

Health Advocate

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[CARA, the 21st Century Cures Act: Tools to Address the Opioid Epidemic](#)

[Medicaid & the ACA: Vital Tools in Addressing the Opioid Epidemic](#)

Medicaid Caps and the Opioid Epidemic

By [Héctor Hernández-Delgado](#)

The opioid epidemic continues unabated. In 2015, over 30,000 Americans died due to an unintentional opioid-related overdose, more than any year on record. On average, 91 individuals die of an opioid overdose in the U.S. each day, more than the number of people who die each day from auto collisions and from gun-related injuries.

Despite recent efforts to increase awareness of the importance of medication-assisted treatment (MAT) in reducing the effects of substance use disorders (SUD), the majority of individuals with SUD are currently not receiving treatment. As currently financed, Medicaid is a vital tool in increasing insurance coverage and access to treatment for individuals with SUD. By converting the Medicaid program to block grants or per capita caps, however, states will lose millions in funding for these life-saving services, leading to preventable suffering, injury, and death.

Medicaid as a Tool to Prevent SUD

Access to timely, mental health preventive services is crucial for reducing the burden of the opioid epidemic, and Medicaid plays a vital role in preventing development of SUDs. The program provides access to mental health and substance use screening for individuals at risk of SUD and is essential in providing preventive services for both children and adults.

First, under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, all beneficiaries under age 21 must be provided with periodic mental health assessment and substance use screening. In addition, all children enrolled in Medicaid are entitled to more in-depth screening when needed to detect a suspected condition not present or discovered during an initial exam. If during mental health and substance use screening it is determined that there may be a need for further assessment or for treatment to prevent development of a SUD, the beneficiary must be provided with the necessary diagnostic and/or treatment services.

Second, under the Affordable Care Act (ACA), all beneficiaries eligible under the Medicaid expansion are entitled to coverage of mental health and SUD preventive services on par with other medical and surgical preventive services. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires most Medicaid plans to provide mental health and SUD benefits that are

not less favorable than coverage of services for physical conditions. The ACA requires Medicaid to offer preventive medical services, like screening for blood pressure and diabetes, to all Medicaid expansion beneficiaries. While the ACA's required preventive services do not include screening and evaluation for substance use, the parity rule extends the ACA's preventive services requirement to mental health and SUD and, thus, requires Medicaid coverage of preventive services for these conditions on the same level as other covered preventive services.

Medicaid's Comprehensive Coverage of SUD Treatment

Medicaid represents the single largest source of insurance coverage for SUD treatment. Of the 20.2 million adults in the U.S. with an SUD, 23 percent are covered by Medicaid. Medicaid is a key player in the fight against the opioid epidemic, as the program is in a unique position to provide access to evidence-based treatment for individuals with SUD at risk of overdose.

Medicaid's coverage of SUD services is generally more extensive than private plan coverage, and includes access to MAT with the medications methadone and buprenorphine, access to the overdose-reversal drug naloxone, and coverage for mental health inpatient treatment for individuals with more serious SUDs. As of 2016, all 50 state Medicaid programs provide coverage for buprenorphine, and 31 states, including 20 Medicaid expansion states, offer coverage of all three FDA-approved opioid agonists to treat SUD (buprenorphine, methadone, and naltrexone).

Medicaid's comprehensive coverage of MAT and naloxone has also been strengthened by the ACA's essential health benefits (EHBs) requirement. As part of the ten EHBs, Medicaid benefits for the expansion population must cover at least one drug in every category of the U.S. Pharmacopeia (USP), a compendium of drug information published annually by the U.S. Pharmacopeial Convention. Because the USP classifies naloxone as the only drug in its pharmacologic category, Medicaid programs in all states must provide beneficiaries with access to naloxone. The prescription drug requirement has also led states to expand coverage of buprenorphine treatment, since buprenorphine is the more cost-effective of the two drugs in the USP Opioid Dependence Treatment category.

