



Medicaid and the Affordable Care Act: Vital Tools in Addressing the Opioid Epidemic

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Substance and opioid use disorders (OUD) continue to be among the most pressing public health issues facing our country. Despite growing recognition of and attempts to address the problem, the number of Americans reporting a substance use disorder (SUD) continues to increase. Opioid-related overdoses are more common today than any other time in history, and the epidemic affects every state and demographic group. Early interventions to prevent SUD and increase access to evidence-based treatment save lives and resources, and are essential to reducing opioid-related deaths, injuries, and costs. This issue brief explores how Medicaid and the Affordable Care Act (ACA) have been instrumental in increasing access to evidence-based prevention and treatment for people with and at risk for SUD. It also analyzes how proposed changes to the Medicaid program would disproportionately impact people already made vulnerable by multiple overlapping health concerns and affected by problems accessing care, and reverse gains made by the ACA.

Background

In December 2016, the Centers for Disease Control and Prevention (CDC) released a startling report that dramatically highlights the extent of the opioid overdose epidemic on American families. According to the CDC, 33,091 Americans died due to an accidental or unintentional opioid-related overdose in 2015, more than any year on record and a significant increase from the 28,647 deaths reported in 2014.¹ Ninety-one Americans die of an opioid-related overdose each day, more than auto collisions and, for the first time in U.S. history, higher than the number of gun-related deaths.² Most of the opioid-related overdose deaths in 2015 involved the use of

¹ Rose A. Rudd et al. *Increase in Drug and Opioid-Involved Overdose Deaths – United States, 2010 – 2015*, 64 *Morbidity and Mortality Weekly Rep.* 1378 (2016). Because of the way CDC calculates these data, this number is a lower bound; the actual number of Americans who died due to opioid-related causes is almost certainly higher. Personal communication with Peter Davidson, Ph.D., January 16, 2016.

² Kenneth D. Kochanek et al., *Deaths: Final Data for 2014*, 65 *National Vital Statistics Reports* 1 (2016); Christopher Ingraham, *Heroin deaths surpass gun homicides for the first time, CDC data shows*, *The Washington Post*, December 8, 2016, https://www.washingtonpost.com/news/wonk/wp/2016/12/08/heroin-deaths-surpass-gun-homicides-for-the-first-time-cdc-data-show/?utm_term=.12c9447b2d6 (last visited Jan. 23, 2017).

illicit opioids, particularly heroin, but opioid pain relievers (OPRs) also accounted for a significant percentage.³

Similarly, the number of non-fatal overdoses has reached unprecedented levels. The Agency for Healthcare Research and Quality (AHRQ) recently reported that opioid-related emergency department (ED) visits and hospitalizations increased nationwide by 99% and 64%, respectively, from 2005 to 2014.⁴ During that ten-year period, ED visits for conditions related to opioid misuse grew at a rate of 8% per year, while opioid-related inpatient stays increased at a rate of 5.7% per year.⁵

The CDC and AHRQ reports underscore both the severity and scope of the epidemic, which has caused over half a million preventable deaths since 2000 and affects Americans from every state and all walks of life.⁶ The regions with the highest opioid-related death rates in 2015 were New England and Appalachia, with West Virginia, New Hampshire, Rhode Island, and Ohio reporting the highest number of fatal opioid overdoses.⁷ The states with the highest percentage increase in the rate of opioid-related hospitalizations from 2009 to 2014 were Oregon, North Carolina, and South Dakota; Ohio, South Dakota, Minnesota, and Kentucky saw the highest percentage increases in opioid-related ED visits.⁸ In contrast to previous drug-related epidemics, which were largely concentrated in urban areas, the human suffering and economic losses caused by the opioid epidemic have fallen most heavily on states with large rural and working-class communities.⁹

The epidemic, however, knows no geographic, racial, or class boundaries. While the largest increase in opioid-related deaths has occurred in middle-aged non-Hispanic white men, the prescription opioid overdose mortality gap between women and men has been shrinking, and the rate of increase for heroin-related deaths from 2014 to 2015 was higher among women than men.^{10, 11} This rise in opioid misuse and dependence among women has had the unfortunate

³ Of the over 33,000 opioid-related deaths in 2015, 12,990 were attributed to heroin overdoses, an increase of 23% from 2014, and 17,536 deaths involved prescription opioids, up from 16,941 in 2014. Rudd et al., *supra* note 1.

⁴ A.J. Weiss et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009 – 2014*, 219 AHRQ Statistical Brief 1 (2016). In 2014, there were 177.7 opioid-related ED visits and 224.6 opioid-related hospitalizations per 100,000 population. *Id.* at 2.

⁵ *Id.* at 2.

⁶ Rose A. Rudd, et al., *Increases in Drug and Opioid Overdose Deaths — United States, 2000 – 2014*, 64 Morbidity and Mortality Weekly Rep. 1378, 1380 (2015) (reporting that “From 2000 to 2014 nearly half a million persons in the United States have died from drug overdoses . . . Opioids, primarily prescription pain relievers and heroin, are the main drugs associated with overdose deaths.”).

⁷ Christopher Ingraham, *Where opiates killed the most people in 2015*, The Washington Post, December 13, 2016, https://www.washingtonpost.com/news/wonk/wp/2016/12/13/where-opiates-killed-the-most-people-in-2015/?utm_term=.d9283bcab30d (last visited Jan. 23, 2017).

⁸ Weiss et al., *supra* note 4 at 5–8.

⁹ Interestingly, these communities predominantly supported Donald Trump in the 2016 presidential election. Harrison Jacobs, *The revenge of the “Oxy electorate” helped fuel Trump’s election upset*, Business Insider, November 23, 2016, <http://www.businessinsider.com/trump-vote-results-drug-overdose-deaths-2016-11> (last visited Jan. 23, 2017).

¹⁰ The CDC has reported that prescription opioid overdose rates are the highest among men aged 25 to 54 years and among non-Hispanic whites and American Indians. Prescription Opioid Overdose Data, Centers for Disease Control and Prevention (2016), <https://www.cdc.gov/drugoverdose/data/overdose.html> (last visited Feb. 3, 2017).

effect of increasing neonatal abstinence syndrome, a painful condition affecting newborns that is caused by in utero exposure to opioids.¹² Similarly, opioid abuse has been widely reported in children and adolescents.¹³ Although initially spared many of the harshest effects of the epidemic, deaths rates from heroin increased 213% among African-American and 137% among Hispanic Americans from 2010 to 2014.¹⁴

Much of this increase in OUD and related harms has been driven by an increase in prescriptions for opioids to treat pain.¹⁵ Pain is a serious societal, economic, and public health issue, and reducing it is a worthy goal.¹⁶ In a recent systematic survey, more than one-quarter of Americans reported that they had low back pain that lasted at least one day in the past three months; approximately 15% reported the same for migraine and 14% for neck pain.¹⁷ In a separate report, knee pain was reported by nearly 20% of Americans, and shoulder pain by 9%.¹⁸ In addition to the morbidity caused by pain itself, chronic pain is associated with a number of other negative conditions including anger, depression, and anxiety.¹⁹

Disparities exist both in pain and its treatment. Numerous studies have documented higher rates of pain among women compared to men, and systematic under-treatment of pain appears to be prevalent among at least some racial and ethnic minorities.²⁰ A recent meta-analysis found that Hispanic and Latino Americans were 22% less likely to be prescribed opioid analgesics than

¹¹ Multiple Cause of Death 1999 – 2014 on CDC WONDER Online Database, Centers for Disease Control and Prevention (2015), <http://wonder.cdc.gov/mcd-icd10.html> (last visited Jan. 23, 2017); Rudd et al., *supra* note 1.

¹² Veeral N. Tolia et al., *Increasing Incidence of the Neonatal Abstinence Syndrome in U.S. Neonatal ICUs*, 372 *New England Journal of Medicine* 2118 (2015).

¹³ Joshua M. Sherman et al., *Opioid Abuse in the Pediatric Population: Addressing a Real Public Health Epidemic*, 13 *Pediatric Consultant* 256 (2014).

¹⁴ Sarah Childress, *How the Heroin Epidemic Differs in Communities of Color*, *Frontline*, February 23, 2016, <http://www.pbs.org/wgbh/frontline/article/how-the-heroin-epidemic-differs-in-communities-of-color/> (last visited Jan. 23, 2017). The increase in heroin deaths among African-Americans and Hispanics is exacerbated by the fact that these communities tend to be in a worse economic position than other groups in the country. In fact, while the U.S. unemployment rate is currently at 4.3%, the lowest in nine years, 7.8% of African-Americans and 5.9% of Hispanics reported being unemployed in December 2016. Ana Swanson, *It's not the white working class that is hurting the most*, *The Washington Post*, January 12, 2017, https://www.washingtonpost.com/news/wonk/wp/2017/01/12/its-not-the-white-working-class-that-is-hurting-the-most/?utm_term=.2aacec508a00 (last visited Jan. 23, 2017).

¹⁵ Unfortunately, and as will be discussed below, many of these prescriptions will do little to help the patient, and some will cause harm.

¹⁶ See Inst. of Med. (US) Comm. on Advancing Pain Research, Care, and Educ., *Relieving pain in America: a blueprint for transforming prevention, care, education, and research* (2011) (hereinafter “IOM Report”).

¹⁷ Richard A. Deyo et al., *Back Pain Prevalence and Visit Rates: Estimates from U.S. National Surveys, 2002*, 31 *Spine* 2724, 2725 (2006).

¹⁸ IOM Report, *supra* note 16, at 62.

