



# State Principles for Financing Substance Use Care, Treatment, and Support Services

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# Developing the State Principles for Financing Substance Use Disorder (SUD) Services

In refining the principles presented in this report, CHCS undertook a comprehensive process to understand the current SUD services and financing landscape and develop consensus among a group of stakeholders with expertise in SUD financing, including research and policy experts, providers, state officials, and people with lived experience accessing the treatment system. The process was iterative, with multiple opportunities for stakeholders to review and offer insights, through interviews, a virtual convening, and a convening poll. While a reliable consensus was achieved, it does not mean that all project stakeholders are in absolute alignment with the final wording of each principle. See [Appendix A. Methodology](#), for further details.

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## Executive Summary

**M**ore than 932,000 people in the U.S. have died from a drug overdose since the Centers for Disease Control and Prevention started tracking this data in 1999, with preliminary 2022 data pointing toward another annual all-time high.<sup>1</sup> Opioids, mainly synthetic opioids, are driving the surge in recent years, and overdoses from psychostimulants, such as methamphetamine, are also increasing recently.<sup>2</sup> Over 46 million individuals in the U.S. aged 12 or older meet the clinical criteria for having a substance use disorder (SUD), 29.5 million are classified with alcohol use disorder and 24 million are classified with drug use disorder.<sup>3</sup> Roughly 94 percent of people in the U.S. with a SUD do not receive any treatment and only a fraction of those with opioid use disorder (OUD) receive medications that are considered the gold standard of care.<sup>4,5</sup> People with SUD frequently experience barriers to accessing care and challenges in navigating fragmented health delivery systems, but certain communities of color and under-resourced communities are far more likely to be affected by treatment barriers with too often fatal consequences.<sup>6,7,8,9,10</sup>

To reverse this deadly trajectory and address inequities, states must strengthen their SUD treatment systems, including sustainable financing strategies. This includes accounting for the different needs of people with SUD along a continuum of care, from prevention, early intervention, treatment, and recovery supports, as well as harm reduction services to support people who use drugs and may not be ready or willing to engage in treatment. For most of the last 50 years, federal and state strategies to address SUD have focused on criminalizing substance use, instead of increasing public health approaches.<sup>11,12</sup> This failed “war on drugs” disproportionately targeted communities of color and under-resourced communities and has contributed profoundly to negative societal perceptions of people with SUD.<sup>13,14</sup> Although this legacy of discrimination and stigma persists today, there is now, fortunately, a broader understanding that SUD is a chronic, treatable medical disease and it involves factors related to genetics, the environment, life experiences, and brain chemistry.<sup>15</sup> Also, the evidence base for effective treatments is growing, including medications for OUD (MOUD), behavioral and psychosocial interventions (e.g., cognitive-behavioral therapy, contingency management), as well as culturally and linguistically competent care.

**Strengthening SUD treatment systems requires strategic investments to increase access to evidence-based SUD services and address inequities.** In the last decade, there have been dramatically more opportunities for states to leverage public funds for their SUD treatment systems. The most prominent is the Affordable Care Act (ACA), which enabled many states to expand eligibility for Medicaid to more beneficiaries, a group disproportionately affected by SUD. The ACA also made SUD treatment a required benefit for this newly eligible population and resulted in increased SUD benefits for many other Medicaid enrollees.<sup>16</sup> Many other federal funding streams have become available in the past several years to address the opioid epidemic, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response (SOR) grants, along with greater investments in the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant program, with some funding tied to COVID-19 relief. Additionally, tens of billions of dollars will be flowing into states and localities over the next decade from opioid-related litigation and

settlements. With all these varied funding streams, it is critical that states leverage these dollars in the most coordinated, impactful, and sustainable ways.

With support from The Pew Charitable Trusts, the Center for Health Care Strategies (CHCS) refined a set of 10 key financing principles that can guide states in strengthening the long-term availability of robust SUD treatment and recovery services. The principles were shaped through a process that sought to develop consensus among a group of stakeholders with expertise in SUD financing, including research and policy experts, providers, state officials, and people with lived experience accessing treatment. The report details opportunities for state policymakers, including legislators, governors, Medicaid agencies, substance use agencies, and others to advance each principle, including a review of barriers, opportunities for adoption, state examples, and potential policy actions.

## The Principles



**1. Use Medicaid funds strategically to expand and sustain access to evidence-based substance use prevention, treatment, and recovery support services.** Given the expanded coverage requirements for SUD benefits under the ACA and the Mental Health Parity and Addiction Equity Act (MHPAEA), states have new opportunities and requirements to leverage Medicaid to increase the availability of quality SUD prevention, treatment, and recovery support services.



**2. Direct flexible federal funds — to the fullest extent allowable — toward boosting infrastructure, prevention, harm reduction, and recovery support services.** Given that Medicaid funds are available to support a broad array of direct treatment services for eligible populations, states can focus the use of other federal funds to promote: (1) infrastructure [e.g., workforce development, IT upgrades, billing/claims support, mobile services equipment, bricks and mortar]; (2) prevention [including addressing social determinants]; (3) harm reduction services; and (4) recovery support services, not otherwise covered by Medicaid.



**3. Conduct an inclusive decision-making process for allocating opioid settlement funds and prioritize funds for investments in services and infrastructure needs not covered by Medicaid and other existing state/federal funding streams.** Since these funds are the outcome of historic lawsuits against opioid manufacturers, distributors, and retailers, states should find ways to give a diverse group of people with lived experience in recovery and people who use drugs decision-making capacity along with other subject matter experts who understand how to best address the service needs of the most impacted communities. As in Principle 2, states are encouraged to prioritize these funds for infrastructure, prevention, harm reduction, and recovery support services.



**4. Incentivize and sustain “no wrong door” approaches to substance use care, treatment, and support services.** Since so few people with SUD receive the care they need, states should ease barriers to care by taking a “no wrong door approach” for people to access SUD treatment. This approach creates entryways to substance use treatment and recovery support services through existing medical and behavioral health practices and explores possibilities for outreach and engagement activities in community-based settings, such as community-based organizations, homeless shelters, mobile units, syringe service programs, and correctional settings, among others.



**5. Ensure patients are placed in the most appropriate level of care, including non-residential, community-based substance use treatment, and recovery support services.** A number of factors including homelessness and criminal-legal system involvement have created an overreliance on residential treatment. States can use funds to expand access to community-based care, treatment, and support services so these options are available to patients, as needed.



**6. Address substance use treatment disparities for historically marginalized groups and communities.** There are prominent disparities in substance use treatment for historically marginalized groups, particularly among Black, Latino, and Indigenous populations. Contributing to these disparities are structural barriers that impact service accessibility, under-resourced community-based providers, and a lack of an adequate, diverse, and culturally competent health care workforce. States can leverage statutory, regulatory, and payment requirements and incentives to promote the delivery of quality services in these communities.



**7. Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement.** People with SUD are disproportionately involved in multiple social service sectors (e.g., housing/homelessness, child welfare systems, mental health systems) and the criminal legal system, and people of color are particularly affected more punitively by those systems. People with multi-system involvement often face a diverse range of challenges in accessing treatment, which can lead to poor outcomes. States can leverage policy mechanisms to increase access to quality behavioral health care services for these populations.



**8. Use data to drive effective, equitable care and outcomes.** States can use a variety of strategies to leverage local, state, and federal data — as well as patient-reported outcome measures — to make informed decisions about their SUD treatment system.



**9. Require specialty substance use treatment providers to offer evidence-based treatments, particularly medications for opioid use disorder.** Given that evidence-based, life-saving medications exist for people with SUD, states can use policy levers to require specialty SUD providers to offer evidence-based treatment, including MOUD. States can offer technical assistance and other on-ramping supports to providers to facilitate MOUD expansion efforts.



**10. Bolster the substance use prevention, treatment, and recovery support service network for children and youth.** Because early substance use correlates to substance use problems later in life, and parent/family experience of an SUD can lead to poor outcomes for the child, promoting access to and strengthening the substance use treatment and recovery support service network for children and youth is critical.

# Ten State Financing Principles for Promoting Substance Use Services

**B**y making strategic investments in substance use disorder (SUD) treatment, harm reduction, and recovery systems of care, states can increase access to evidence-based SUD services and address inequities. This report outlines 10 principles that can guide states in strengthening the long-term availability of robust SUD treatment, harm reduction, and recovery services. Each principle includes a set of potential policy action steps and examples to inform state policymaker planning efforts to improve SUD treatment systems.

## HOW TO USE THIS REPORT

Each of the SUD financing principles outlined in this report includes practical policy action steps and concrete examples to help state policymakers and other stakeholders seeking to improve SUD treatment systems. Use the quick links below to navigate to topics of interest:



**Principle 1:** Use Medicaid funds strategically to expand and sustain access to evidence-based substance use prevention, treatment, and recovery support services.



**Principle 2:** Direct flexible federal funds — to the fullest extent allowable — toward boosting infrastructure, prevention, harm reduction, and recovery support services.



**Principle 3:** Conduct an inclusive decision-making process for allocating opioid settlement funds and prioritize funds for investments in services and infrastructure needs not covered by Medicaid and other existing state/federal funding streams.



**Principle 4:** Incentivize and sustain “no wrong door” approaches to substance use care, treatment, and support services.



**Principle 5:** Ensure patients are placed in the most appropriate level of care, including non-residential, community-based substance use treatment, and recovery support services.



**Principle 6:** Address substance use treatment disparities for historically marginalized groups and communities.



**Principle 7:** Advance equitable access and outcomes for substance use care, treatment, and recovery support services among populations with multiple system involvement.



**Principle 8:** Use data to drive effective, equitable care and outcomes.



**Principle 9:** Require specialty substance use treatment providers to offer evidence-based treatments, particularly medications for opioid use disorder.



**Principle 10:** Bolster the substance use prevention, treatment, and recovery support service network for children and youth.



**PRINCIPLE 1**

## Use Medicaid Funds Strategically to Expand and Sustain Access to Evidence-Based Substance Use Prevention, Treatment, and Recovery Support Services

Given the expanded coverage requirements for SUD benefits under the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), states have new opportunities and requirements to leverage Medicaid to increase the availability of quality SUD prevention, treatment, and recovery support services.



Medicaid is a pillar for financing substance use treatment services in the U.S., as the single largest payer of behavioral health services, which includes mental health and substance use services.<sup>17</sup> Medicaid’s prominence as a payer for behavioral health services increased after the passage of the ACA in 2010, as Medicaid expanded coverage (in all but 10 states) to nonelderly adults below 138% of the federal poverty level. As of 2020, one in five Medicaid beneficiaries (21%) had a diagnosed SUD.<sup>18</sup> Also under the ACA, behavioral health coverage became a required essential health benefit (EHB) for the newly eligible population, and some states have sought to align these required benefits with their traditional Medicaid plans.<sup>19,20</sup> Additionally, MHPAEA regulations were introduced alongside the ACA, intending to level the playing field between physical health and behavioral health services by requiring payers, including Medicaid,<sup>\*</sup> to cover behavioral health services in a manner that is no more restrictive than for physical health services.