Medicaid Caps Would Leave Millions of Individuals at Risk of Overdose without Health Coverage

Republicans are seeking to convert the Medicaid entitlement program into per capita caps or, at state option, block grants. Under the per-capita cap option, instead of matching states' Medicaid funds with federal dollars, the federal government makes payments to states up to a capped amount. Capping Medicaid's federal funding effectively shifts the costs of the program onto state budgets. There are many ways in which Medicaid caps would reduce access to medical services for low-income individuals with SUDs, with much of the impact falling disproportionately on individuals in states hardest hit by the opioid epidemic.

First, changing the Medicaid program into block grants or per-capita-caps may result in states reducing Medicaid eligibility for low-income, non-disabled adults. Some states are likely to elect to revoke their Medicaid expansion, which would leave millions of low-income adults with SUD without health insurance and without access to SUD services that prevent opioid-related overdoses, including MAT and naloxone. SUD services are expensive and access would be cost prohibitive for individuals if they could no longer get this care through the Medicaid program.

There are approximately 4.5 million individuals with SUD in Medicaid, many of whom are at risk of overdose. Capping Medicaid funding would result in a significant number of these individuals losing coverage for services that are effective in preventing overdose deaths.

Medicaid Caps Would Limit Access to SUD Treatment for Medicaid Beneficiaries

Some of the states most impacted by the epidemic have expanded Medicaid to provide services for low-income individuals with SUD. In Ohio, for example, 50 percent of the state's buprenorphine treatment is paid for by the Medicaid program. Similarly, the Medicaid program in West Virginia, which is currently seeking increased federal funding to include methadone treatment as a covered service, accounts for 45 percent of the state's total MAT spending for SUDs. Capping Medicaid's federal funding would significantly reduce the amount of money states receive for their Medicaid program and will hamper their ability to fund SUD services for their low-income populations.

Capping Medicaid will also reduce the effectiveness of the parity requirement. While Medicaid is generally prohibited from imposing limitations on SUD treatment that are more restrictive than limitations on other medical and surgical benefits, this requirement provides protection for beneficiaries with SUD insofar as robust medical and surgical coverage remains in place. Seeking to reduce Medicaid spending, states will likely reduce coverage of medical and surgical services and, thus, might be allowed to reduce the array of SUD services currently covered through their Medicaid programs.

Medicaid Caps Would Lead States to Impose Onerous Requirements on SUD Services

Under Medicaid law, states may impose utilization review on beneficiaries' access to covered services as long as states continue to provide medically necessary services. Facing the prospect of reduced federal funding under a Medicaid funding cap, states will likely begin imposing more burdensome utilization controls on SUD services to reduce Medicaid spending. For instance, states will likely require prior authorization before covering buprenorphine or methadone treatment, which may require the beneficiary's mental health provider to certify that the treatment is medically necessary to improve the patient's condition.

States may also impose simultaneous counseling requirements on MAT coverage, which require beneficiaries with SUD to provide documentation that they are receiving or have received counseling therapy before treatment with medications like buprenorphine and methadone is covered by Medicaid. Finally, states may impose quantity limits on MAT coverage and may subject beneficiaries to "lock-in" programs, which require individuals to obtain some or all SUD services from particular providers for reasonable periods of time. While these restrictions may be effective in controlling the overutilization of some medical services, they are potentially problematic for SUD services if they unreasonably restrict beneficiaries' access to evidence-based and life-saving treatment.

Conclusion

Medicaid is essential in reducing the impact of the opioid epidemic. The program represents the largest source of coverage for Americans with SUD and provides access to preventive mental health and SUD services. In addition, Medicaid offers comprehensive coverage of evidence-based MAT, naloxone, and other life-saving services. Most of the adults with SUD enrolled in

Medicaid became eligible for coverage under the Medicaid expansion. At the same time, Medicaid's coverage of SUD services has been strengthened by the ACA's expansion of the mental health parity rule and the law's EHB provision. But the benefits of Medicaid for low-income individuals with SUD depend to a large extent on the existing Medicaid financing structure and entitlement. Capping Medicaid's federal funding will significantly reduce the funding states receive for their programs and will lead many states to limit Medicaid eligibility of adults with SUD and to cut coverage of SUD services. States may also seek to impose burdensome cost utilization controls, which will further restrict access to life-saving SUD medication and services for low-income adults.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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