¹⁹ Lachlan A. McWilliams et al., *Depression and Anxiety Associated with Three Pain Conditions: Results from a Nationally Representative Sample*, 111 *Pain* 77, 79 (2004) (finding that psychiatric disorders were much more pronounced in individuals with arthritis, migraine, and back pain than in individuals without those conditions); Carmen R. Green, et al., *Cancer-Related Chronic Pain: Examining Quality of Life in Diverse Cancer Survivors*, 117 *Cancer* 1994, 1999 (2011) (pain associated with depression).

²⁰ Roberto Bernabei, et al., *Management of Pain in Elderly Patients with Cancer*. SAGE Study Group. *Systematic Assessment of Geriatric Drug Use via Epidemiology*, 279 *JAMA* 1877 (1998) (black nursing home residents 63% less likely than similarly situated whites to receive opioids for cancer pain); Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) (citing numerous examples).

their Caucasian counterparts, while African Americans were 29% less likely than similarly situated Caucasian to be prescribed opioids.²¹

Both untreated pain and untreated SUD place a substantial burden on the U.S. economy. SUD and related conditions are estimated to cost more than \$600 billion each year, and a 2013 report estimated the total economic burden of the opioid epidemic alone to be \$78.5 billion per year.²² The epidemic also causes approximately \$20 billion in lost productivity yearly, including reduced productive hours and lost production for incarcerated individuals.²³ Similarly, one recent review estimated the cost of persistent pain in the U.S. at approximately \$560 to \$635 billion annually.²⁴ The indirect and direct cost of lower back pain alone has been estimated at a minimum of between approximately \$20 and \$120 billion per year, with one estimate of over \$624 billion.²⁵

The rise in opioid misuse has also led to an increase in preventable bloodborne infections. In the last decade, Hepatitis C infection rates have risen dramatically due in large part to increasing prescription opioid and heroin injection and the lack of syringe exchange and sterile syringe access.²⁶ For example, in 2015, officials linked a large HIV outbreak in Indiana to the sharing of needles used to inject prescription opioids, particularly the medication Opana.²⁷

The Many Benefits of Evidence-Based SUD Treatment

Because OUD is closely linked to other SUDs as well as physical and mental health needs, efforts to address these problems are key to improving the lives of individuals with and at risk of the condition. Strategies to fight the epidemic, therefore, must be integrated with efforts to address untreated pain, SUD, and mental health conditions. In the U.S., 21.6 million individuals aged 12 or older have an SUD, of which 2 million have a SUD involving OPRs and 591,000 have an SUD involving heroin.²⁸ It is estimated that four in five new heroin users started by

²¹ The paper reported that these differences are “sufficiently large to impact clinical outcome.” Salimah H. Meghani, et al., *Time to Take Stock: A Meta-Analysis and Systematic Review of Analgesic Treatment Disparities for Pain in the United States*, 13 *Pain Medicine* 150, 156-159 (2012). They may also be part of the reason that people of color have had lower rates of opioid misuse and overdose compared to Caucasian Americans.

²² Substance Abuse and Mental Health Services Admin., *Prevention of substance abuse and mental illness*, August 9, 2016, <https://www.samhsa.gov/prevention> (last visited Jan. 13, 2017); Curtis S. Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013*, 54 *Med. Care* 901 (2016).

²³ The costs associated with the opioid epidemic are likely to have risen since the report’s publication because opioid overdoses have more than doubled and opioid-related hospital utilization rates have significantly increased since 2013.

²⁴ Darrell J. Gaskin & Patrick Richard, *The economic costs of pain in the United States*, 13 *J. Pain* 715, 723 (2012) (calculating the cost of pain-related health care at \$261-300 billion and lost productivity at \$297-336 billion).

²⁵ Simon Dagenais et al., *A Systematic Review of Low Back Pain Cost of Illness Studies in the United States and Internationally*, 8 *Spine J.* 8, 19 (2008).

²⁶ Anil G. Suryaprasad et al., *Emerging Epidemic of Hepatitis C Virus Infections Among Young Nonurban Persons Who Inject Drugs in the United States, 2006 – 2012*, 59 *Clinical Infectious Diseases* 1411 (2014).

²⁷ Ind. State Dep’t of Health, *HIV Outbreak in Southeastern Indiana* (2015), <http://www.in.gov/>.

²⁸ Substance Abuse and Mental Health Services Admin., *Mental and substance use disorders*, <https://www.samhsa.gov/disorders> (last visited Jan. 13, 2017); American Society of Addiction Medicine, *Opioid*

misusing prescription OPRs and that 23% of individuals who use heroin develop an opioid addiction.²⁹ In 2015, 122,000 adolescents reported having an addiction to prescription OPRs and 21,000 reported using heroin in the past year.³⁰

Evidence-based treatment significantly reduces both the harmful effects and costs of OUD. Medication Assisted Treatment (MAT), which consists of pharmacotherapy (often in conjunction with behavioral therapy) is the evidence-based standard for opioid use disorder treatment. Treatment with the medications methadone and buprenorphine has been proven effective in mitigating the negative effects of OUD in numerous ways.

First, both medications are highly effective in improving treatment retention and reducing the risk of relapse, with one study of Medicaid patients demonstrating that individuals receiving MAT were 50% less likely to relapse than those receiving non-medication-assisted therapy.³¹ Methadone maintenance treatment (MMT) also results in patients remaining in treatment for longer periods of time and is associated with higher opioid abstinence during the treatment period.³² Methadone and buprenorphine reduce heroin and other opioid cravings, increasing the chances that the patient will remain in treatment. MAT also lowers rates of drug-related behaviors, including decreasing heroin and cocaine use, and is associated with a reduction in the incidence of drug-related criminal activity, improved family relations, and successful return to employment.³³

Second, MAT is effective in reducing bloodborne disease infections such as the HIV epidemic that recently gripped Scott County, Indiana.³⁴ Methadone and buprenorphine treatment have been consistently associated with reductions in injecting drug use and a reduction in individuals sharing needles for injecting drug use.³⁵ MAT also leads to reductions in other risk behaviors, like multiple sex partners and the exchange of sex for money or drugs.³⁶ This reduction in risky activity has been linked to a decrease in the number of cases of HIV infection and may lead to a

Addiction 2016 Facts & Figures, <http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf> (last visited Jan. 13, 2017).

²⁹ *Id.*

³⁰ *Id.* Prescribing rates for OPRs among adolescents and young adults nearly doubled from 1994 to 2007.

³¹ Sean M. Murphy et al., *Show Me the Money: Economic Evaluations of Opioid Use Disorder Interventions* (2016), <https://perma.cc/G79N-VJX5> (“A study of Medicaid patients found that those receiving either BMT or MMT were 50% less likely to relapse than those receiving behavioral treatments only.”).

³² Catherine A. Fullerton et al., *Medication-assisted treatment with methadone: assessing the evidence*, 65 *Psychiatric Serv.* 146 (2014).

³³ See generally, Wayne Hall et al., *Effectiveness of MMT on Heroin Use and Crime*. Harwood Academic Publishers. 1998; Bennett W. Fletcher & Robert J. Battjes, *Introduction to the Special Issue: Treatment Process in DATOS*, 57 *Drug and Alcohol Dependence* 81 (1999).

³⁴ For more information on this outbreak, see Caitlin Conrad et al., *Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxycodone — Indiana, 2015*, 64 *Morbidity and Mortality Weekly Rep.* 443 (2015) and Phillip J. Peters et al., *HIV Infection Linked to Injection Use of Oxycodone in Indiana, 2014–2015*, 375 *New England Journal of Medicine* 229 (2016).

³⁵ Monique E. Wilson et al., *Impact of Interim Methadone Maintenance on HIV Risk Behaviors*, 87 *J Urban Health* 586 (2010); Linda Gowing et al., *Oral Substitution Treatment of Injecting Opioid Users for Prevention of HIV Infection*, 8 *Cochrane Database of Systematic Reviews* CD004145 (2011).

³⁶ *Id.*

reduction in the number of new cases of other transmittable diseases such as Hepatitis B and Hepatitis C.³⁷

Perhaps most importantly, MAT is effective in reducing the risk of opioid-related overdose death. A study of MAT in Baltimore revealed that increased access to methadone and buprenorphine was associated with a nearly 50% reduction in heroin overdose deaths.³⁸ According to this peer-reviewed study, “jurisdictions have the potential to reduce heroin overdose deaths through policies that support the expansion of evidence-based medication treatment of opiate dependence.”³⁹

Increased access to the medication naloxone can also reduce opioid-related harm, including fatal overdose. Naloxone, which is a prescription drug but not a controlled substance, binds to the opioid receptors in the brain more strongly than drugs like heroin and oxycodone, blocking those receptors.⁴⁰ It is highly effective in reversing opioid-related overdoses and can be easily administered by laypersons and first responders.⁴¹ A majority of states now have laws expanding access to naloxone, and studies have shown that this increased access can lead to increased community knowledge of overdose recognition and management and a reduction in the number of opioid-related overdose deaths.⁴² The CDC estimates that from 1996 to 2014, naloxone distribution programs trained and provided naloxone to over 150,000 laypersons, resulting in over 26,000 drug overdose reversals (see Figure 1).⁴³

³⁷ *Id.*

³⁸ Robert P. Schwartz, et al., *Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009*, 103 *Am J Public Health* 917 (2013). The study found that from 1995 to 2009, the number of patients treated with methadone in Baltimore almost doubled from 4,204 to 8,359 and the number of patients treated with buprenorphine increased from 577 in 2003 to 7,479 in 2009 leading to a reduction in overdose deaths during the period from 1995 to 2009.