### Barriers to Effective SUD Care Financing and Quality

While the ACA profoundly improved behavioral health coverage and utilization for Medicaid beneficiaries, much room for improvement still exists in Medicaid for serving people with behavioral health needs. Some important successes in Medicaid since ACA implementation for people with SUD include reduced coverage barriers and increased utilization of medications for opioid use disorder (MOUD).<sup>†,21,22</sup> Unfortunately, during this same time period and through today, there has been an increase in the prevalence of SUD in the U.S. and sharp rises in drug overdose and mortality rates, which year-after-year reach historic levels, while only a fraction of people who need SUD treatment receive any.<sup>23,24</sup> While Medicaid alone cannot be expected to resolve this crisis, some key pain points include:

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<sup>\*</sup> When regulations were published in 2010, MHPAEA targeted payers, including Medicaid Alternative Benefit Plans (ABPs) for the newly eligible population in expansion states. This law was updated in 2017 to include Medicaid managed care organizations (MCOs) and Children’s Health Insurance Program (CHIP).

<sup>†</sup> Throughout this report, we use the term “medication for opioid use disorder” (MOUD) instead of “medication for addiction treatment” (MAT). A primary focus of this report is to explore policy opportunities to increase access to medication for opioid use disorder *specifically*, which provide effective, stand-alone treatment options proven to improve outcomes and saves lives of people with opioid use disorder. We acknowledge that there are also effective medications to treat other SUDs, that may fall into the broader MAT group, though this is not the focus of this document.

- **Provider network inadequacy and workforce shortages.** Although there is great variability among states, many SUD providers do not accept Medicaid. For example, only 40% of SUD providers accept Medicaid in California.<sup>25</sup> Historically, specialty SUD providers operated outside of mainstream health care, relying on grants, especially the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant.<sup>†</sup> There are many factors that inhibit provider participation in Medicaid. Particularly for providers who have not previously accepted insurance, becoming a Medicaid provider can pose significant administrative burdens, requiring the need to adapt for a range of capacities, including staffing (e.g., degree and licensure requirements for reimbursement) and technology (e.g., billing, reporting).<sup>26,27</sup> There is also widespread provider dissatisfaction with Medicaid reimbursement rates for SUD services.<sup>28</sup> Even when providers accept Medicaid, they may not be accepting new Medicaid patients.<sup>29</sup> Also, recently documented behavioral health workforce shortages<sup>30</sup> — stemming in part from frontline health worker burnout since the COVID-19 pandemic<sup>31</sup> — greatly impact Medicaid beneficiaries, who live with SUD at disproportionate rates compared to other groups.<sup>32</sup> Provider scarcity is particularly troubling in under-resourced communities, such as rural communities, where fewer qualified counselors and treatment services are available.<sup>33</sup>
- **Insufficient pathways to SUD treatment, including integrated care.** There are also a lack of sufficient pathways into SUD treatment from other, non-specialty SUD provider types such as primary care physicians. Recognizing that there are complex reasons underlying people's motivations to seek treatment for SUDs, including fears about stigma and difficulties navigating the treatment system, the integration of behavioral health into primary care practice settings has been a growing interest in the field for many years. However, this progress appears incremental.<sup>34</sup> Also, though federally qualified health centers (FQHCs) do provide some mental health care, substance use treatment services are less widely available in these settings.<sup>35</sup> A number of states have made progress, including New Jersey, which aligned incentives for primary care providers to deliver MOUD in their practices using an office-based addiction treatment (OBAT) model, though further supports are needed for states to move the delivery system in the direction of integrated care.<sup>36</sup>
- **More states are beginning to cover key services along the SUD continuum of care that are available through Medicaid, but more effort and investment is needed.** Though Medicaid requires behavioral health coverage for the newly eligible population in expansion states through the EHB requirement, the specific services are not defined.<sup>37</sup> As a result, states typically piece together different coverage options for SUD services and these plans can vary widely state-to-state.<sup>38</sup> In the last several years, over 30 states have implemented waivers in their Medicaid program that intend to increase access to a broad continuum of SUD treatment services, but more investments and effort is needed to make progress. A comprehensive substance use treatment system would include: a range of treatment services to address the various and changing clinical needs of patients; recovery support services to address the wraparound supports that help people in recovery stay in remission; and harm reduction services to support people who use drugs to

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<sup>†</sup> Formerly the Substance Abuse Prevention and Treatment Block Grant (SABG or SAPT).

avoid overdose and other consequences of drug use. (For detailed information about the SUD continuum of care and how states are providing coverage for various services through Medicaid, see [Appendix B](#)).

- **Less access to Medicaid coverage and SUD care among certain racial and ethnic groups.** Persistent racial and ethnic group disparities in health coverage, including Medicaid, affect access to SUD care. Nonelderly American Indian and Alaska Native, Hispanic, Native Hawaiian and other Pacific Islander, and Black people are less likely to be insured compared to white people, despite the overall coverage gains seen in Medicaid and marketplace plans in the years since ACA implementation.<sup>39</sup> The coverage gap for Black and Hispanic people compared to white people is exacerbated in non-expansion states.<sup>40</sup> There is also growing evidence of racial and ethnic group disparities in receipt of MOUD — considered the gold standard in OUD treatment — among Medicaid beneficiaries with OUD, including one study that found non-Hispanic Black people were 42% less likely to receive buprenorphine than white people.<sup>41</sup>

## Principle 1: Potential Policy Actions

As a cornerstone for substance use services for people of low-income and people with disabilities, Medicaid offers a steady, sustainable funding stream for eligible populations and covers an expansive array of services. States have a critical opportunity to examine what services are currently being funded through other sources that could alternatively be covered under Medicaid, as well as where opportunities exist to newly offer or strengthen access to SUD services and supports.

Select policy actions include:

- ✓ **Adopt a coordinated approach to align federal and state funds for services, particularly as state Medicaid programs move to cover services historically supported through other funding streams.**

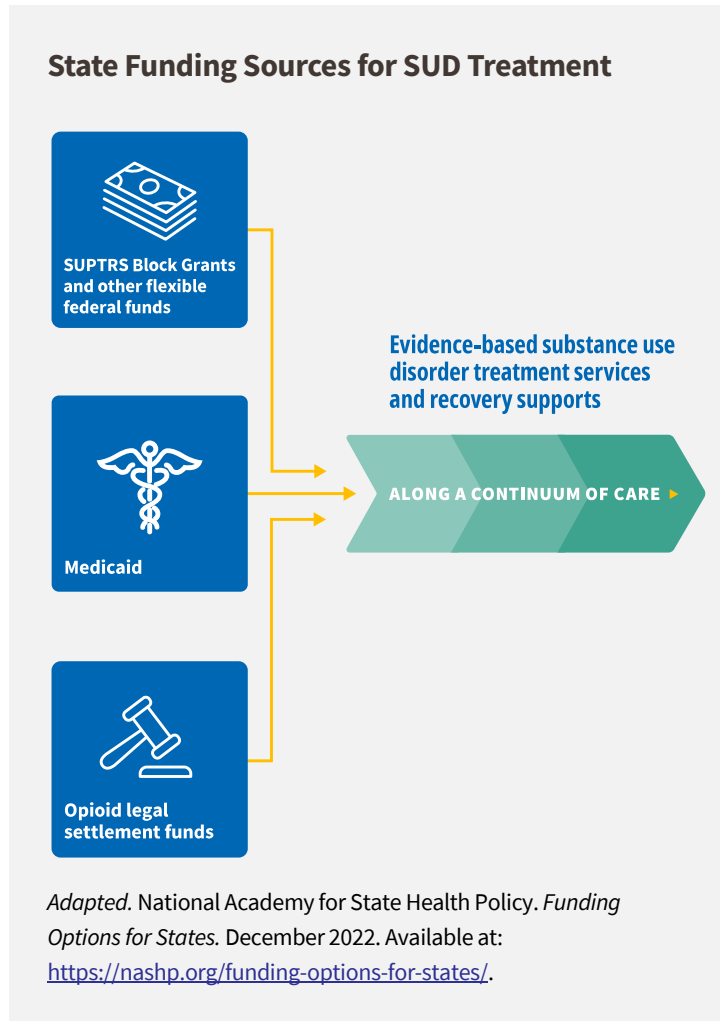
Without intentional interagency collaboration at the state level to align SUD service funding, the funds may remain siloed, contributing to inadequate, fragmented care at the community level. Many states have already implemented strategies or structures (e.g., task forces) to align SUD funding. However, these efforts can be complicated by the recent introduction of new SUD funding streams and increases for existing SUD funding. Further, efforts must be made to ensure that key system leaders and stakeholders are represented when making funding allocation decisions, to ensure that gaps in treatment



**Intervention is really needed above the level of agency heads. These leaders — state mental health and substance use directors, Medicaid directors — have constrained bandwidth, and they have so much else going on. Sometimes it takes high-level leadership to push people to examine the dollar streams together — Medicaid, opioid settlement funds, SAMHSA grants — to make sure you are deploying Medicaid as fully as you can for treatment services and bringing in grant or other dollars for things that promote treatment and recovery that are not covered under Medicaid.**

- Vikki Wachino, MPP, Principal, Viaduct Consulting LLC and Former Deputy Administrator, Center for Medicaid and CHIP Services

systems are being addressed and evidence-based treatment services are prioritized. Key stakeholders include representatives from the governor’s office, the Medicaid director’s office, the substance use agency, the mental health agency, the department of health, the corrections department, and the office of children and families, among others. It is also crucial to include representatives from the different systems that people with SUD interact with, such as housing services, and criminal legal services, schools, as well as people with lived experience and subject matter experts knowledgeable about evidence-based services. The group should focus on inventorying SUD services available in the state through Medicaid or other federal or state funding (see sidebar), identifying any critical service gaps, and examining how services are currently paid for alongside a state-specific analysis indicating what Medicaid authority (e.g., state plan, waivers) may cover specific services (if any).



- ✓ **Apply for an SUD 1115 waiver to maximize services, for both residential and community-based services, including harm reduction.** Under federal law, Medicaid does not reimburse behavioral health treatment services delivered in “institutions for mental disease” (IMDs) if the individual is 21 to 64 years old. This is known as the “IMD exclusion.” While this exclusion does not apply to general hospitals with inpatient behavioral health units (because they do not primarily provide behavioral health care), it has historically applied to inpatient behavioral health settings, including SUD residential treatment settings (e.g., sober living homes, recovery homes, rehabs) and inpatient psychiatric hospitals. However, a Section 1115 demonstration waiver was made available to states through guidance from the Centers for Medicare & Medicaid Services (CMS) in 2015<sup>42</sup> (revised in 2017)<sup>43</sup> that allows federal funding for services in these settings for Medicaid beneficiaries, as long as states are also investing in building out a comprehensive continuum of care that includes investments in community-based services. Waivers are currently in place in 34

states.<sup>44</sup> States that receive waiver approval can free up funds previously used to support residential treatment (sometimes through SUPTRS) to invest in the care continuum.

