and outpatient SUD treatment services, makes residential treatment available to Medicaid beneficiaries and covers methadone maintenance treatment by OTPs. It adds coverage for recovery support services and supports wide implementation of SBIRT as well as Narcan distribution. The WV Bureau for Medical Services webpage has an updates and announcements on the two-phased roll out of expanded services, with coverage of methadone treatment and other services effective January 2018. The Medicaid Behavioral Health Rehabilitation Manual includes a new section on coverage of MAT.

Prescription Drug Coverage - PDL Formulary, October 2018: Preferred medications are listed as naloxone, Narcan nasal spray, Suboxone film and Vivitrol. Vivitrol no longer requires clinical pre-authorization. Buprenorphine formulations require pre-authorization and re-authorization every six months. Coverage is subject additional requirements including dosage limits: maximum of 24 mg for the first 60 days; maximum maintenance dose – 16 mg. Non-preferred pre-authorization criteria are available online for: buprenorphine tablets, buprenorphine/naloxone tablets, Bunavail, and Zubsolv. Methadone provided by OTPs is now covered. Sublocade has been added with PA requirements.

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 2016 was: 52. (per 100,000); rate of fatalities attributed to opioids: 43.4 (per 100,000). Both fatality rates increased more than 20% over the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 997 which is just over a 13% increase from the 879 reported for 2016.

Wisconsin expanded Medicaid eligibility to adults with incomes up 100% of poverty level through its existing waiver program.

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.

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, with minimal co-pays. Under a CMS approved 1115 waiver, the state extended Medicaid eligibility to families and caretaker relatives with income up to 200% of FPL through the State's BadgerCare Plus Standard Plan. A limited benefit package with higher copayments (BadgerCare Plus Benchmark Plan) is offered for children and pregnant women with income between 200% and 300% of the FPL. BadgerCare Plus Core Plan is a limited coverage plan with some co-payments offer to childless adults with income at or below 200% FPL.

4. Current Medicaid Covered Services – verified as of 2/2018: Wisconsin current 1115 waiver program extends coverage to individuals with income at or below 100% of poverty level. It expires at the end of 2018, and an application to extend the program has been filed which may require copays from some beneficiaries and other requirements, such as drug testing and participation in work programs, but it would also provide full coverage of residential substance use disorder treatment for all BadgerCare Plus beneficiaries. Wisconsin DHS website opioid treatment information on MAT choices available lists: methadone, buprenorphine formulations, and naltrexone. "Methadone to treat addiction is dispensed only at specially licensed treatment centers [OTPs]. Buprenorphine and naltrexone are dispensed at treatment centers or prescribed by doctors." A continuum of services is also covered, including assessment, detox, inpatient and outpatient treatment, counseling, recovery coaching, and the state has recently implemented additional grant funded opioid treatment services available to all residents in response to increasing overdose fatalities.

Prescription Drug Coverage - PDL Formulary, September 2018: The preferred drug list includes methadone, Suboxone film, Zubsolv, oral naltrexone, Vivitrol, naloxone vial & syringes, Narcan nasal spray. Non-preferred drugs include buprenorphine mono and buprenorphine/naloxone SL tablets, Bunavail, and Sublocade. Preferred medications for treatment of opioid use disorders all require pre-authorization; however, modifications are under consideration.

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 2016 is projected at: 19.3 (per 100,000); rate of fatalities attributed to opioids: 15.8 (per 100,000), which represents an increase in overall drug overdose fatalities of 25% and a 41% increase in opioid overdose deaths from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 1,176 which is nearly a 10% increase from the 1,079 reported for 2016.

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: indicated both 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 2018: ***WY Medicaid Community Mental Health & Substance Use Treatment Services Manual,*** revised 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." Effective November 2017, pre-certification is required for coverage of most behavioral health services; coverage is available for selected telehealth services and SBIRT among beneficiaries age 18 and over.

Prescription Drug Coverage – July 2018 -PDL Formulary: Suboxone is listed as a preferred medication with clinical criteria requirement for authorization and subject to dosage limits of 16 mg for the first two years and 8 mg after that. Oral buprenorphine mono formula can be pre-authorized for pregnant or nursing women and those with a documented allergy to naltrexone. Vivitrol and oral naltrexone are listed as preferred medications, available without preauthorization if required clinical criteria are met. Bunavail, Zubsolv, buprenorphine and buprenorphine/naloxone 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, but not specified as covered for treatment of OUDs. Generic naloxone is covered without pre-authorization for beneficiaries only (not family or friends obtaining it on his or her behalf). Nasal naloxone appears to require pre-authorization as of 1/24/18.

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 for 2016 is projected at: 17.6 (per 100,000); rate of fatalities attributed to opioids: 8.7 (per 100,000), which represents a 10% increase in overall drug overdose fatalities and a 7% increase in opioid death from the previous year. Provisional 2017 CDC data show the number of reported drug overdose deaths at 64 which is a nearly a 44% decrease from the 93 reported for 2016.