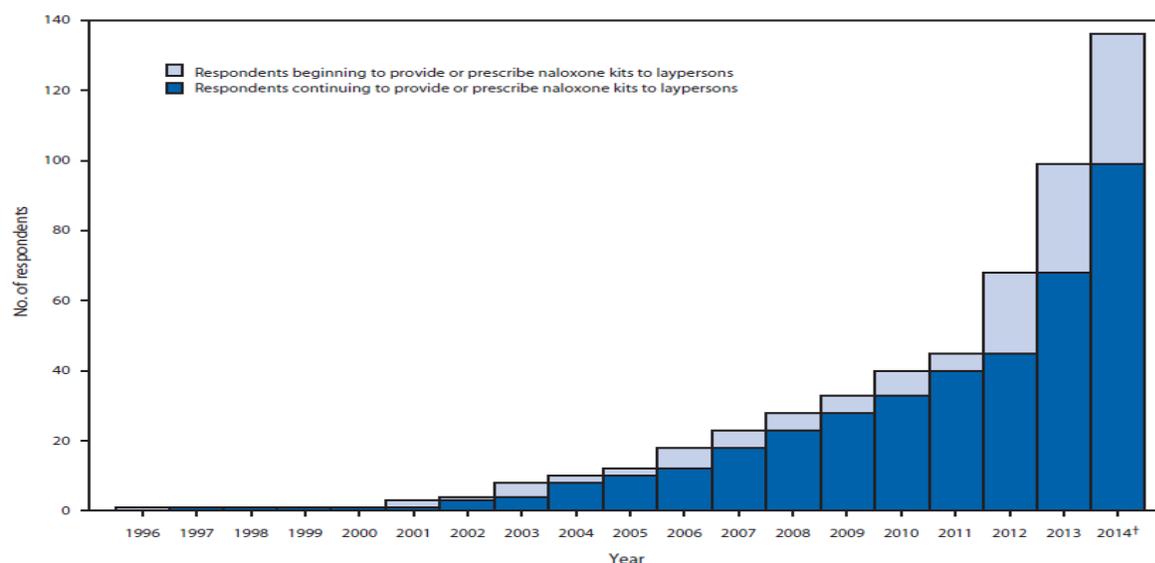
³⁹ *Id.* at 921.

⁴⁰ See James M. Chamberlain & Bruce L. Klein, *A Comprehensive Review of Naloxone for the Emergency Physician*, 12 *Am. J. Emergency Med.* 650 (1994) (providing an exhaustive explanation of the mechanism and effect of naloxone).

⁴¹ Rebecca E. Giglio et al., *Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis*, 2 *Injury Epidemiology* 1 (2015).

⁴² Corey S. Davis, *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws*, *The Network for Public Health Law* (2016); Corey S. Davis & Derek Carr, *Legal Changes to Increase Access to Naloxone for Opioid Overdose Reversal in the United States*, 157 *Drug & Alcohol Dependence* 112, 113 (2015) (describing legal and policy barriers to naloxone access, as well as modifications to state law intended to address them); Giglio et al., *supra* note 41.

⁴³ Eliza Wheeler et al., *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons – United States, 2014*, 64 *Morbidity and Mortality Weekly Rep.* 631 (2015).

Figure 1. Increase in Number of Laypersons Accessing Naloxone, 1996 - 2014. Source: CDC

The distribution of naloxone to high-risk individuals has also been proven to be cost-effective.⁴⁴ Because medical knowledge is not required to administer naloxone, the expenses involved in training laypersons to use the medication are minimal. Based on its safety, effectiveness, and low cost, the distribution of naloxone to laypersons has been compared to routine medical procedures, like screening for high blood pressure at a physician's office.⁴⁵

Despite the demonstrated effectiveness of MAT and naloxone in mitigating the adverse outcomes associated with SUD and opioid dependence, the vast majority of individuals with SUD in need of treatment do not receive it. While the opioid epidemic continues to grow, the percentage of individuals with OUD receiving substance abuse treatment has remained relatively stagnant.⁴⁶ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that, in 2015, less than 20% of all individuals with OUD, including less than 11% of those under age twenty-five, received treatment, and it is estimated that less than 12% of the 22.6 million individuals with SUD are currently receiving MAT.⁴⁷ Numerous factors contribute to this

⁴⁴ Philip O. Coffin & Sean D. Sullivan, *Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal*, 158 *Annals of Internal Med.* 1, 6 (2013) (finding that “[n]aloxone distribution to heroin users would be expected to reduce mortality and be cost-effective even under markedly conservative assumptions of use, effectiveness, and cost”).

⁴⁵ *Giving Naloxone to Heroin Users Reduce Overdose Death and Is Highly Cost-Effective*, http://naloxoneinfo.org/sites/default/files/Cost%20Effectiveness%20Summary_EN.pdf (last visited Jan. 13, 2017).

⁴⁶ Brendan Saloner & Shankar Karthikeyan, *Changes in Substance Abuse Treatment Use Among Individuals with Opioid Use Disorders in the United States, 2004-2013*, 314 *JAMA* 1515 (2015) (“During the decade from 2004 to 2013, use of treatment remained low for individuals with OUDs and did not increase after accounting for changing population characteristics, underscoring substantial room for improvement.”). Importantly, this study did not measure MAT use.

⁴⁷ Substance Abuse and Mental Health Services Admin., *Behavioral Health Barometer: United States, 2015*, https://www.samhsa.gov/data/sites/default/files/2015_National_Barometer.pdf (last visited Jan. 13, 2017); Substance Abuse and Mental Health Services Admin., *Substance Use and Mental Health Estimates from the 2013*

low utilization of MAT, including misconceptions, stigma, and the lack of available prescribers.⁴⁸ In addition, gaps in insurance coverage and roadblocks such as prior authorization and utilization review have been a key barrier.

Vital Importance of Medicaid in Preventing and Treating SUD

The most effective way of preventing opioid dependence and overdose deaths is to identify and treat mental health, substance abuse, and physical problems before SUD develops. Access to timely, evidence-based preventive services saves money and lives.⁴⁹ Medicaid plays an important role in providing access to mental health and substance abuse screening for individuals at risk of SUD and is essential in providing preventive services for both children and adults.

Coverage of preventive services for children and adolescents is a cost-effective way of reducing the impact of substance dependence. The Institute of Medicine and National Research Council has estimated that the cost-benefit ratios for early treatment and prevention programs for addiction and mental illness in this population range from 1:2 to 1:10.⁵⁰ In other words, a \$1 investment in SUD prevention and early treatment leads to between \$2 and \$10 of savings in healthcare costs, criminal justice costs, educational costs, and productivity gains.

Unfortunately, the Surgeon General estimates that approximately two thirds of children and adolescents who have a mental health or substance use condition are not identified and do not receive necessary services.⁵¹ Moreover, the rate of illicit drug use among adolescents is 25% higher than the rate of illicit drug use among adults.⁵² Medicaid is helping to close this gap. Under Medicaid's early and periodic screening, diagnosis, and treatment (EPSDT) benefit, Medicaid-enrolled individuals under age 21 must be provided with periodic mental health assessment and substance use screening provided at set intervals.⁵³ Additionally, Medicaid-enrolled children are entitled to screening when needed to detect a suspected illness or condition not present or discovered during an initial exam, as well as subsequent evaluations to diagnose a suspected condition.⁵⁴ If it is determined that there may be a need for further assessment or for

National Survey on Drug Use and Health: Overview of Findings, September 4, 2014, <https://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm> (last visited Jan. 13, 2017).

⁴⁸ Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 *New Eng. J. Med.* 2063, 2064 (2014).

⁴⁹ Substance Abuse and Mental Health Services Admin., *Prevention of substance abuse and mental illness*, August 9, 2016, <https://www.samhsa.gov/prevention> (last visited Jan. 13, 2017).

⁵⁰ Mary E. O'Connell et al., *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, National Research Council and Institute of Medicine (2009).

⁵¹ Centers for Medicare and Medicaid Services, *Informational Bulletin on Prevention and Early Identification of Mental Health and Substance Use Conditions*, March 27, 2013, <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> (last visited Jan. 13, 2017).

⁵² *Id.*

⁵³ Centers for Medicare and Medicaid Services, *Early and periodic screening, diagnostic, and treatment*, <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html> (last visited Jan. 13, 2017).

⁵⁴ Centers for Medicare and Medicaid Services, *Informational Bulletin on Prevention and Early Identification of Mental Health and Substance Use Conditions*, March 29, 2013, <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf> (last visited Jan. 13, 2017).

treatment to prevent development of a SUD, the beneficiary must be provided with necessary diagnostic or treatment services.⁵⁵

Mental health and SUD preventive services are also covered for many Medicaid-enrolled adults. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires most health insurance plans to treat mental health and SUD benefits on equal footing with medical and surgical benefits.⁵⁶ The ACA extended the MHPAEA's requirements to all insurance plans offered through an ACA Marketplace and all Medicaid Alternative Benefit Plans (ABPs).⁵⁷ The Centers for Medicare and Medicaid Services (CMS) recently adopted a rule that formalizes the requirements for state Medicaid programs, including Medicaid plans operated by managed care organizations, to comply with the provisions of the MHPAEA.⁵⁸

Additionally, Medicaid must cover a wide range of preventive medical services for beneficiaries newly eligible under the ACA, who, pursuant to the law, must be offered coverage through a Medicaid ABP.⁵⁹ While the ACA's required preventive services do not include screening and evaluation for substance abuse and opioid dependence, the parity rule requires Medicaid ABPs to include preventive services for mental health and SUD that are not less favorable than preventive services for other physical conditions. Consequently, since the ACA requires that preventive services be provided for a number of conditions, like blood pressure and diabetes, the parity rule

⁵⁵ *Id.*

⁵⁶ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–512 (2008).