Many project stakeholders, who participated in either the convening or individual interviews, expressed serious concerns about the quality and effectiveness of residential treatment providers, which typically use abstinence-based treatment approaches. One recent study found many residential treatment providers do not offer, or actively discourage the use of certain MOUD among program participants.<sup>45</sup> Under the 2017 waiver guidance, residential care and other providers are required to ensure access to MOUD within one to two years of the waiver approval, but there is a lack of research regarding whether states are monitoring compliance of these practices in residential care treatment settings (see also [Principle 9](#) on requiring specialty substance use treatment providers to offer evidence-based treatments, particularly MOUD). States implementing waivers should monitor compliance with these programs.

**PRINCIPLE 1 POLICY IN ACTION** **Spotlight on Virginia**

Virginia is one of 34 states that has been approved for the Section 1115 substance use waiver.<sup>46</sup> Like many states, Virginia established its waiver as part of a broader initiative to develop its continuum of care. Starting in 2017, Virginia’s effort — called the Addiction Recovery and Treatment Services (ARTS) program — sought to model their delivery system based on the American Society of Addiction Medicine (ASAM) placement criteria, increase coverage of and access to MOUD and peer recovery supports, increase SUD treatment payment reimbursement rates, integrate physical and behavioral health care through a managed care “carve in,” among other goals while also adopting Medicaid expansion in 2019.<sup>47</sup> Early findings from Virginia’s ARTS program show increases in treatment rates for OUD as well as decreases in emergency department and inpatient usage among Medicaid beneficiaries.<sup>48</sup>

***Following is an initial set of potential state policy actions:***

PRINCIPLE 1 POLICY ACTION	STATE EXAMPLES
Adopt a coordinated approach to align federal and state funds for services, particularly as state Medicaid programs move to cover services historically supported through other funding streams.	<a href="#">Pennsylvania’s</a> governor issued a Disaster Proclamation in 2018 that issued executive orders to combat the state’s opioid crisis and improve outcomes for people with SUDs, including the establishment of an Opioid Command Center made up of 17 different state agencies that interface with people in the state with OUD or other SUDs. This collaborative group developed a <a href="#">three-year strategic plan</a> that centers on strategies that emphasize prevention, rescue (harm reduction), treatment (including the expansion of MOUD), recovery and sustainability of these efforts.

PRINCIPLE 1 POLICY ACTION	STATE EXAMPLES
Apply for an SUD 1115 waiver to maximize services for both residential and community-based services, including harm reduction.	<a href="#">Virginia's</a> Addiction Recovery and Treatment Services (ARTS) program sought to model their delivery system based on the American Society of Addiction Medicine (ASAM) placement criteria and increase coverage of and access to MOUD and peer recovery supports.
Use value-based payment approaches that reward providers for equitable outcomes and quality services, as defined and agreed upon by various stakeholders including people with lived experience.	The <a href="#">Pennsylvania</a> Rural Health Model incentivizes participating rural hospitals for reducing overdose deaths, reducing rural health disparities and increasing connections to primary and specialty care.
Allow for presumptive eligibility for members in the process of applying for Medicaid.	<a href="#">Indiana</a> is one of several states that expanded presumptive eligibility for several eligibility groups, including childless adults and former foster care youth. The state offers <a href="#">a range of qualified entities</a> to conduct determinations, including FQHCs and community mental health clinics.
Broaden eligibility pathways: (a) Expand eligibility for up to 12 months postpartum; and (b) In non-expansion states, consider elevating the benefit that expansion plays on increasing access to SUD care.	<a href="#">West Virginia</a> is one of 36 states, including DC, as of July 2023, that have implemented a Medicaid postpartum coverage extension of 12 months. <a href="#">Other states</a> are planning to implement 12-month extension and there is some variation in the eligible population and benefits across states.
Cover telehealth for MOUD and ensure privacy, data ownership and program integrity measures.	<a href="#">Virginia</a> Medicaid covers the tele-prescribing of MOUD. Of note, the U.S. Drug Enforcement Administration (DEA), in collaboration with SAMHSA, is <a href="#">currently considering a permanent rule regarding</a> allowing for prescribing of certain controlled medications via telemedicine without an in-person medical evaluation. A temporary rule, initially adopted during COVID-19, allowing for this flexibility is currently in place.
Explore new pathways for states to use Medicaid funds to address social determinants of health.	<a href="#">Arizona</a> is one of <a href="#">many states</a> approved for a Section 1115 waiver to address the health-related social needs of Medicaid beneficiaries for certain populations. Arizona's waiver, which <a href="#">was approved in October 2022</a> , is targeted at Medicaid beneficiaries who are homeless or at risk of becoming homeless and who have certain physical or behavioral health diagnoses and social risk factors. The services include several housing supports (e.g., post-transition rent for up to six months, utility costs) and case management and other supports (e.g., benefit application assistance, benefit program application fees). For other examples, this 1115 waiver <a href="#">tracker</a> has a section for social determinants of health.
Cover all evidence-based and evidence-informed services, including harm reduction and recovery supports, allowed by Medicaid and use a level of care criteria to ensure placements in the lowest level of care necessary.	<a href="#">New Mexico's</a> SUD continuum of care is described in Attachment D of a Special Terms and Conditions Letter regarding its CMS approved Medicaid 1115 SUD Demonstration, which includes many Medicaid-covered services described along the ASAM levels of care. New Mexico covers a range of evidence-based SUD treatment under its Medicaid program, including MOUD ( <a href="#">without prior authorizations</a> ) and <a href="#">peer recovery supports</a> .

PRINCIPLE 1 POLICY ACTION	STATE EXAMPLES
Provide adequate reimbursement for all Medicaid services.	<a href="#">New Jersey</a> , in 2016, invested \$127.5 million to increase Medicaid rates for behavioral health services following an updated assessment of the costs of providing high-quality services. The higher rates, generally set at the existing Medicare rate, <a href="#">resulted in an increased number</a> of providers participating in the Medicaid program.
Incentivize team-based care coordination through Medicaid, including in office-based settings.	<a href="#">Vermont</a> developed a “hub and spoke” model for their opioid-focused health home program, where hubs (Opioid Treatment Programs) and spokes (Office-based Opioid Treatment) receive a monthly bundled payment for health home services and opioid use disorder treatment. Rates were designed based on prospective staffing levels (e.g., program directors, registered nurses, clinical case managers).
Seek Medicaid waiver authority to offer substance use treatment and other services to people before their release from jails and prisons and suspend (not terminate) Medicaid eligibility during incarceration.	<a href="#">California</a> will cover an array of pre-release services, including behavioral health consultation and MOUD, among other services provided through a recently approved 1115 waiver amendment.
Remove non-evidence-based utilization management policies that inhibit access to MOUD (e.g., prior authorization, tapering requirements).	As of April 2020, <a href="#">13 states and DC</a> limit Medicaid from imposing prior authorizations on medications for SUD using state law. Other states have used non-legislative policy actions to remove prior authorizations, including <a href="#">Virginia</a> , which <a href="#">removed</a> prior authorization from its Medicaid program for prescribing some MOUD by designating some MOUD as preferred drugs on the Medicaid Common Core Formulary preferred drugs list.
Cover non-medical transport coverage for individuals taking methadone.	<a href="#">Pennsylvania’s</a> Medicaid program covers transportation to medical appointments, including methadone clinics, through its <a href="#">Medical Assistance Transportation Program</a> .

## PRINCIPLE 2

### Direct Flexible Federal Funds — to the Fullest Extent Allowable — Toward Boosting Infrastructure, Prevention, Harm Reduction, and Recovery Support Services

Given that Medicaid funds are available to support a broad array of direct treatment services for eligible populations, states can focus the use of other federal funds to promote: (1) infrastructure (e.g., workforce development, IT upgrades, billing/claims support, mobile services equipment, bricks and mortar); (2) prevention (including addressing social determinants); (3) harm reduction services; and (4) recovery support services, not otherwise covered by Medicaid.



Prior to the ACA, publicly financed SUD services were supported primarily through state and local funds, as well as the federal SUPTRS block grant. SUPTRS, administered by SAMHSA, has long been and continues to be a pillar of states' SUD treatment systems, as the largest federal block grant provided to state alcohol and drug authorities. In expansion states, costs for SUD services have largely shifted to Medicaid. At the same time, SUPTRS funding was not decreased for expansion states, however, this block grant funding has not kept pace with inflation. For these states, this means there is unprecedented funding to support the SUD treatment system. This creates opportunities to direct block grant funds toward needed investments in the SUD treatment system that are not coverable by Medicaid.

#### Barriers to Effective SUD Care Financing and Quality

For federal fiscal year 2023, SUPTRS block grants totaled \$1.8 billion, distributed by formula to states. As with any grant, there are restrictions on the use of funds, including a 20% set aside for prevention services, five percent restriction on administration, and restriction on payment for certain infrastructure like bricks-and-mortar. With the rise of the opioid epidemic — which was exacerbated by the COVID-19 pandemic — Congress approved three additional investments for SUPTRS, totaling \$5 billion and authorized other discretionary grant programs for SUD treatment, such as the State Opioid Response (SOR) grant program that has amounted to over \$1 billion each year since it began in 2019.<sup>49,50</sup> SOR replaced the State Targeted Response to the Opioid Crisis (STR) program that was initially appropriated in 2017.<sup>51</sup> Although these federal grant dollars are critically necessary, relying on them to build out the SUD treatment systems poses challenges, including:

- **The SUPTRS block grant is not keeping pace with inflation, despite the rising health care costs and needs.** Over a 10-year period, the purchasing power of SUPTRS decreased by 24%,<sup>52</sup> as funding levels stayed relatively the same, while health care prices escalated and the SUD crisis in the U.S. has grown more dire. Recent investments by Congress into SUPTRS were primarily considered emergency funds related to COVID-19 relief and states had short timeframes to spend those dollars down.



- **Federal grants can be limited, including restrictions related to use of funds.** For example, SOR grants are critical for addressing the needs of people with OUD, but have less flexibility for targeting other types of SUDs, such as alcohol use disorder. The FY22 SOR grant did lift opioid-related activity restrictions on the funds to allow for services that address stimulant use, which is critical as use of stimulants (e.g., methamphetamine, cocaine) — and related overdose deaths — have increased in recent years.<sup>53</sup>
- **Annual authorizations and appropriations make budgeting inefficient.** SOR and SUPTRS are authorized and appropriated each year, making it difficult for state policymakers to budget effectively and pushing them to spend down the dollars by the end of each year.<sup>54</sup>
- **Some states are spending federal grant dollars for services allowable in Medicaid.** For example, as of 2022, at least two states do not cover methadone to treat OUD, despite CMS guidance from 2020 requiring states to provide Medicaid coverage for all forms of FDA-approved medications, including methadone.<sup>55,56</sup>

## Principle 2: Potential Policy Actions

State policymakers achieve stronger and more equitable treatment systems by using these flexible federal dollars in coordination with their Medicaid SUD program. For example, there are many hidden organizational capacity costs to developing strong SUD treatment systems that are not claims-based/reimbursable by Medicaid, such as workforce training, technical assistance for implementing claims and reporting IT systems, purchasing telehealth equipment, and renovating aging facilities, among others.