⁵⁷ 42 U.S.C. § 18031(j) (2010), as added by Pub. L. No. 111-148, § 1311 (2010) (applying the MHPAEA's parity requirements to qualified health plans); 42 U.S.C. § 1396u-7(b)(6)(A) (2014), as added by Pub. L. No. 111-148, § 2001 (applying the MHPAEA's parity requirements to Medicaid ABPs, previously known as benchmark and benchmark-equivalent Medicaid plans); 42 U.S.C. § 1396u-2(b)(8) (2015) (applying the MHPAEA's parity requirements to Medicaid managed care organizations).

⁵⁸ 42 C.F.R. §§ 438, 440, 456, 457 (2016). For the language of the rule extending the parity requirements to Medicaid managed care plans, *see* 42 C.F.R. §§ 438.900–438.930. Pursuant to the rule, states have until September 2017 to comply with the new requirements. While the ACA did not extend the requirements of the MHPAEA to traditional fee-for-service (FFS) Medicaid plans, states may still request a waiver to extend the parity benefits to Medicaid beneficiaries in FFS. For more information on the mental health parity rule, *see* Centers for Medicare and Medicaid Services, Medicaid Factsheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP, March 29, 2016, <https://www.medicaid.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf> (last visited Jan. 13, 2017). This rule is explained in more detail below.

⁵⁹ 42 U.S.C. § 1396a(k) (2016), as added by Pub. L. No. 111-148, § 2001(a)(2) (stating that newly eligible Medicaid beneficiaries must be covered under an ABP); 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), as added by Pub. L. No. 111-148, § 2001(a)(1)(C) (stating that all newly eligible Medicaid beneficiaries must be provided with preventive services). For a list of preventive services that must be covered for newly eligible Medicaid beneficiaries, *see* 42 U.S.C. 300gg-13 (2010), as added by Pub. L. No. 111-148, § 1001(5). While states are not required to cover preventive services for individuals who qualify for Medicaid under categories other than the new ACA eligibility category, the law incentivizes states to expand coverage of preventive services for these beneficiaries by increasing the state's FMAP by 1% if the preventive services are covered for all beneficiaries. 42 U.S.C. 1396d(b)(5) (2013), as added by Pub. L. No. 111-148, § 4106(b)(2). For more information on Medicaid's coverage of SUD preventive services for adults, *see* Alexandra Gates et al., *Coverage of Preventive Services for Adults in Medicaid*, Kaiser Family Foundation, November 13, 2014, <http://kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/> (last visited Jan. 13, 2017).

requires ABPs to offer all newly eligible individuals coverage for mental health and SUD preventive services on equal footing as these other medical and surgical preventive services.⁶⁰

Medicaid also represents the single largest source of insurance coverage for behavioral health services and SUD treatment.⁶¹ While the opioid epidemic affects people at many income levels, SUD may be particularly prevalent among low-income Americans.⁶² Nearly 12% of adults in Medicaid and 6% of children and adolescents have an SUD, a higher percentage than adults and adolescents with SUD in the general population (8.5% and 5%, respectively).⁶³ Of the 20.2 million adults in the U.S. with an SUD, 23% are covered by Medicaid.⁶⁴

The number of Americans with an SUD who have Medicaid coverage has increased significantly with the ACA's Medicaid expansion, and this number is expected to continue to rise as more states expand Medicaid eligibility. As of 2016, 1.2 million Americans with SUD have gained coverage in states that adopted the expansion; as many as 1.1 million more individuals with SUD would gain access to health insurance if the remaining states expanded Medicaid.⁶⁵ Largely because of the Medicaid expansion, the share of people below 400% of the federal poverty level foregoing mental health care because they cannot afford it decreased by about 25% between 2010 and 2015.⁶⁶

Medicaid expansion also eases burdens on hospitals and other health care providers. The share of uninsured hospitalizations for substance use or mental health disorders fell from 22% to 14% after the ACA's insurance provisions went into effect and, in states that expanded Medicaid, the uninsured proportion of hospitalizations for SUD or mental health problems decreased from 20%

⁶⁰ Richard G. Frank et al., *Behavioral Health Parity and the Affordable Care Act*, 13 J Soc Work Disabil Rehabil. 31–43 (2014) (“[I]n combination, the four channels through which the ACA and MHPAEA interact mandate coverage at parity for all those gaining coverage through [...] the Medicaid expansion [...]”).

⁶¹ Deborah Bachrach et al., *Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis*, July 2016, <http://statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf> (last visited Jan. 13, 2017).

⁶² Christopher M. Jones et al., *Vital Signs: Demographic and Substance Use Trends Among Heroin Users – United States, 2002–2013*, 64 Morbidity Mort. Weekly Report 719–725 (2015) (Average annual rates of past-year heroin use highest among individuals with household income below \$20,000/year).

⁶³ Centers for Medicare and Medicaid Services, Reducing Substance Use Disorders, <https://www.medicare.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html> (last visited Jan. 13, 2017); Substance Abuse and Mental Health Services Admin., Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health, September 4 2014, <https://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf> (last visited Jan. 13, 2017); Substance Abuse and Mental Health Services Admin., Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015, <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> (last visited Jan. 13, 2017).

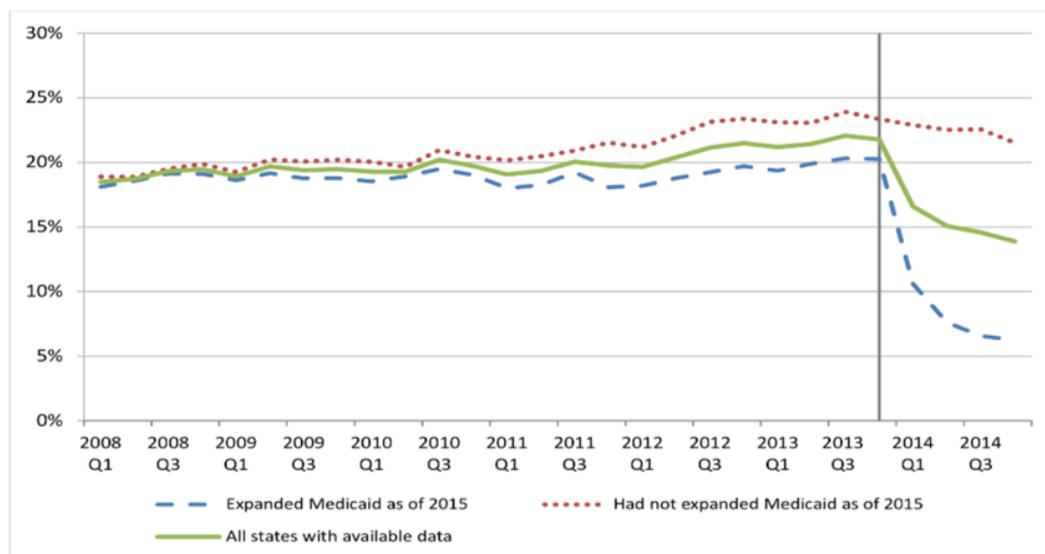
⁶⁴ Mir M. Ali et al., *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for uninsured individuals with a behavioral health condition*, November 18, 2015, https://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf (last visited Jan. 13, 2017). See also Susan H. Busch et al., *Characteristics of Adults with Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA*, 64 Psychiatric Services 520–526 (2013).

⁶⁵ Ali et al., *supra* note 64.

⁶⁶ *Id.*

in 2013 to 5% in 2015 (see Figure 2).⁶⁷ Uncompensated care costs in safety-net hospitals have also decreased considerably since enactment of the ACA. In 2014, it was estimated that hospitals experienced a \$7.4 billion decrease in costs associated with uncompensated care, a reduction of 21% from the previous year. This reduction was most evident in states that expanded Medicaid, where uncompensated care costs were reduced by 26% from 2013 to 2014.⁶⁸

Figure 2. Adult Uninsured Hospitalizations as a Share of Total Hospitalizations for SUD and Mental Health Disorders, 2008 - 2015. Source: ASPE



The Medicaid expansion has particularly benefitted the states hardest hit by the opioid epidemic. For example, Kentucky, Ohio, and West Virginia have some of the highest rates of SUD and opioid-related overdose deaths in the country. These states have all expanded Medicaid, which now covers over 20% of the population in each of the three states⁶⁹ and has become an increasingly important source of coverage for adults with SUD. In Ohio, almost 500,000 individuals, over 50% of all newly insured Ohioans, have received SUD services since the state expanded its Medicaid eligibility.⁷⁰

⁶⁷ Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Continuing Progress on the Opioid Epidemic: The Role of the Affordable Care Act*, January 11, 2017.

⁶⁸ Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act*, May 23, 2015. Individual providers have also experienced a decrease in uncompensated care costs. See Adam Searing & Jack Hoadley, *Beyond the Reduction in Uncompensated Care: Medicaid Expansion is Having a Positive Impact on Safety Net Hospitals and Clinics*, Georgetown University Center for Children and Families, June 1, 2016.

⁶⁹ Kaiser Family Foundation, Health insurance coverage of the total population, 2015, <http://kff.org/other/state-indicator/total-population/?currentTimeframe=0> (last visited Jan. 13, 2017).