Additionally, as most states are still not yet covering many recovery support services through their Medicaid programs (though many of these services are available to be covered in Medicaid, either through state plans, waivers or demonstration programs; see [Appendix B](#)), the dollars can be directed toward these services until the time they become available through the state’s Medicaid program. Finally, since Medicaid does not currently cover key harm reduction services, such as sterile syringe distribution and overdose prevention counseling (see [Appendix B](#)), states should seek to cover these services using flexible federal funds.



**It is important to note that flexible federal funds can be used to pilot Medicaid services. Whenever I wanted to try out a program and evaluate it, I would try and use federal grant funds, because then I didn’t have to apply for a 1915(b) waiver for geographical or provider limits. I could simply test a case — using SAMHSA funds — see if it worked and decide if it was worth trying to build into an 1115 Demonstration or take statewide via State Plan.**

- Zoe Barnard, MA, Senior Advisor, Manatt Health and former Montana Mental Health Commissioner

Select policy actions include:

- ✓ **Use available federal funding sources for infrastructure spending to the maximum extent allowable, understanding that some of these funding sources come with restrictions on administrative/non-treatment spending.** For example, Missouri used STR funds to address low utilization of MOUD by training specialty SUD providers on the science of MOUD and the value of low barrier/low-threshold treatment approaches to MOUD delivery.<sup>57</sup> In Pennsylvania, the Department of Corrections used SOR dollars to fund naltrexone and buprenorphine medications for anyone booked into a correctional facility who had been enrolled in an MOUD program in the community.<sup>58</sup>

In other cases, these funds can go toward ancillary, infrastructure-related costs for Medicaid-covered services. For example, SAMHSA now encourages the use of SUPTRS block grant funds for mobile units to provide SUD outreach, screening, assessment, and recovery support services, including dispensing MOUD.<sup>59</sup> While MOUD is covered under Medicaid, the one-time equipment purchases needed to establish one of these mobile programs is not, such as purchasing vehicles. Additionally, under American Rescue Plan Act of 2021, there is now an enhanced federal matching rate for three years for states that choose to cover mobile crisis intervention services through Medicaid. Flexible federal dollars will be necessary to purchase the mobile crisis team equipment and implement dispatch systems. New Jersey is an example of one state using SUPTRS and SOR funds to stand up mobile medication vehicles for people with SUD.<sup>60</sup> Providers who are awarded contracts, after going through an RFP process, will be awarded up to \$300,000 to purchase an outreach van.

#### **PRINCIPLE 2 POLICY IN ACTION** Spotlight on Rhode Island

There is a growing body of evidence for emergency department (ED)-based peer recovery support programs suggesting that peers who engage with patients after a non-fatal overdose can successfully connect them to MOUD and other recovery supports.<sup>61,62</sup> The AnchorED program in Rhode Island opened in 2014 with support from SUPTRS.<sup>63,64</sup> In 2018, CMS authorized reimbursement of peer supports in Rhode Island under an 1115 demonstration waiver. Although Medicaid funding is now available, the AnchorED program continues to rely on the flexibility of grant funds to cover program expenses that Medicaid cannot.

**Following is an initial set of potential state policy actions:**

PRINCIPLE 2 POLICY ACTION	STATE EXAMPLES
<p>Use flexible federal funding sources for infrastructure spending to the maximum extent allowable, understanding that some of these funding sources come with restrictions on administrative/non-treatment spending.</p>	<p><a href="#">Missouri</a> used STR funds to address low utilization of MOUD by training specialty SUD providers on the science of MOUD and the value of low barrier/low-threshold treatment approaches to MOUD delivery. In <a href="#">Pennsylvania</a>, the Department of Corrections used SOR dollars to fund naltrexone and buprenorphine medications for anyone booked into a correctional facility who had been enrolled in an MOUD program in the community.</p>
<p>Create a comprehensive fiscal map of all Medicaid and non-Medicaid federal, state, and local funds that support SUD services across all state agencies to better use these funds to complement existing Medicaid and state funding.</p>	<p><a href="#">Maine's</a> governor, through an executive order in 2019, established a Director of Opioid Response position <a href="#">to identify and coordinate funding</a> for substance use prevention, treatment and recovery services, and established a cabinet consisting of representatives of state agencies that are related to people with substance use needs. Their 2021 strategic plan is evidence of the coordinated and comprehensive approach the director and cabinet have taken to align funding streams toward state SUD priorities.</p>
<p>Conduct a needs assessment to understand the state's greatest areas of need for service system infrastructure dollars and direct funds to those areas.</p>	<p><a href="#">Colorado</a> conducted a statewide behavioral health needs assessment in 2020. The assessment served to better identify and understand the causes of disparities, to guide the development of a long-term behavioral health strategic plan and be responsive to their behavioral health block grants, which require the state to complete needs assessments.</p>
<p>Use flexible federal funds to support workforce development, including for peer support services, to the extent Medicaid reimbursement is not available.</p>	<p><a href="#">Delaware</a> is using SOR funds to build out the training and certification of the peer workforce within the community and the prison system. Peer support specialist training is now offered as a workforce pathway training within state prisons for people prior to release.</p>
<p>Use flexible federal funds (e.g., within SUPTRS) to pay for harm reduction and recovery support services.</p>	<p><a href="#">Washington State</a>, in 2017, used STR funds to establish integrated hub and spoke networks, which included syringe exchange programs as spokes to better support people with OUD to access MOUD or other treatment. Washington's SOR funds will support syringe exchange programs, as well as other community-based sites, as hubs to better increase access to treatment for people in more rural areas.</p>
<p>Use flexible federal dollars to fund service pilots, including for harm reduction, recovery supports and other innovative SUD services, that can be evaluated and brought to scale through Medicaid in the future.</p>	<p>An Indianapolis hospital pilot <a href="#">used STR funds</a> to employ peers to assist people recovering from overdose in the emergency department. <a href="#">Indiana's</a> Medicaid program now covers peer services.</p>

PRINCIPLE 2 POLICY ACTION	STATE EXAMPLES
<p>Explore the need to finance the IT infrastructure (e.g., electronic health records (EHR)) that SUD providers need in order to review their data, measure the quality of their care, conduct reporting, coordinate with other providers, and set up billing infrastructure.</p>	<p><a href="#">Illinois</a> established the Medicaid Technical Assistance Center in 2021 to provide technical assistance to strengthen the business infrastructure of community-based behavioral health providers, to enhance these providers’ abilities to serve more Medicaid beneficiaries.</p>
<p>Support partnerships across state agencies and sectors, which are a necessary but often overlooked category when it comes to allocating grant dollars for services that are not covered through Medicaid.</p>	<p><a href="#">Kansas</a> capitalized on two federal grants from SAMHSA and CDC to improve cross-agency collaboration on addressing SUD and develop a comprehensive, aligned statewide <a href="#">SUD strategic plan</a>.</p>
<p>Address other existing Medicaid gaps, for example: services for people not covered by Medicaid; when Medicaid can cover the linkage to support services, but not the services themselves; and/or when Medicaid covers components of certain SUD services but are not fully reimbursable.</p>	<p><a href="#">Maine</a> relied on SUPTRS block grant funds to launch MOUD programming in their state prison system, then developed continuity of care protocols to ensure that program participants could enroll in Medicaid immediately upon their release into the community.</p>
<p>Use SOR grants to fund services and supports for OUD <i>and</i> stimulant use disorders not covered by Medicaid.</p>	<p><a href="#">Wisconsin</a> has used SOR grant funds in a variety of ways to address both opioid use and stimulant use disorders, including <a href="#">providing grants to tribal nations and counties</a> to address local unmet treatment needs.</p>

### PRINCIPLE 3

## Conduct an Inclusive Decision-Making Process for Allocating Opioid Settlement Funds and Prioritize Funds for Investments in Services and Infrastructure Needs Not Covered by Medicaid and Other Existing State/Federal Funding Streams

Since opioid settlement funds are the outcome of historic lawsuits against opioid manufacturers, distributors, and retailers, states should find ways to give a diverse group of people with lived experience in recovery and people who use drugs decision-making capacity along with other subject matter experts who understand how to best address the service needs of the most impacted communities. As in Principle 2, states are encouraged to prioritize these funds for infrastructure, prevention, harm reduction, and recovery support services.



It is estimated that states and localities will receive lawsuit settlements in excess of \$50 billion from opioid manufacturers, distributors and retailers over 15 years.<sup>65</sup> There are many parameters on spending for how states and localities may use these funds, including the requirement that 70% must be spent on opioid-related expenses and an expectation that the interventions supported reflect certain evidence-based/evidence-informed strategies, as outlined in Exhibit E of the settlement.<sup>66</sup> There is also wide variation in the structures and processes for allocating these funds across states, regions and localities, including significant flexibility in how states enforce spending guardrails.<sup>67,68</sup>

### Barriers to Effective SUD Care Financing and Quality

Because the opioid settlements represent a historic and guaranteed funding opportunity over the course of at least a decade, there are inherently some risks for how states and localities handle these dollars including:

- **Risk of not learning from the experience of the tobacco settlement.** Based on lessons from how states managed the 1998 tobacco settlement, there are concerns among public health experts that the opioid-related settlement funds will be re-purposed to address other state needs. Of the overall \$246 billion that states received from the tobacco settlements, less than three percent were spent on smoking prevention or cessation programs.<sup>69</sup> Without mechanisms to hold states accountable, the tobacco trust funds went toward filling state budget gaps, building roads and bridges, and other state projects.
- **Lack of transparency in allocation decision-making and reporting could damage the public trust and be counterproductive.** Despite the precedent set by tobacco settlement funds, transparency is not a requirement embedded in the largest national settlement to date. Public reporting is only required for the 15% of funds that will be used on spending categories unrelated to the opioid epidemic. Only 13 states have committed to publicly sharing where the funds are to be spent.<sup>70</sup>

### Principle 3: Potential Policy Actions

States and localities receiving opioid settlement funds have an important opportunity to invite people with firsthand knowledge of the opioid crisis into decisions about how to spend these dollars in a way that ensures they are put to maximal use in addressing the opioid epidemic and to invest in harm reduction infrastructure and services.

Select policy actions include:

- ✓ **Develop transparent and accountable processes for deciding how to allocate the funds, including shared decision-making with people with lived experience.** Given that disturbingly high overdose death rates persist year after year in most states, it is particularly important to use these funds to consider the views of people with lived experience, their family members, and community-based providers that work to support them. By developing collaborative relationships with these community partners, states and localities can better assess needs (which may include gaps that cannot yet be filled through Medicaid and other flexible federal funds). Also, establishing more democratic structures with community partners for how these resources are allocated has the potential to drive equity and empower those most impacted and uncover more responsive approaches to reducing the effects of the overdose crisis and addressing health disparities. Collaborative projects, such as the [Principles for the Use of Funds from the Opioid Litigation](#), have also emphasized the need for states and localities to include people with lived experience and other important groups in their allocation decision-making processes.



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**We must highlight the importance of transparency as to the use of these funds. The way the tobacco settlement dollars were managed is not the way to do this; in some states, those funds went toward building roads and bridges. These funds should be flexible and go toward treatment, recovery, and support — all of those pieces of the puzzle that increase treatment opportunities.**

- Patrice Harris, MD, MA, Co-Founder & CEO, eMed and Medical Editor In Chief At Large, Everyday Health; President, American Medical Association (2019-2020)

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### PRINCIPLE 3 POLICY IN ACTION Spotlight on Maine and Rhode Island

**Maine** is one of 11 states to establish an opioid settlement council that has decision-making authority, as opposed to advisory only.<sup>71</sup> The [Maine Recovery Council](#), established in [state law](#), is composed of 15 members, appointed by the Attorney General and other government officials, and includes individuals or family members impacted by the opioid crisis, people with an SUD or recovery community experience, and public health experts in treatment or prevention. The council's charge is to "direct the disbursement of funds within the Maine Recovery Fund for approved uses." These approved uses include evidence-based or evidence-informed programs, including expanding the use of naloxone and MOUD. Meetings are open to the public (in-person or via video) and decisions require at least a majority of members.

**Rhode Island** established an [opioid settlement advisory committee](#) where five of 18 members are "community and expert representatives," including people with lived experience. The advisory committee [provides annual recommendations](#) to the state on how to use the settlement funds and it has conducted a highly transparent process for broadcasting to the public [how the council was formed and how it functions](#), including sharing its modified consensus-building approach for recommendation-making. Additionally, the committee shared how the nomination process worked for the five community/expert representatives, including accounting for the status of achieving diverse representation (racial and ethnic minorities, languages other than English, gender identity, sexual orientation, age, disability, Veteran status, and geographic representation, including non-cities).

- ✓ **Use opioid settlement funds to support the development and/or expansion of harm reduction infrastructure and services.** Historically, harm reduction services have been highly stigmatized and federal and state funding has followed suit — paling in comparison to treatment and recovery services funding. This lack of support has left harm reduction infrastructure severely lacking in virtually every state — especially when considered in the context of recent year-after-year increases in overdose deaths. Given the unprecedented opportunity for input from people with lived experience, the prioritization of transparency and accountability, increased flexibility around the use of funds, as well as low administrative and reporting burdens, opioid settlement funds are ideal for supporting harm reduction infrastructure. States can consider using settlement dollars to quickly stand up lifesaving harm reduction services given rising overdose deaths, while simultaneously assessing opportunities for sustainable harm reduction infrastructure (e.g., brick and mortar centers, mobile outreach vehicles). Funds can also be used to address stigma toward people who use drugs within health care settings and communities at-large, and pilot the integration of harm reduction philosophy and services in "traditional" health care settings where many people who use drugs seek care.

**PRINCIPLE 3 POLICY IN ACTION** Spotlight on Rhode Island

In 2021, Rhode Island became one of the first states to allow for the licensing of a [harm reduction center](#), specifically an overdose prevention center/supervised consumption site, where people who use drugs can be monitored by medical professionals. The site is scheduled to open in Providence in 2024 and receive roughly \$2 million in opioid settlement funds to operate it.<sup>72,73</sup> Funds from a National Institute of Health grant will support a research team from Brown University to investigate the center’s efficacy for lowering rates of fatal and non-fatal overdoses, substance-related medical conditions, and ED visits, as well as explore cost-savings and if the center promotes engagement in substance use treatment.<sup>74</sup>

**Following is an initial set of potential state policy actions:**

PRINCIPLE 3 POLICY ACTION	STATE EXAMPLES
Develop transparent and accountable processes for deciding how to allocate the opioid settlement funds, including providing decision-making capacity to people with lived experience.	In addition to the examples of <b>Maine</b> and <b>Rhode Island</b> described in detail in the sidebar on page 23, <b>North Carolina</b> has committed to a transparent and accountable process regarding the settlement funds, including developing <a href="#">public dashboards</a> that will display county plans and county spending (annually reported) for the settlement dollars.
Use opioid settlement funds to support the development and/or expansion of harm reduction infrastructure and services.	<b>Rhode Island</b> became one of the first states to allow for the licensing of a harm reduction center, specifically an overdose prevention center/supervised consumption site, where people who use drugs can be monitored by medical professionals. The site is scheduled to open in Providence in 2024 and receive roughly <a href="#">\$2 million in opioid settlement funds</a> to operate it.
Establish a dedicated fund for opioid settlement funds that is separate from general treasury funds.	<a href="#">This tracker from the Prescription Drug Abuse Policy System</a> displays data on key laws that states are establishing for the opioid litigation proceeds, including the many states have established a fund dedicated for the opioid litigation proceeds (see filter question #2, “Does the state mandate establishment of an opioid litigation proceeds fund (‘Fund’)?”) and links to the legislation from each state, which help to ensure the funds do not become co-mingled in the states’ general funds and remain dedicated for opioid use prevention, harm reduction, treatment and recovery supports.
Ensure that opioid settlement funds do not supplant funding for related services.	<b>New York State</b> strengthened protections for how these funds are spent through its legislation to establish a separate opioid settlement fund. It reads, “Money expended from such fund shall be used to supplement and not supplant or replace any other funds, including federal or state funding, which would otherwise have been expended for SUD prevention, treatment, recovery or harm reduction services or programs. Provided further, general operating funds or baseline funding shall not be reduced due to monies expended from the fund.”



PRINCIPLE 3 POLICY ACTION	STATE EXAMPLES
<p>Develop regional organizations of counties, or other regional authorities (such as public health authorities), that can help with coordination of managing opioid settlement funds.</p>	<p><b>North Carolina</b> is encouraging collaborative strategic planning, which is inclusive of a broad range of perspectives and considers ways to maximize opportunities for these funds at the local level. In some instances, counties are working collaboratively to develop regional solutions, such as Burke County that is seeking to partner with several western North Carolina counties to <a href="#">form a consortium</a>, with each participating county dedicating 50% of their county settlement funds to planning and operating a 68-bed treatment center for people with acute SUD and long-term needs.</p>

**PRINCIPLE 4**

## Incentivize and Sustain “No Wrong Door” Approaches to Substance Use Care, Treatment, and Support Services

Since so few people with SUD receive the care they need, states should ease barriers to care by taking a “no wrong door approach” for people to access SUD treatment. This approach creates entryways to substance use treatment and recovery support services through existing medical and behavioral health practices and explores possibilities for outreach and engagement activities in community-based settings, such as community-based organizations (CBOs), homeless shelters, mobile units, syringe service programs, and correctional settings, among others.



### Barriers to Effective SUD Care Financing and Quality

There is a glaring need to reduce barriers in the U.S. for people with SUD to receive quality treatment. In 2020, over 41 million people age 12 or older in the U.S. needed substance use treatment, yet only four million people receive any treatment.<sup>75</sup> For people with a need for OUD treatment in 2019, only one in four received MOUD.<sup>76</sup> While recent changes implemented at the federal level promise to address this divide — including the SUPPORT Act requirement that Medicaid cover MOUD through September 2025 and the ending of the Drug Addiction Treatment Act waiver (X-Waiver) requirement for buprenorphine prescribing — there remain many barriers to accessing SUD care.<sup>77,78</sup> These include the stigma that surrounds SUD, which in turn negatively impacts health care providers’ attitudes about people seeking SUD treatment, as well as difficulties in accessing and staying in treatment. Some specific challenges include:

- **Substance use treatment is separated from mainstream health care.** SUD is a chronic medical condition, yet it is well documented that substance use treatment is siloed from mainstream health care. This is due, in part, to how SUD services have operated as specialty treatment providers with separate funding streams and different training and regulatory/licensing requirements. This siloed approach perpetuates stigma about SUD among non-specialty health care providers, who often lack training on SUD, which is necessary to increase understanding about available treatments and may reduce negative attitudes about people who use drugs. Despite state efforts, integrated care models have not adequately reached scale.<sup>79</sup> The lack of integration of SUD care into mainstream health care, including EDs, contributes to health care disparities and adverse health outcomes.
- **Mental health services and substance use treatment are often siloed.** According to the National Institute on Drug Abuse, 38% of adults in the U.S. with an SUD also have a co-occurring mental illness.<sup>80</sup> Yet, too often, people with co-occurring conditions receive siloed services that fail to treat both conditions. There is a need for licensing and training to be distinct, yet — with these trainings and licensing tracks often segregated into separate state agencies — there lacks a coordinated approach. Many people with co-occurring disorders do not end up receiving the care they need

and as many as one in nine adults with co-occurring disorders become involved in the criminal legal system annually.<sup>81</sup>

- **People with SUD and the criminal legal system.** The U.S. lacks public health strategies to better reach and engage people with SUD into a comprehensive treatment system. Instead, a punitive approach is more common, and communities of color have been disproportionately targeted.<sup>82</sup> Per data from 2007-2009, more than half of people in state prisons and more than two-thirds of people sentenced in local jails met the criteria for drug dependence or abuse.<sup>83</sup> Yet, despite a 1976 Supreme Court decision stating that deliberate indifference to the serious medical needs of incarcerated people is a violation of the Eighth Amendment and its prohibition against cruel and unusual punishment, fewer than three in 10 of these individuals in the 2007-2009 report received drug treatment or participated in a program in their correctional facility.<sup>84,85</sup> Furthermore, studies show that periods of incarceration are very vulnerable events for people with SUD, placing them at risk for forced withdrawal, and they are 100 times more likely to die of overdose after release compared to the general population.<sup>86,87</sup> Additionally, there is a growing understanding that relying on drug treatment court mandates as pathway to treatment for this population is ineffective and problematic.<sup>88</sup>

## Principle 4: Potential Policy Actions

There are many opportunities for states to provide “no wrong door” approaches in their SUD treatment systems, and some of the initial work involves considering, selecting, and implementing the approaches that are the best fit for the needs of each state. States like Massachusetts have reviewed state agency data to get a better understanding of where people with SUD needs are coming into contact with the medical, public health, and correctional systems, as a starting point for designing more integrated and effective interventions. One study, done in partnership with several universities and the Massachusetts Department of Public Health, found up to 50% of opioid overdose deaths had the potential to be averted if interventions were delivered at certain touchpoints, including after nonfatal overdose episodes in EDs or upon release from incarceration.<sup>89</sup>



**States are looking at different models and strategies, thinking of what is right for them to achieve integration with substance use provision and other services. Some states are looking at the Certified Community Behavioral Health Clinic model as one pathway, but that won't necessarily be right for every state. Others will consider [using] managed care contracts. Another pathway is building providers' capacity to communicate with other providers. Since I don't think we're going to see a world where co-location is happening everywhere, it's important to set expectations about communication and coordination, and [give] tools to help them do that.**

- Lindsey Browning, MPP, Director of Medicaid Programming, National Association of Medicaid Directors

Select policy actions include:

- ✓ **Leverage value-based payment (VBP) models to incentivize high-quality, coordinated, and integrated health care service delivery.** VBP models, which aim to reward value rather than volume and are tied to performance on targeted quality measures, may incentivize the proliferation of substance use treatment services that demonstrate better outcomes for patients. Studies have found successful examples of behavioral health-related VBP models that demonstrated improved access, engagement, and effectiveness.<sup>90</sup> VBP can support “no wrong door” approaches through a variety of mechanisms, including incentivizing the establishment of low-barrier treatment options, such as low-barrier buprenorphine in hospitals, or adding SUD measures as part of a broader quality measures set in existing VBP models like accountable care organization (ACO) programs.