⁷⁰ Catherine Candisky & Alan Johnson, *Medicaid expansion covers nearly 500,000 Ohioans for mental health, drug treatment*, The Columbus Dispatch, July 17, 2016, <http://www.dispatch.com/content/stories/local/2016/07/17/medicaid-expansion-covers-nearly-500000-for-mental-health-drug-treatment.html> (last visited Jan. 13, 2017). This has not been lost on Republican Governor John Kasich, who has been quoted as saying: “Thank God we expanded Medicaid because that Medicaid money is helping rehab people.” Jo Ingles, *Gov. Kasich Credits Medicaid Expansion for Helping Ohio Fight Drug Abuse Problem*,

This coverage is essential to ensuring access to care for many rural and underserved Americans. About 420,000 people with SUD currently report financial or availability of care difficulties for accessing SUD treatment.⁷¹ A repeal of the ACA would increase that coverage gap by more than 50%, and would result in approximately 2.8 million Americans with SUD, 222,000 of whom have an opioid use disorder, losing some or all of their health insurance and their access to mental health treatment that could potentially save their lives from an opioid-related overdose.⁷² This includes the 214,000 West Virginians with serious mental illnesses that have gained insurance through the ACA's Medicaid expansion, and 78,000 Tennesseans and 22,000 Arizonans with SUD that have gained insurance through the ACA's marketplace (see Table 1).⁷³

Table 1. Increase in Health Insurance Coverage for Individuals with SUD in States with High Rates of Drug Overdoses. Source: Frank & Glied, note 71.

State	Drug Overdose Death Rate (per 100,000)	Number of People with SUD in Medicaid Expansion	Number of People with SUD in an ACA Marketplace Plan	Percent Share of Buprenorphine Paid by Medicaid
AK	16.0	5,389	2,754	34.2%
AZ	19.0	15,400	21,553	14.9%
ME	21.2	N.A.	8,306	37.8%
OH	29.9	151,257	29,656	49.5%
PA	26.3	80,910	51,415	29.2%
TN	22.2	N.A.	30,466	10.0%
WV	41.5	22,576	2,916	44.7%

Medicaid's Comprehensive Coverage of SUD Treatment

Medicaid coverage of mental health and SUD services is generally more extensive than private plan coverage, and includes access to MAT, naloxone, and inpatient treatment.⁷⁴ For some Medicaid plans, this comprehensive coverage of SUD services has been strengthened by the application of the ACA's EHBs requirement, which include mental health and SUD services and prescription drugs to treat opioid dependency. In addition, the mental health parity rule requires states to provide SUD coverage to their Medicaid populations that is not less comprehensive than coverage of medical and surgical services.

Statehouse News Bureau, January 4, 2017, <http://statenews.org/post/gov-kasich-credits-medicaid-expansion-helping-ohio-fight-drug-abuse-problem> (last visited Jan. 13, 2017).

⁷¹ Richard G. Frank & Sherry A. Glied, *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses*. The Hill, January 11, 2017, <http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders> (last visited Jan. 13, 2017).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ Ken Cannon et al., *Adult behavioral health benefits in Medicaid and the marketplace*, Kaiser Family Foundation, June 11, 2015, <http://kff.org/medicaid/report/adult-behavioral-health-benefits-in-medicaid-and-the-marketplace/> (last visited January 13, 2017).

Medicaid is one of the most important source of coverage for MAT. As of 2016, all 50 state Medicaid programs cover at least one FDA-approved opioid agonist to treat SUD (buprenorphine, methadone, and naltrexone), and 31 states, including 20 Medicaid expansion states, offer coverage of all three FDA-approved medications.⁷⁵ All states and the District of Columbia provide coverage for buprenorphine and almost all states and the District of Columbia provide coverage for injectable naltrexone through their Medicaid programs.⁷⁶

Medicaid's role in covering MAT has also been strengthened by several rules that expand healthcare practitioner's authority to prescribe buprenorphine. In August 2016, SAMHSA promulgated a rule that allows physicians to obtain a waiver to prescribe buprenorphine for up to 275 patients with SUD at a time.⁷⁷ In addition, the agency also announced new actions that implement a provision of the Comprehensive Addiction and Recovery Act (CARA) to permit nurse practitioners and physician assistants to prescribe buprenorphine for up to 30 patients with SUD.^{78,79} The ACA has also contributed significantly to the increase in health care practitioners prescribing buprenorphine to treat SUD. A recent study showed that both the Medicaid expansion and the establishment of health care marketplaces have led to an increase in the availability of SUD treatment providers, including a significant increase in physicians holding a waiver to prescribe buprenorphine.^{80,81}

⁷⁵ Colleen M. Grogan et al., *Survey Highlights Differences in Medicaid Coverage for Substance Use Treatment and Opioid Use Disorder Medications*, 35 *Health Affairs*, 2289, 2292 (2016).

⁷⁶ *Id.* at 2292

⁷⁷ 42 C.F.R. § 8.610 (2016). Previously, prescribers were limited to 100 patients at a time. For more information on the rule, see Dept. of Health and Human Services, HHS announces new actions to combat opioid epidemic, July 6, 2016, <https://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html> (last visited Jan. 13, 2017).

⁷⁸ 21 U.S.C. § 823(g)(2)(G)(iv) (2016), as added by Pub. L. No. 114-198, § 303(a)(1)(C)(v) (2016); Dept. of Health and Human Services, HHS takes additional steps to expand access to opioid treatment, November 16, 2016, <https://www.hhs.gov/about/news/2016/11/16/additional-steps-expand-opioid-treatment.html> (last visited Jan. 13, 2017).

⁷⁹ Moreover, expanding upon the increasing focus on integration of and coordination between the mental health and healthcare delivery systems, SAMHSA recently finalized a rule that increases removes some barriers to access of SUD treatment records by researchers and providers. The rule maintains the core protections of the Health Insurance Portability and Accountability Act (HIPAA) for personal information of individuals with SUD but reduces barriers to research and care coordination. Under current law, providers must get approval from patients each time substance abuse-related information is shared. The new rule only requires providers to ask patients to sign a single consent form that establishes which information they are disclosing and that the patient is aware of the information being disclosed. 42 C.F.R. § 2 (2017). See also Alicia Ault, *Feds Issue Final Rule on Sharing of Substance Abuse Records*, *Medscape Medical News*, January 13, 2017, <http://www.medscape.com/viewarticle/874445> (last visited Jan. 13, 2017).

⁸⁰ Hannah K. Knudsen et al., *States' Implementation of the Affordable Care Act and the Supply of Physicians Waivered to Prescribe Buprenorphine for Opioid Dependence*, 157 *Drug Alcohol Depend* 36 (2015). Under the Drug Addiction Treatment Act of 2000, qualified physicians are permitted to prescribe or dispense buprenorphine and other medications for the treatment of SUD if they qualify for and are granted the appropriate authority, typically referred to as a waiver. 21 U.S.C. § 823(g). For more information, see Substance Abuse and Mental Health Services Admin., *Buprenorphine Waiver Management*, <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management> (last visited Jan. 13, 2017).

⁸¹ While states have flexibility to impose limitations on medication coverage for their Medicaid population, these limitations are subject to medical necessity criteria and CMS has stated that MAT "should be continued as long as the treatment is medically necessary and the individual participates in treatment as set forth in their treatment plan." See Abbi Coursolle, *Utilization Controls for Medicaid Prescription Drugs*, National Health Law Program,

Medicaid also affords states the option of expanding access to partial hospitalization and inpatient SUD treatment, and a significant number of states have taken advantage of this opportunity. Inpatient treatment of SUD and opioid dependence is effective in reducing the effects of serious mental illnesses and substance dependence, and for the most serious SUD can represent the difference between life and death.⁸² Additionally, although not required under federal law, 26 states and the District of Columbia currently provide coverage for at least one service in each of the four levels of care for SUD treatment specified in the American Society of Addiction Medicine (ASAM) criteria.⁸³ Thirteen states and the District of Columbia offer all services recommended under the four levels of care. Only four states lack coverage in three of the four levels of care, highlighting the importance of Medicaid as a source of coverage for patients with serious SUD that are in need of more intensive care and hospitalization.⁸⁴

The ACA has also expanded and improved Medicaid's coverage of SUD treatment by requiring coverage of mental health benefits in some Medicaid plans, as part of the essential health benefits (EHB) package, and by expanding the Mental Health Parity and Addiction Equity (MHPAE) Act. First, under the ACA, all newly eligible individuals under the Medicaid expansion must be covered through an ABP.⁸⁵ The law requires ABPs to cover, to a minimum degree, all ten of the ACA's EHBs, including "mental health and substance use disorder services."⁸⁶ Inclusion of SUD services as part of the package of EHBs guarantees that all newly eligible Medicaid beneficiaries will have access to basic treatment services for substance and opioid dependence.

November 30, 2016. Nonetheless, at least 44 states require prior authorization for buprenorphine therapy. In contrast, states do not impose prior authorization requirements for methadone treatment, likely due to that drug's much lower cost. Similarly, 30 states currently require some sort of evidence that a patient is attending or will be attending counseling therapy before buprenorphine coverage is approved, although the degree of documentation as evidence of adherence to the counseling requirement varies considerably across states. Suzanne G. Rinaldo & David W. Rinaldo, *State Medicaid Coverage and Authorization Requirements for Opioid Dependence Medications*, 2013, http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final (last visited Jan. 13, 2017). Some patients may be unable or unwilling to attend counseling in addition to taking their medication, and will likely benefit from methadone or buprenorphine treatment alone. See Robert P. Schwartz et al., *Randomized Trial of Standard Methadone Treatment Compared to Initiating Methadone without Counseling: 12-month Finding*. 107 *Addiction* 943 (2012).

⁸² For information on inpatient and residential treatment for SUD, see Substance Abuse and Mental Health Services Admin., *Treatments for Substance Use Disorders*, <https://www.samhsa.gov/treatment/substance-use-disorders> (last visited Jan. 13, 2017).