#### **PRINCIPLE 4 POLICY IN ACTION** Spotlight on Pennsylvania

Pennsylvania established a Hospital Quality Improvement Program for OUD, where participating hospitals receive an incentive payment for increasing the rate of OUD treatment engagement among Medicaid beneficiaries seen in their EDs within seven days post-discharge.<sup>91</sup> In Phase One of the program, in 2019, the state distributed \$30 million in “process” payments for hospitals that implemented between one to four defined clinical pathways between EDs and ongoing OUD care, which will ultimately help to improve the seven-day follow-up performance. These pathways are: (1) warm hand-offs from ED-initiated buprenorphine to community SUD care; (2) warm hand-offs from the ED to MOUD in the community, or abstinence-based care; (3) specialized protocol for pregnant woman with OUD, and; (4) admission from ED to inpatient for methadone or observation for buprenorphine.<sup>92</sup> Participating hospitals were able to receive up to \$193,000 for implementing these pathways.

In Phase Two of the program, participating hospitals can receive incentive payments for providing care to Medicaid beneficiaries and utilizing the established clinical pathways that lead to higher rates of Medicaid beneficiaries receiving OUD treatment within seven days following ED-based treatment. Incentive payments are tied to two different performance metrics — the rate of Medicaid beneficiaries getting seven-day follow-up treatment measured against a state established benchmark, and the rate of Medicaid beneficiaries getting seven-day follow-up treatment measured against the hospital’s prior year’s rate.

**Following is an initial set of potential state policy actions:**

PRINCIPLE 4 POLICY ACTION	STATE EXAMPLES
Leverage VBP models to incentivize high-quality, coordinated, and integrated health care service delivery.	<a href="#">Pennsylvania</a> established a Hospital Quality Improvement Program for OUD, where participating hospitals receive an incentive payment for increasing the rate of OUD treatment engagement among Medicaid beneficiaries seen in their EDs within seven days post-discharge.
Recognize potential role of FQHCs as safety net provider for underserved (including rural) communities, in improving access by integrating SUD care, including harm reduction services, and invest in opportunities to enhance their SUD work.	<a href="#">Florida</a> uses <a href="#">SOR grant dollars</a> to fund a peer-to-peer mentoring program, where specially trained physicians deploy to FQHCs and other providers around the state to educate practitioners on evidenced-based SUD treatment, including MOUD.
Implement Certified Community Behavioral Health Clinics as a strategy to better deliver integrated care.	<a href="#">The SAMHSA Criteria</a> for Certified Community Behavioral Health Clinics requires they employ prescribers who “can prescribe and manage medications independently under state law, including buprenorphine and other FDA approved medications used to treat opioid, alcohol, and tobacco use disorders.” In <a href="#">Missouri</a> , there has been a 122% increase in individuals receiving MOUD between the baseline and the fourth demonstration year.
Fund the provision of mobile, community-based harm reduction services, including basic medical care and linkage to treatment services when appropriate.	<a href="#">Maryland</a> supports a mobile health clinic model in Baltimore, where a van staffed with medical practitioners visits areas of the city impacted by the opioid epidemic and provides buprenorphine, harm reduction services, as well as supplies, basic medical care, and connections to mental health services.
Facilitate and incentivize integration of SUD prevention, treatment, and recovery services into medical systems, including in the general hospital, ED, primary care, and OB/GYN.	<a href="#">California</a> supports the CA Bridge model, which has implemented bridge programs in 278 hospitals in the state that provide low-threshold access to MOUD, peer support, and navigation to ongoing services.
Facilitate and incentivize team-based care coordination and data sharing among all relevant providers in a care ecosystem.	<a href="#">New York State</a> established a Statewide Health Information Network for New York, led by the New York eHealth Collaborative, to coordinate access to electronic health information in a timely fashion and facilitate data exchange across eligible providers statewide, including behavioral health organizations, patient centered medical homes, and more. <a href="#">The Data Exchange Incentive Program</a> provides incentive payments to providers to encourage participation in the network.

PRINCIPLE 4 POLICY ACTION	STATE EXAMPLES
<p>Address administrative fragmentation at the state level by aligning administrative and regulatory requirements, for example by allowing integrated licensure of facilities for co-occurring care for substance use and mental health.</p>	<p>To support greater delivery of integrated care, <a href="#">Arizona</a> consolidated responsibility for all of these services under one authority, leading to greater focus and collaboration on integration efforts and improved regulatory and purchasing processes. Arizona <a href="#">also eliminated additional auditing</a> for patient centered medical homes with behavioral health distinction to encourage greater primary care integration, and plans to also do this for behavioral health homes.</p>
<p>Address billing challenges to integrated care.</p>	<p><a href="#">New Jersey</a> is an example of a state that enables same day billing in FQHCs, as long as the Medicaid beneficiary is being treated by different licensed practitioners for different diagnosis, including a physical and behavioral health encounter.</p>
<p>Optimize managed care organization (MCO) contracting to encourage integration across mental health, SUD, and physical health services, including non-traditional health care settings (e.g., syringe service programs, homeless shelters, mobile units).</p>	<p><a href="#">Pennsylvania</a> also requires their Medicaid physical and behavioral health plans to participate in VBP models, which must also incorporate at least one CBO to address social determinants of health.</p>

## PRINCIPLE 5

### Ensure Patients are Placed in the Most Appropriate Level of Care, Including Considering Non-Residential, Community-Based Substance Use Treatment, and Recovery Support Services

A number of factors including homelessness and criminal-legal system involvement have created an overreliance on residential treatment. States can use funds to expand access to community-based care, treatment, and support services so these options are available to patients, as needed.



#### Barriers to Effective SUD Care Financing and Quality

In the U.S., there has been an overreliance on acute, short-term residential care, also called “rehab,” to support people with SUD needs, despite the availability of more evidence-based and less costly treatments.<sup>93</sup> This overreliance is connected to a broad idea that controlling the surroundings and stimuli of a person with SUD makes it easier to achieve recovery. The criminal legal system contributes to this by mandating residential treatment programs — some of which may not offer MOUD<sup>94</sup> — as part of case adjudication or reentry plans, sometime without considering the person’s clinical appropriateness for this intensive level of care. For instance, sometimes referrals are made primarily because the person lacks housing in the community.

Residential treatment programs are very costly for states, potentially disruptive to patients’ relationships and employment, and not universally indicated based on level of need. In 2020, 36% of SUD treatment admissions in the U.S. were for residential treatment, including detoxification treatment delivered at residential or hospital inpatient programs.<sup>95</sup> For example, in Louisiana in 2018, 58% of Medicaid recipients who received OUD care attended a residential or inpatient facility for a cost of \$34 million, as opposed to outpatient facilities (42%) where the cost was \$6 million.<sup>96</sup> Some other issues regarding the use of residential treatment include:


- **There is limited evidence for residential treatment.** It is challenging to assess the quality of residential treatment programs due to fundamental variability in these programs, including differences in who is accepted into the program, which treatment modalities are used, and how long clients remain in the program. One 2014 systemic review found the evidence was moderate at best, with some studies showing no significant difference between residential and outpatient programs, aside from housing differences.<sup>97</sup> Since the history of these programs is rooted in abstinence-based treatment philosophies, many programs do not offer MOUD, with some requiring tapering prior to program entry. A 2020 study found only 29% of a random sample of residential programs offered MOUD and many dissuaded callers from its use.<sup>98</sup>
- **Despite CMS’ expectation that states approved for the IMD waiver expand their services along the care continuum beyond residential care, there are concerns about lack of enforcement.** The IMD waiver (described in Principle 1) was meant to lift the prohibition on Medicaid

reimbursement for residential treatment, alongside the requirement that states concurrently invest in evidence-based, community-based alternatives, which can be more clinically appropriate and less costly. However, some stakeholders are concerned that there is a lack of oversight about ensuring access to these community-based alternatives.

- **There is a lack of standardization in use of SUD assessment tools.** Routine screenings and assessments are standard practice for many chronic, physical ailments, but not as reliably conducted for SUD treatment. One recent report found that there is a need for greater consistency in approaches for identifying the most appropriate level of care for people with SUD and that states have a role to play in that.<sup>99</sup> Without consistent strategies for identifying appropriate levels of care for people with SUD, there remains a risk that people will be placed in inappropriate levels of care.

## Principle 5: Potential Policy Actions

States should support the development of community-based SUD care to ensure alternatives to residential care as the primary SUD treatment option. The ASAM criteria (described in [Appendix B](#)) is a nationally recognized assessment tool already required of SUD providers in several states (especially in states with Medicaid 1115 waivers), which helps providers determine treatment planning across a continuum of care. The ASAM continuum of care provides a framework for understanding clinical services along the continuum of care, in which three out of five levels of care are community-based (prevention/early intervention, outpatient and intensive outpatient/partial hospitalization) and can be covered by Medicaid (see [Appendix B](#) for details).<sup>100</sup>



**Recovery happens before, during, and after treatment. We don't often think of what it's like for someone ready for treatment to hear that intake is in three weeks. During that wait time, peer recovery coaches should be able to help that person. During treatment, recovery coaches can reduce no-shows and develop a recovery support plan. At the same time, we also need to recognize that many people may not want to participate in treatment, but harm reduction services and other recovery support services could help them on their recovery journey.**

- Patty McCarthy, MS, Chief Executive Office, Faces & Voices of Recovery

Additionally, a care continuum should include non-clinical services, such as recovery services that are increasingly being covered by Medicaid, as well as through federal grants, such as SUPTRS and SOR grants.