⁸³ American Society of Addiction Medicine, *The ASAM Criteria*, <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about> (last visited Jan. 13, 2017). The four levels of care are: outpatient services; partial hospitalization services; inpatient services; and intensive inpatient services.

⁸⁴ At the federal level, CMS has worked to remove barriers for beneficiaries to access inpatient SUD treatment. For example, the agency has proposed to provide states with funding to cover up to 15 days of inpatient rehabilitation services through their Medicaid programs. Ben Allen, *Medicaid may soon pay for some inpatient addiction treatment*, NPR, January 6, 2016, <http://www.npr.org/sections/health-shots/2016/01/06/459226490/medicaid-may-soon-pay-for-some-inpatient-addiction-treatment> (last visited Jan. 13, 2017).

⁸⁵ 42 U.S.C. § 1396a(k), *supra* note 59.

⁸⁶ States can expand upon this requirement but cannot decrease, restrict, or limit coverage of EHBs. See 42 U.S.C. § 1396u-7(b)(5), as added by Pub. L. No. 111-148, § 2001(c)(3) (requiring Medicaid ABPs to provide coverage for all EHBs); see also 42 C.F.R. § 440.347(b) (2014). For a list of EHBs, see 42 U.S.C. § 18022(b)(1) (2010), as added by Pub. L. No. 111-148, § 1302(b)(1).

As part of the ten EHBs, most health insurance plans, including all Medicaid ABPs, must also cover a set of prescription drug benefits.⁸⁷ This requirement has significantly improved access to medications to treat SUD and, in particular, to naloxone for beneficiaries at risk of an overdose. In 2013, the Department of Health and Human Services finalized a rule providing that, for health plans to comply with the prescription drug requirement of the ACA, plans must cover at least one drug in every category and class of the U.S. Pharmacopeia (USP).⁸⁸ Because the USP classifies naloxone as the only drug in the pharmacologic class of toxicologic agents, health plans must provide some form of coverage for naloxone to comply with the EHB rule.⁸⁹ As a result, all Medicaid ABPs in the 50 states must now provide beneficiaries, including all newly eligible beneficiaries, with access to naloxone, making Medicaid one of the most important sources of coverage for this life-saving medication.⁹⁰

Second, as noted previously, the ACA builds on the Mental Health Parity and Addiction Equity Act of 2008, which generally requires health plans that offer benefits for a specific substance use condition in any one of six classifications (inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs), to also provide benefits for that condition in every other classification in which medical or surgical benefits are offered.⁹¹ Moreover, the ACA prohibits insurers from refusing to cover people currently experiencing SUD or with a history of SUD, and prohibits insurers from charging individuals with SUD higher premiums or cost sharing based on their condition.⁹² In March 2016, CMS finalized a rule applying the mental health parity requirement to Medicaid and the Children's Health Insurance Program (CHIP).⁹³ This rule is expected to improve access to substance and opioid abuse services for millions of Medicaid beneficiaries with SUD, including the 23 million enrolled in Medicaid managed care organizations (MCO).⁹⁴ Under the rule, state Medicaid plans must disclose information on mental health and SUD benefits upon request, including the criteria used for determinations of medical necessity. In addition, the parity

⁸⁷ 42 U.S.C. § 18022(b)(1)(F).

⁸⁸ 45 C.F.R. § 156.122(a)(1) (2016).

⁸⁹ For information on the USP Therapeutic Guidelines, *see*

<http://www.fda.gov/RegulatoryInformation/Legislation/SignificantAmendmentstotheFDCAAct/FoodandDrugAdministrationAmendmentsActof2007/FDAAAImplementationChart/ucm232402.htm>.

⁹⁰ For further information on Medicaid naloxone coverage, *see* Naomi Seiler et al., *Medicaid Reimbursement for Take-home Naloxone: A Toolkit for Advocates*, Milken Institute School of Public Health, October 2014, http://prescribetoprevent.org/wp2015/wp-content/uploads/naloxone_medicaid_report_gwu.pdf (last visited Jan. 13, 2017).

⁹¹ 45 C.F.R. § 146.136(c)(2)(ii)(A) (2015).

⁹² 42 U.S.C. § 300gg-3(a) (2010), as added by Pub. L. No. 111-148, § 1201(2)(A) (prohibiting health insurance issuers from imposing preexisting condition exclusions); 42 U.S.C. § 300gg-4(a) (2010), as added by Pub. L. No. 111-148, § 1201(4) (prohibiting health insurance issuers from establishing rules of eligibility based on any health status-related factor); 42 U.S.C. § 300gg-4(b)(1) (prohibiting health insurance issuers from imposing higher premiums based on health status-related factors).

⁹³ 42 C.F.R. § 438.920 (2016).

⁹⁴ For more information on the Medicaid and CHIP mental health parity rule, *see* Centers for Medicare and Medicaid Services, CMS finalizes mental health and substance use disorder parity rule for Medicaid and CHIP, March 29, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html> (last visited Dec. 16, 2016).

rule requires states to disclose the reason for any denial of payment for services with respect to mental health and SUD services.⁹⁵

Although the parity rule does not apply to traditional fee-for-service Medicaid, it does require Medicaid plans to comply with parity in mental health and SUD services regardless of whether services are provided through a Medicaid Managed Care Organization (MCO) or other managed care entities, like prepaid inpatient health plans and prepaid ambulatory health plans.⁹⁶ This means that states that have decided to provide Medicaid services through such managed care entities can continue to do so for mental health and SUD services as long as the state ensures provision of such services on equal footing as medical and surgical services.

Medicaid's comprehensive coverage of SUD treatment services has also been improved by the ACA's Medicaid expansion, which has injected a significant amount of funding for opioid abuse treatment into the system. As with the insurance coverage expansion, eliminating the influx of federal funding available for states to expand the SUD services offered through Medicaid would disproportionately affect the states hardest hit by the opioid epidemic, many of which have opted to expand Medicaid in an effort to add more SUD treatment services to their Medicaid programs' coverage. States like Kentucky, Maryland, Ohio, and West Virginia have used the ACA funding to provide expanded access to MAT for low-income adults with SUD, and Medicaid now pays for between 35% and 50% of all MAT in those states.⁹⁷

Specifically, an ACA repeal threatens to cut 35% of Alaska's funding for MAT using buprenorphine, 30% of the funding for buprenorphine treatment in Pennsylvania, 50% of the funding for buprenorphine treatment in Ohio, and 45% of the funding for buprenorphine treatment in West Virginia.⁹⁸ These states have among the highest rates of opioid dependence and opioid-related overdose deaths and repealing the ACA would substantially threaten their efforts to curb the opioid epidemic. Health economists have estimated that an ACA repeal would effectively eliminate \$5.5 billion each year from treatment currently being received by low-income individuals with SUD and opioid dependence.⁹⁹

State Medicaid Innovations to Address SUD

States have flexibility to tailor their Medicaid programs in a way that addresses each state's most pressing health care needs, so long as they comply with all federal requirements. Through this flexibility, states can act as laboratories for policy innovation and adopt new strategies for SUD service delivery that improve the way Medicaid beneficiaries access substance use treatment.

⁹⁵ For more information on the MHPAEA of 2008 and respective federal regulations see Elizabeth Edwards, *Mental Health Parity and Addiction Equity Act of 2008 Final Regulations and Federal Guidance*, National Health Law Program, January 2014.

⁹⁶ However, states are allowed to include the cost of providing additional mental health and SUD services and the cost of removing treatment limitations in their capitation rate methodology used to determine the payment to other organizations providing Medicaid benefits. Centers for Medicare and Medicaid Services, Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP, March 29, 2016, <https://www.medicare.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf> (last visited Jan. 13, 2017).

⁹⁷ Richard G. Frank & Sherry A. Glied, *supra* note 71.

⁹⁸ *Id.*

⁹⁹ *Id.*

Federal agencies have provided states with several specific opportunities to address the opioid epidemic. In 2014 CMS, CDC, SAMHSA, and the National Health Institute (NHI) issued a Joint Informational Bulletin highlighting the importance of MAT and behavioral therapies in treating SUD, as well as strategies that Medicaid programs can follow for managing MAT.¹⁰⁰ These strategies include adding medications to treat OUD to Medicaid's preferred drug lists (PDLs), requiring evidence that a patient seeking a substance abuse medication is receiving behavioral therapy, and implementing Patient Review and Restriction programs to address overuse of Medicaid services and prescription drugs.

The 2014 Informational Bulletin also provided examples of state-based initiatives to expand SUD and mental health treatment coverage for Medicaid beneficiaries. For example, to improve the coordination of care for individuals with SUD and to facilitate MAT use, Vermont developed a proposal for a health home model, called *Hub and Spoke*. Under the model, individuals with complex SUD and co-occurring mental health conditions receive care through specialty treatment centers responsible for coordinating care across the health and substance abuse treatment systems of care.¹⁰¹ Similarly, Ohio's Medicaid program now allows certain facilities and qualified practitioners to provide MAT, with specific standards of practice for buprenorphine and buprenorphine/naloxone products.¹⁰²

CMS has also issued informational bulletins on treatment for young people with SUD and on best practices to address OPR overdose, misuse, and addiction. In 2015, the agency released a Joint Informational Bulletin with SAMHSA that sought to help states identify strategies to identify, prevent, and treat SUD in adolescents and youth and emphasized ways in which Medicaid programs can finance the full continuum of care for this population.¹⁰³ In addition, in 2016, CMS issued an Informational Bulletin that provided guidance to state Medicaid programs on how to address the overuse and misuse of prescription opioids, including requiring prior authorization by Medicaid before an opioid prescription, prescription quantity limits, and OPR utilization review.¹⁰⁴ This bulletin also emphasized the importance of expanding Medicaid coverage of naloxone.¹⁰⁵

¹⁰⁰ Centers for Medicare and Medicaid Services, Informational Bulletin on Medication Assisted Treatment for Substance Use Disorders, July 11, 2014, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf> (last visited Jan. 13, 2017).