Select policy actions include:

- ✓ **Invest in recovery supports including developing recovery community centers and the peer workforce.** Peer recovery coaches (also known as peer specialists and peer support workers, among others), in the substance use treatment context, are people with lived SUD experience who support others with SUD and foster wellness and recovery. Because of their own lived experience with SUD, they can build uniquely trusting bonds with the people they serve and support engagement with individuals who might otherwise be hard to reach. The growing evidence on peer recovery coaches shows that peers can lower intensive acute care use



(hospitalization and withdrawal management) and can increase engagement in outpatient SUD services, including among populations with co-occurring disorders.<sup>101</sup> As a key component of the continuum of care, peer recovery coaches can be effectively embedded in: outpatient treatment settings to support patients from the point of intake and throughout the recovery plan; EDs to support patients with SUD as they transition back into the community after discharge; and criminal legal system reentry programs to facilitate continuity of care upon reentry. States can invest in recovery supports through a variety of mechanisms, such as Medicaid and grants. For instance, covering peer recovery services in the Medicaid benefit, or using block grant funds to initiate recovery community centers.

**PRINCIPLE 5 POLICY IN ACTION** **Spotlight on New Jersey**

New Jersey’s Medicaid program covers peer support services for beneficiaries with an SUD, one of 38 states doing so based on 2019 data.<sup>102</sup> Peer Support Specialists in New Jersey are certified, have two years of experience of successful recovery from an SUD diagnosis, and can practice in outpatient settings with supervision conducted by a licensed clinician.<sup>103</sup> They support people with SUD in treatment planning, developing goals and skill building, motivational interviewing, providing linkages to treatment and support, and play a positive role in the person’s life. New Jersey also operates two state-funded and 10 SOR-funded Community Peer Recovery Centers, which are primarily run by peers to provide support, information and linkages to treatment and events, and a sense of community and belonging for people in recovery.<sup>104</sup>

**Following is an initial set of potential state policy actions:**

PRINCIPLE 5 POLICY ACTION	STATE EXAMPLES
Invest in recovery supports including developing recovery community centers and the peer workforce.	<a href="#">New Jersey’s</a> Medicaid program covers peer support services for beneficiaries with an SUD and operates two state-funded and 10 SOR-funded <a href="#">Community Peer Recovery Centers</a> , which are primarily run by peers to provide support, information and linkages to treatment and events, and a sense of community and belonging for people in recovery.
Standardize routine screening and assessment (and re-assessments) of people in the SUD treatment system to ensure placement into clinically appropriate treatment and recovery supports throughout treatment.	CMS requires that states with Section 1115 waivers for SUD treatment require SUD providers <a href="#">to use an evidence-based, SUD patient assessment tool</a> . <a href="#">Illinois</a> , a state that has been approved for the Section 1115 waiver, requires SUD providers to conduct an assessment, consistent with the ASAM criteria, prior to admission to any level of care.

PRINCIPLE 5 POLICY ACTION	STATE EXAMPLES
<p>Implement a centralized “conflict free” assessment that is not conducted by SUD providers.</p>	<p>While not often seen in the SUD field, level of care determinations and conflict free case management are federal requirements in long-term services and supports. This <a href="#">New York State</a> presentation explains the conflict-free case management concept in children’s home- and community-based services service delivery, where the same entity cannot participate in both service eligibility determination and service delivery.</p>
<p>Train providers on the ASAM (or other selected) patient assessment tool, and consider incentivizing or requiring providers to use it.</p>	<p><a href="#">Pennsylvania</a> requires use of ASAM criteria by all SUD providers that receive funding for treatment services through agreements with Single County Authorities (SCAs) and/or MCOs. The Commonwealth also conducts a <a href="#">monthly ASAM technical assistance series</a> for providers that covers a range of topics including implementing the criteria, and delivering MOUD across the care continuum, <a href="#">which is covered</a> either by providers themselves or the SCAs.</p>
<p>In states with managed care delivery systems (or ACOs), include requirements related to ASAM level of care placement in the MCO/ACO contract.</p>	<p><a href="#">Arizona</a> requires that Medicaid plans and SUD providers use the ASAM criteria to conduct treatment planning and make determinations about appropriate levels of care.</p>
<p>Develop provider oversight mechanisms to ensure compliance with standardized assessment tools (e.g., secret shopper studies, EQRO reviews, reporting requirements).</p>	<p>In addition to mandating that SUD providers use the ASAM criteria, <a href="#">New Hampshire</a> state law requires health plans that provide SUD coverage to file an annual attestation of compliance related to this level of care criteria.</p>
<p>Ensure State Medical Board guidance does not contradict best practice guidance from ASAM (e.g., no requirements for forced tapering).</p>	<p>States that are authorized to implement Section 1115 demonstration waivers for substance use treatment, which allows for reimbursement for residential care in IMDs, are expected also to implement continuums of care for SUD, including early intervention, outpatient, and recovery services. Some of these states, such as <a href="#">California</a>, adopted their care continuum based on the nationally recognized, evidence-based ASAM criteria, cross-walked SUD provider licensing regulations, and altered state regulations to conform with the ASAM criteria, such as requiring SUD providers to obtain an “ASAM designation.” States should also evaluate their State Medical Board guidance to conform with ASAM criteria.</p>

## PRINCIPLE 6

# Address Substance Use Treatment Disparities for Historically Marginalized Groups and Communities

There are prominent disparities in substance use treatment for historically marginalized groups, particularly among Black, Latino, and Indigenous populations. Structural barriers contribute to these disparities and include service accessibility, under-resourced community-based providers, and a lack of an adequate, diverse, and culturally competent health care workforce. States can leverage statutory, regulatory, and payment requirements and incentives to promote the delivery of quality services in these communities.



## Barriers to Effective SUD Care Financing and Quality

Black, Latino, and Indigenous populations are disproportionately burdened by substance use related problems and often face higher rates of morbidity and mortality when compared to other racial and ethnic groups.<sup>105</sup> Poor outcomes for these populations are closely associated with disparities in accessing treatment and services. Of individuals who may benefit from treatment for substance use, Black, Latino, and Indigenous populations had lower treatment utilization rates (24.5%, 24%, and 26% lower, respectively) when compared to their white counterparts.<sup>106</sup> There are several factors that exacerbate these disparities in treatment access including:

- **Structural barriers to accessing care.** Research demonstrates that people often need significant support on their recovery journey, specifically related to navigating the SUD treatment system and addressing barriers to service access. Structural barriers include economic hardship, a lack of childcare and transportation, waitlists and appointment scheduling delays, and general provider inaccessibility.<sup>107,108</sup> These barriers often compound and can have detrimental impacts on health outcomes for historically excluded groups and communities, who already face significant disparities in accessing SUD services. Additionally, explicit and implicit bias among health care providers can reinforce structural dimensions of the health care system, including medical education, which perpetuate racial and ethnic health disparities.<sup>109</sup>
- **Shortages in the behavioral health care workforce.** The behavioral health workforce shortage greatly impacts SUD treatment capacity and acts as a barrier to care for many patients.<sup>110</sup> While the workforce shortage is widespread, its impact is particularly detrimental for Medicaid populations as some providers only accept a limited number of Medicaid patients or may not accept new Medicaid patients at all.<sup>111</sup> Racial and ethnic minority groups, particularly Black, Latino and Indigenous populations, economically disadvantaged communities,<sup>112</sup> and residents of rural areas<sup>113</sup> are often disproportionately impacted by the workforce shortage given the long-term impacts of historic redlining policies — or policies which discriminate against an individual based on the location in which they live<sup>114</sup> — and the disproportionate enrollment of these groups in Medicaid.<sup>115,116</sup> A 2022 research study examined clinician supply across redlined neighborhoods and reported decreased availability of behavioral health clinicians in redlined communities.<sup>117</sup>

- **Lack of diversity among providers and staff.** The significant underrepresentation of Black and Indigenous People of Color (BIPOC) within the SUD workforce<sup>118</sup> and limited availability of culturally and linguistically effective providers are systemic factors that perpetuate disparities in access to SUD treatment.<sup>119</sup> Patients may not engage with or remain in services that do not reflect their cultural and language preferences or needs, often leaving non-white, non-English speaking patients without desirable treatment options. Research demonstrates that a behavioral health workforce that is reflective of the community it serves leads to greater patient satisfaction and stronger working alliances between patients and providers.<sup>120</sup> This may be particularly important in SUD treatment, where effective engagement is so critical.
- **Low-resourced community-based organizations.** CBOs are typically non-profit entities that work at the local level to provide support, services, and resources to communities. CBOs differ from traditional SUD treatment providers as they take a more holistic approach to patient care and offer services ranging from awareness and education campaigns to support programs for families and harm reduction services.<sup>121</sup> Within the broader SUD workforce landscape, CBOs play an important role, as they often serve historically excluded groups, are deeply embedded within these communities, and have built trusting relationships with community members.<sup>122</sup> While this positions CBOs well to actively address disparities in SUD treatment and services, CBOs are often small organizations and face significant resource limitations that impact their ability to deliver quality, behavioral health treatment. These barriers include staff shortages, excessive paperwork, managing reporting requirements, as well as costs and complexity related to obtaining and sustaining licensure.<sup>123,124</sup>

## Principle 6: Potential Policy Actions

By addressing issues related to capacity, cultural competency, and staff diversity within the SUD workforce, states can promote increased access to quality SUD treatment and services. The policy and financing options noted in this section can serve as key drivers of behavioral health equity for historically marginalized populations.

Select policy actions include:

- ✓ **Strengthen and diversify the SUD workforce pipeline by leveraging funding opportunities from flexible federal funds, workforce development grants through the U.S. Department of Labor,<sup>125</sup> and loan repayment programs that focus on supporting health care professionals.**<sup>126</sup> Funding from these various streams can be used to build peer to clinician pipelines, fund addiction medicine fellowships, enact tuition reimbursement policies, and develop partnerships with local colleges and universities, historically Black colleges and universities, and other institutions dedicated to



**It is important to ensure representation of communities and providers who are not normally part of these conversations. Their perspectives have great potential to change the SUD landscape and address some of the many racial inequities in the addiction treatment field.**

- Tracie M. Gardner, Senior Vice President of Policy Advocacy, Legal Action Center

serving under-represented populations. To diversify their SUD treatment workforce, states can also examine how culturally and linguistically effective care considerations are present within their existing service system.

- ✓ **Require and incentivize providers to be trained in and provide culturally informed treatment options to promote increased access to culturally and linguistically appropriate services.** States can leverage contract language with MCOs and ACOs to build in these requirements and ensure that they are contracting with providers who reflect the communities they serve.
- ✓ **Eliminate barriers and offer targeted technical assistance to community-based providers to become Medicaid providers.** This may include providing support with data infrastructure to better manage burdens related to data collection, billing, and coding as well as grant management and strategic planning supports, which can lead to enhanced organizational and programmatic capacity and sustainability.<sup>127</sup> Investing in community-based substance use treatment and recovery support providers who serve historically excluded groups and communities can also directly address substance use treatment disparities. States can also develop statutory requirements that set aside state funding for CBOs to sustain their long-term growth.
- ✓ **Require MCOs and ACOs to build member engagement strategies into contracts.** Centering the voices and perspectives of people with lived experience and people who use drugs, through meaningful and sustained community engagement strategies, can support states in building a more robust, accessible, and equitable substance use treatment and services system that better reflect community needs. These contractual requirements can obligate MCOs/ACOs to engage with Medicaid members through a range of potential modalities including surveys, focus groups, community advisory boards, and even including members on their governing body. States can also connect with their existing Medicaid Advisory Committee and/or connect directly with members through leveraging trusted community partners, such as CBOs, for feedback and guidance around implementing policy approaches and leveraging funding to address common barriers to accessing services, including transportation, childcare supports, and other accommodations.