¹⁰¹ For more information on Vermont's Hub and Spoke Model, see <https://www.pcpcc.org/initiative/vermont-hub-and-spokes-health-homes>.

¹⁰² Centers for Medicare and Medicaid Services, Informational Bulletin on Medication Assisted Treatment for Substance Use Disorders, July 11, 2014, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf> (last visited Jan. 13, 2017).

¹⁰³ Centers for Medicare and Medicaid Services, Informational Bulletin on Coverage of Behavioral Health Services for Youth with Substance Use Disorders, January 26, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf> (last visited Jan. 13, 2017).

¹⁰⁴ Centers for Medicare and Medicaid Services, Informational Bulletin on Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction, January 28, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf> (last visited Jan. 13, 2017).

¹⁰⁵ In January 2017, CMS also issued an Informational Bulletin that emphasized the importance of state flexibility in facilitating access to naloxone for Medicaid beneficiaries at risk of overdose. The bulletin highlighted that, using the flexibility afforded to them by the Medicaid program, 40 states have authorized pharmacists to dispense naloxone using "standing orders" issued by licensed healthcare providers authorized by law to prescribe an opioid antagonist.

In 2014, CMS began establishing programs for states to introduce policy, program, and payment reforms that enable Medicaid programs to better identify individuals with SUD, expand access to SUD treatment, and introduce innovative payment mechanisms for SUD prevention and treatment coverage. One of these programs is the Medicaid Innovation Accelerator Program (IAP), through which CMS provides technical assistance and support to states interested in accelerating development and testing of SUD service delivery innovations.¹⁰⁶ The IAP Substance Use program began in February 2015 with two projects: The High-Intensity Learning Collaborative (HILC) program and the Targeted Learning Opportunities (TLO) program, which helps states improve their SUD service system through a monthly web-based learning series.

HILC provides participating states with access to a range of resources to assist them in meeting defined measurable goals for SUD service improvement. There are currently seven states participating in HILC, and IAP offers each state technical support to tailor solutions around their own needs.¹⁰⁷ Kentucky, for example, wanted to ensure appropriate delivery of MAT services and explore bundled payment models for MAT. IAP assisted the state in standardizing its managed care organization data and developing structured programming language to facilitate reporting of quality measures. Similarly, Texas was interested in increasing utilization of SUD services for adult Medicaid beneficiaries by 100%. Through IAP, the state received technical support to calculate a return on investment for SUD system investments, match data across different payers and data systems, and engage their MCO partners in the efforts to overcome barriers for SUD treatment.

CMS has also provided states with the opportunity to develop a full continuum of care for Medicaid beneficiaries with SUD, including short-term residential treatment, under section 1115 of the Social Security Act. Under Section 1115 demonstrations, states can receive federal financial participation (FFP) for costs that would not otherwise be matched under Medicaid. Under CMS's new service delivery opportunity for individuals with SUD, section 1115 demonstration proposals must be aimed at undertaking or complementing broader SUD delivery system transformation efforts.¹⁰⁸ Upon approval of a demonstration project, states are expected to introduce strategies to address the opioid epidemic, including improving opioid prescribing practices, expansion of MAT, and expanded use and distribution of naloxone. Section 1115 demonstrations present an ideal opportunity for states to receive federal funding and technical

Centers for Medicare and Medicaid Services, Informational Bulletin on State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols, January 17, 2017, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib011717.pdf> (last visited Jan. 20, 2017).

¹⁰⁶ Centers for Medicare and Medicaid Services, Medicaid Innovation Accelerator Program Factsheet: Reducing Substance Use Disorders, <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/sud-factsheet.pdf> (last visited Jan. 13, 2017).

¹⁰⁷ For information on HILC states and their IAP initiatives, see Centers for Medicare and Medicaid Services, SUD Program Area High Intensity Learning Collaborative Factsheet, <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/learn-hilc-iap.pdf> (last visited Jan. 13, 2017).

¹⁰⁸ Centers for Medicare and Medicaid Services, Federal Policy Guidance: New Service Delivery Opportunities for Individuals with a Substance Use Disorder, July 27, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf> (last visited Jan. 13, 2017).

help to transform their delivery systems for SUD and introduce innovative strategies that address the specific needs of their populations.

Several states, some of which have been disproportionately affected by the opioid epidemic, have already taken advantage of this opportunity and have requested permission to implement 1115 demonstrations to reform the way they deliver care to their Medicaid beneficiaries with SUD (see Table 2). For example, New Hampshire's section 1115 demonstration seeks to transform the state's behavioral healthcare system through a statewide network of regionally based Integrated Delivery Networks (IDN).¹⁰⁹ These IDNs are currently helping the state to integrate mental health issues in appropriate settings and to develop new expertise to address the current opioid dependence crisis. New Hampshire estimates that the demonstration will have a positive impact on 140,000 Medicaid beneficiaries with behavioral health needs.¹¹⁰

Similarly, through its section 1115 demonstration, California provides a continuum of care modeled after the ASAM criteria for treatment of SUD.¹¹¹ The Drug Medi-Cal Organized Delivery System (DMC-ODS) enables more local control and accountability by requiring counties to provide mental health and SUD services for their populations and by providing county behavioral health agencies with the opportunity of participating in pilot programs that seek to expand access to treatment for Californians at risk of opioid-related overdose. As of January 2017, eighteen counties had applied for implementation of these pilot programs at the local level.¹¹² California's section 1115 demonstration has also introduced strategies to integrate Medi-Cal's behavioral and SUD delivery systems with the rest of the healthcare system.

West Virginia, a state disproportionately impacted by the opioid epidemic, is also seeking to take advantage of the section 1115 demonstration opportunity. The state has submitted a proposal to transform its SUD delivery system in order to expand the availability of addiction treatment for its Medicaid population.¹¹³ The demonstration proposal seeks to expand the number of community-based and outpatient SUD providers, to offer inpatient residential treatment for Medicaid beneficiaries with serious SUD, and to increase the availability and affordability of MAT. The proposal is a critical component of West Virginia's effort to tackle the opioid epidemic and is expected to significantly decrease the number of individuals with SUD and reduce the number of overdose deaths in the state by 2021.¹¹⁴

¹⁰⁹ Centers for Medicare and Medicaid Services, New Hampshire's Building Capacity for Transformation Factsheet, January 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-building-capacity-transformation-fs.pdf> (last visited Jan. 13, 2017).

¹¹⁰ *Id.*

¹¹¹ California Dept. of Healthcare Services, Drug Medi-Cal Organized Delivery System Waiver Factsheet, <http://www.dhcs.ca.gov/provgovpart/Documents/DMC%20ODS%20FACT%20SHEET.pdf> (last visited Jan. 13, 2017).

¹¹² Rachel Wick, *California's Bold New Steps for Treating Drug and Alcohol Use Through Medicaid: Lessons Learned*, Health Affairs Blog, January 26, 2017, <http://healthaffairs.org/blog/2017/01/26/californias-bold-new-steps-for-treating-drug-and-alcohol-use-through-medicaid-lessons-learned/> (last visited Feb. 3, 2017).

¹¹³ West Virginia Dept. of Health and Human Resources, Proposed Medicaid Section 1115 Waiver Application: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders, September 19, 2016, <http://www.dhhr.wv.gov/bms/News/Documents/WV%20Proposed%20Medicaid%20SUD%20Waiver%20Application.pdf> (last visited Jan. 13, 2017).

¹¹⁴ *Id.*

Table 2. Examples of Section 1115 Demonstration Proposals that Include SUD Delivery System Transformation

State	Program Name	Status
CA	Drug Medi-Cal Organized Delivery System (DMC-ODS)	Active
IL	Illinois' Behavioral Health Transformation	Pending Approval
ID	Health Indiana Plan (HIP) 2.0	Pending Approval
KY	Kentucky HEALTH Program	Pending Approval
MI	Pathway for Integration	Pending Approval
MA	MassHealth 1115 Demonstration	Active
MD	HealthChoice	Active
MO	Mental Health Crisis Prevention Project	Pending Approval
NH	Building Capacity for Transformation	Active
NJ	FamilyCare 1115 Comprehensive Demonstration	Active
OR	Oregon Health Plan 1115 Demonstration Project	Active
VA	Addiction Treatment Services Delivery System Transformation	Pending Approval
WV	Creating a Continuum of Care for Medicaid Enrollees with SUD	Pending Approval

While funding for guidance and technical assistance to state Medicaid programs and for implementation of section 1115 demonstrations is not directly tied to the ACA, states could see their local efforts to address the opioid epidemic crippled if the ACA is repealed, if some of its provisions are dismantled, or if the way the Medicaid program is financed is substantially altered. Several states, including Arkansas, Indiana, Iowa, and New Hampshire, have expanded Medicaid through the use of section 1115 demonstrations.¹¹⁵ If the ACA's Medicaid expansion provision is repealed, these section 1115 demonstrations will likely be terminated, leaving most low-income adults in states that expanded Medicaid using section 1115 without access to life-saving SUD treatment.

Moreover, the incoming administration will have the authority to re-interpret section 1115 of the Social Security Act in a way that could lead to denial of demonstration requests that seek to expand access to coverage for Medicaid beneficiaries with SUD. The new administration could also terminate demonstration projects already in place in other states and that have been effective in transforming SUD treatment and delivery at the state level.

¹¹⁵ Robin Rudowitz & MaryBeth Musumeci, *The ACA and Medicaid Expansion Waivers*, Kaiser Family Foundation November 20, 2015, <http://kff.org/medicaid/issue-brief/the-aca-and-medicare-expansion-waivers/> (last visited Feb. 2, 2017); Leonardo Cuello, *Health Advocate: Medicaid Expansion Section 1115 Demonstrations Update*, National Health Law Program, August 2016.

Finally, the new administration has proposed block grants and per capita caps as mechanisms to control Medicaid expenditures.¹¹⁶ Converting Medicaid into a block grant or applying a per capita cap would significantly reduce the amount of funding available to states for coverage of their low-income populations and states will be hard pressed to eliminate non-mandatory coverage from their Medicaid plans in order to reduce the spending associated with the program.¹¹⁷ If the ACA's expansion of the mental health parity requirement and the law's inclusion of mental health benefits as part of the EHBs package are repealed, some states would likely reduce investments in innovative strategies to expand the access to SUD treatment and reform the way SUD services are delivered. No such actions would comport with President Trump's vow to "dramatically expand access to treatment slots and end Medicaid policies that obstruct inpatient treatment."¹¹⁸

Recent Legislative Opportunities

The coverage and opportunities created by Medicaid and the Affordable Care Act are essential in improving the lives of people with and at risk for SUD, as well as their families, communities, and states. Reductions in these programs would have devastating effects on Americans – including many working class rural Americans – that would be felt for generations to come.

Luckily, Congress has recently recognized the importance of addressing the epidemic with the passage of two important laws. In July 2016, President Obama signed the bipartisan Comprehensive Addiction and Recovery Act (CARA), which contains several provisions that support local interventions for SUD treatment and prevention. Most notably, CARA authorizes the Secretary of HHS to award grants of up to \$200,000 per year for the establishment of naloxone programs, training of healthcare providers on naloxone co-prescribing, purchase of naloxone, and to off-set co-payments imposed on naloxone coverage.¹¹⁹ These grants will be available for federally qualified health centers (FQHCs), opioid treatment programs (OTPs), and practitioners waived to prescribe buprenorphine.

CARA also authorizes the HHS secretary to award grants to state substance abuse agencies, local governments, and nonprofit organizations in areas with high rates of opioid use.¹²⁰ This provision expands upon state flexibility to implement strategies that serve the needs of their populations by providing \$25 million to meet the goal of expanded access to MAT for individuals with SUD. The secretary also has the authority to award additional grants for states to establish a plan to combat the opioid epidemic.¹²¹ Finally, as mentioned above, CARA permits

¹¹⁶ See Healthcare Reform to Make America Great Again, <https://www.donaldjtrump.com/positions/healthcare-reform>.

¹¹⁷ Leonardo Cuello, *Per Capita Caps vs. Block Grants in Medicaid*, National Health Law Program, December 2016; Sara Rosenbaum et al., *What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid*, The Commonwealth Fund, November 2016; Phil Galewitz, *Millions Could Lose Medicaid Coverage Under Trump Plan*, Kaiser Health News, November 9, 2016, <http://khn.org/news/millions-could-lose-medicaid-coverage-under-trump-plan/> (last visited Jan. 13, 2017).

¹¹⁸ Donald Trump Outlines Plan to End the Opioid Epidemic in America. 2016, <https://www.donaldjtrump.com/press-releases/donald-j.-trump-remarks-in-portsmouth-nh>.

¹¹⁹ 42 U.S.C. § 290dd-3 (2016), as added by Pub. L. No. 114-198, § 107(a).

¹²⁰ 42 U.S.C. § 290bb-10 (2016), as added by Pub. L. No. 114-198, § 301.

¹²¹ 42 U.S.C. § 290ee-3 (2016), as added by Pub. L. No. 114-198, § 601.

the HHS secretary to expand the number of health care practitioners providing MAT by allowing nurse practitioners and physician assistants to obtain a waiver to prescribe buprenorphine.¹²²

In December 2016, Congress enacted a second law that has the opportunity to improve access to treatment for people with SUD. This law, the 21st Century Cures Act, reauthorizes several grants for programs for mental health treatment, provides support for mental health courts and diversion programs, creates a new HHS assistant secretary in charge of mental health and SUD services, and authorizes grants for community treatment and assisted outpatient treatment for SUD patients.¹²³

The law also expands upon Medicaid's role as a source of coverage for Americans with SUD in several ways. First, it expands EPSDT benefits for children enrolled in Medicaid by covering the full range of EPSDT services when provided in an institution for mental diseases (IMD).¹²⁴ The law also allows mental health providers to bill Medicaid for services furnished to beneficiaries on the same day as primary care services, facilitating access to mental health services and improving coordination between primary and mental health care.¹²⁵ Most importantly, relying on state flexibility to enact policies that meet the needs of their residents, the Cures Act appropriated \$1 billion in grants to be disbursed to states for opioid addiction prevention and treatment programs.¹²⁶ This funding will be distributed across the 50 states, which can use the funds to expand SUD services provided through their Medicaid programs.

Despite the funding opportunities available to states through CARA and the Cures Act, a potential repeal of the ACA and cuts to Medicaid funding threaten the sufficiency of states' resources to reduce the impact of the opioid epidemic. Because Medicaid continues to be the largest payer of SUD services in the country, securing the gains achieved by expanding Medicaid coverage for Americans with SUD is essential to reducing the many harms associated with OUD. It is estimated that repealing the ACA and the Medicaid expansion would result in four million Americans with mental illnesses or SUD losing access to life-saving treatment, 220,000 of whom have an OUD and are at risk of an opioid-related overdose.¹²⁷ While the Cures Act would provide states with an additional \$1 billion to fight the epidemic, a repeal of the ACA would

¹²² 21 U.S.C. § 823(g)(2)(G)(iv), *supra* note 78.

¹²³ Pub. L. No. 114-255, § 14018 (2016); Pub. L. No. 114-255, §§ 14003–14017; Pub. L. No. 114-255, § 60001; Pub. L. No. 114-255, § 9015.

¹²⁴ 42 U.S.C. § 1396d(a)(16), as amended by Pub. L. No. 114-255, § 12005(a)(2). Under Medicaid law, federal financial participation (FFP) is not available for services provided to an individual who is under age 65 and is a patient in an IMD. 42 U.S.C. § 1396d. This limitation is known as the IMD exclusion, and, prior to the Cures Act, included preventive services provided for Medicaid-enrollees under 21 provided in these institutions. The Cures Act lifts this restriction enabling Medicaid-enrollees under 21 who are being treated in IMDs to receive the full range of preventive services included in Medicaid's EPSDT benefit.

¹²⁵ Pub. L. No. 114-255, § 12001. Prior to the passage of the Cures Act, Medicaid beneficiaries had to schedule primary care and mental health services on different days regardless of the proximity of the providers' place of business. This policy also made it difficult for Medicaid to integrate mental health with primary care and other services. Under the Cures Act, both mental health and primary care providers are now able to bill Medicaid for services provided to a beneficiary on the same day, a fix that is expected to help patients with SUD by facilitating access to mental health treatment that can be received on the same day as primary care services and by providing for the integration of mental health care with physical care.

¹²⁶ Pub. L. No. 114-255 § 1003.

¹²⁷ Richard G. Frank & Sherry A. Glied, *supra* note 71.

result in a \$5.5 billion cut in funding for SUD and mental health treatment.¹²⁸ Thus, any gains that could be achieved through recent federal legislation would be dramatically outweighed by cutting Medicaid coverage.

Access to MAT for individuals with SUD is essential to reducing the impact of the opioid epidemic. Treatment with methadone, buprenorphine and naloxone dramatically improves outcomes and reduces overdose-related deaths. CARA and the Cures Act go a long way in expanding access to these life-saving medications, but their provisions will be ineffective without the support of the ACA and the Medicaid expansion. For example, CARA provides funding for organizations to off-set copayments that health plans impose on naloxone and for state-level expansion of MAT coverage. Converting federal funding for Medicaid into block grants or per capita caps or repealing the ACA's cost sharing reduction (CSR) payments to marketplace plans would work against those gains as plans would likely reduce coverage or impose more onerous preauthorization requirements on these medications. Moreover, if the ACA's expansion of the mental health and SUD parity requirement is eliminated, plans will almost certainly reduce their coverage for these services.

Along the same lines, the Cures Act allocates \$1 billion to be distributed across states for their fights against the opioid epidemic. With the ACA in place, states can use this funding to strengthen coverage of MAT for their Medicaid population, a population that has been predominantly and disproportionately affected by substance and opioid misuse. If the Medicaid expansion and the ACA marketplaces are repealed, the \$1 billion provided by the Cures Act will be ineffective and insufficient in reducing the impact of the epidemic.

Conclusion

In many of the states hardest hit by the opioid epidemic, like Ohio and West Virginia, the Medicaid expansion has been instrumental in fighting the epidemic and in increasing access to care for individuals with SUD. In some states, Medicaid now pays for as much as 50% of MAT, funds that both help people overcome addiction and provide much-needed jobs in those states. Any cuts to the funding that states receive for their Medicaid programs would have devastating consequences for Americans with and at risk for SUD, while a repeal of the ACA would undo the achievements made in the last few years. These actions would also weaken the impact of recent federal legislation enacted with bipartisan support to reduce the impact of mental illnesses and substance use disorder, resulting in higher health care costs and preventable suffering, injury, and death.

¹²⁸ *Id.*