**PRINCIPLE 6 POLICY IN ACTION** **Spotlight on Tennessee and Kentucky**

**Tennessee** takes a comprehensive approach to behavioral health workforce development. In addition to more general programs such as the [Tennessee Promise Program](#), a statewide scholarship and mentoring program, the state has convened topic-specific workgroups, such as the [Public Behavioral Health Workforce Workgroup](#), to address workforce challenges for the behavioral health system. Some long- and short-term strategies include creating employee-focused incentives and benefits, researching the cost of services to better understand provider costs and adjust rates, expanding internship opportunities, loan forgiveness programs, and future workforce pipeline planning. A key area of focus for the workgroup is building a more diverse and inclusive workforce through comprehensive diversity and inclusion planning efforts in all areas of service delivery and targeted recruitment efforts.

[The Kentucky Opioid Response Effort \(KORE\)](#) aims to build a robust, sustainable, and equitable SUD system of care, through SAMHSA funding. As a part of these efforts, contract language was added to all KORE-funded agencies requiring disaggregation of data by relevant demographic or social determinant of health factors and the inclusion of at least one equity-focused initiative in grant-funded work. Additionally, KORE activities focused on increasing the capacity of BIPOC-led and BIPOC-serving CBOs through a funding opportunity focused on implementing culturally relevant interventions to reduce overdoses, addressing barriers to contracting with the state, and facilitating monthly grantee learning collaborative and technical assistance efforts.

***Following is an initial set of potential state policy actions:***

PRINCIPLE 6 POLICY ACTION	STATE EXAMPLES
<p>Strengthen and diversify the SUD workforce pipeline by leveraging funding opportunities from flexible federal funds, workforce development grants through the Department of Labor, and loan repayment programs that focus on supporting health care professionals.</p>	<p><a href="#">Tennessee</a> convened a Public Behavioral Health Workforce Workgroup to address workforce challenges for the behavioral health system. Some strategies included creating employee-focused incentives and benefits, researching the cost of services to better understand provider costs and adjust rates, expanding internship opportunities, loan forgiveness programs, and future workforce pipeline planning.</p>
<p>Require and incentivize providers to be trained in and provide culturally informed treatment options to promote increased access to culturally and linguistically appropriate services.</p>	<p><a href="#">New York State</a> requires Medicaid MCOs to ensure (through annual certifications) that all of their network provider staff, who have regular and substantial contact with enrollees, complete state-approved cultural competence training, including training on the use of interpreters.</p>

PRINCIPLE 6 POLICY ACTION	STATE EXAMPLES
<p>Eliminate barriers and offer targeted technical assistance to community-based providers to become Medicaid providers.</p>	<p>As part of <a href="#">New York's</a> transition for carving behavioral health services into Medicaid managed care, the state funded the Managed Care Technical Assistant Center, operated by a non-profit organization, to provide training and technical assistance to behavioral health providers in New York. New York continues to sustain this funding to strengthen the clinical and business practices of behavioral health providers, <a href="#">with over 1,100 trainings offered and over 16,000 behavioral health providers reached.</a></p>
<p>Require MCOs and ACOs to build member engagement strategies into contracts.</p>	<p>The <a href="#">Massachusetts</a> Health Policy Commission's ACO Certification program requires ACOs to collect and use information from patients to deliver and improve patient-centered care.</p>
<p>Leverage contract language with MCOs and ACOs to promote health equity and address health disparities.</p>	<p><a href="#">Minnesota's</a> Department of Human Services administers an <a href="#">Integrated Health Partnerships model</a>, where participating health care providers work together across specialties and service settings to deliver more efficient and effective health care. The program incorporates a value-based payment model and includes measures around health equity.</p>
<p>Offer targeted technical assistance including grant management support, strategic planning, and budget development to small CBOs to support increasing capacity and prioritize reaching these providers when releasing/disseminating request for proposals or other state-provider funding mechanisms.</p>	<p><a href="#">King County in Washington State</a> partners with the Office of Equity and Social Justice to offer technical assistance ranging from grant writing to technology solutions to small, local CBOs.</p>
<p>Pursue innovative policy approaches to address common barriers to accessing services including transportation and childcare supports.</p>	<p>The Center for Great Expectations, an SUD provider in <a href="#">New Jersey</a>, houses an on-site, licensed child development center that offers daily professional childcare to children of patients receiving treatment as a part of their philosophy to offer a full continuum of care.</p>
<p>Contract with community-based providers and CBOs to ease burdens associated with billing under the fee-for-service model and to cultivate ongoing partnerships with these communities.</p>	<p>In <a href="#">Pennsylvania</a>, managed behavioral health organizations and MCOs are required to incorporate CBOs into moderate and high-risk value-based purchasing arrangements as an effort to address social determinants of health.</p>

PRINCIPLE 6 POLICY ACTION	STATE EXAMPLES
<p>Develop systems of community engagement, particularly for people with lived experience and people who use drugs, to routinely obtain feedback to better understand the needs of specific communities and how rollouts of grants/services have been harmful or useful.</p>	<p><b>Washington State</b> developed a group comprised of people with lived experience called the Council of Expert Advisors on Drug Use (CEADU). The CEADU provides feedback and support on harm reduction related efforts in the state.</p>
<p>Expand SUD curriculum in state colleges/university medical schools, add SUD questions to medical licensing exams, and incentivize medical students to pursue specialty addiction medicine training.</p>	<p>In <b>Illinois</b>, Rush University created a <a href="#">fellowship training program</a> with incentives, <a href="#">including up to 29 hours of continuing medical education units and a stipend</a>, to help expand buprenorphine treatment.</p>
<p>Engage in tribal consultation efforts to promote the delivery of efficient and effective resources and services to American Indian and Alaska Native populations.</p>	<p><b>Minnesota</b> has created an American Indian Team within its Behavioral Health Division. The goal of this team is to provide technical assistance, foster mutual collaboration and build a more robust and equitable SUD system of care for American Indian families, children, communities, and Tribal Nations within Minnesota.</p>
<p>Streamline requirements across state credentialing bodies that offer overlapping credentials/licenses (e.g., SUD counselor, clinical SUD counselor, SUD supervisor, peer recovery) to reduce complexity for early career professionals interested in joining the SUD workforce.</p>	<p><b>New Hampshire</b> used funding from the Department of Labor, Employment and Training Administration to evaluate and streamline licensing requirements with a particular focus on the behavioral health workforce.</p>



## PRINCIPLE 7

### Advance Equitable Access and Outcomes for Substance Use Care, Treatment, and Recovery Support Services Among Populations with Multiple System Involvement

People with SUD are disproportionately involved in multiple social service sectors (e.g., housing/homelessness, child welfare systems, mental health systems) and the criminal legal system, and people of color are particularly affected more punitively by those systems. People with multi-system involvement often face a diverse range of challenges in accessing treatment, which can lead to poor outcomes. States can leverage policy mechanisms to increase access to quality behavioral health care services for these populations.



#### Barriers to Effective SUD Care Financing and Quality

People who are involved in multiple social service sectors (such as the child welfare system and criminal legal system) or who receive services from a social service agency (including aging, disability and immigration supports) are often faced with complex barriers when trying to access SUD treatment.<sup>128</sup> Some barriers include:

- **Potential fear of reprisal or a loss of benefits.** Parents and caregivers involved in the child welfare system or the criminal legal system, TANF recipients, and people who receive services from other social service agencies may not ask for support or referrals to treatment and services for SUD due to fear of temporary or permanent loss of child custody, negative impacts on probation or parole status, or loss of benefits more broadly. In some cases, these are perceived fears, but in many cases these fears are often actualized due to stringent regulations around mandated reporting.<sup>129</sup> These perceptions can also impact the actions of program staff, who have reported that substance use screening and assessment can be intrusive and lead to participant disengagement in services.<sup>130</sup>
- **Limited collaboration and differences in priorities between social service agencies and SUD treatment programs and providers.** Social service organizations often provide broad family level supports to their clients, whereas SUD providers focus on the specific needs of their patients. This can create differences in priorities between the two and acts as a barrier to collaboration. Limited collaboration between SUD providers and social service agencies can also lead to referrals that are not well matched to the SUD-related needs of patients and an overall lack of knowledge of the available SUD service options.<sup>131</sup> This can have extremely negative effects on people with multisystem involvement as it impacts their ability to access appropriate and timely substance use treatment.

- **The systems and agencies that provide support to people with multi-system involvement often operate in siloes.** Oftentimes these systems have separate government oversight and funding streams that do not promote cross-system collaboration efforts. This can lead to limited information sharing that can result in poor coordination in the provision of SUD services and missed opportunities to leverage and align funding opportunities across systems to better serve patients with more complex needs.<sup>132</sup>

## Principle 7: Potential Policy Actions

States can pursue policy reforms to improve alignment between and expand access to services for individuals within these systems.

Select policy actions include:

- ✓ **Leverage state grant funds to cross-train SUD treatment staff and staff from social service agencies.** States can provide funding and opportunities for SUD treatment staff to receive support working with individuals with developmental disabilities, immigrant populations, and other communities that may often receive services from multiple social service systems. Relatedly, staff at these agencies should receive training to better understand the impact of SUD on patients as well as available treatment and services. Staff development efforts, particularly through education and training, are vital to building and sustaining strong cross-system initiatives.<sup>133</sup> Training can also help SUD treatment staff and staff from social service agencies better understand the complex and interconnected needs of people with SUDs and their families. Cross-training staff across systems can also enhance the capacity of multidisciplinary care teams to provide more coordinated service delivery, promoting long-term recovery and improved health outcomes.<sup>134</sup>
- ✓ **Implement policies that aim to connect people who are arrested for non-violent, drug-related offenses with treatment programs that offer MOUD.** States can consider creating funding opportunities for innovative programs that pilot diversion paths to avoid incarceration for individuals with an SUD. Diversion programs,<sup>135</sup> such as intensive case management supports, and policy changes to move away from criminalization and family regulation can build meaningful relationships between criminal legal and behavioral health agencies. These relationships can focus on connecting people with appropriate SUD treatment and services with the long-term goal of preventing them from entering the criminal legal system. This can support more positive health and overall outcomes for this population.



**This is about populations with multiple system involvement — the criminal legal system, the child welfare system, the aging and disability service system. I think we all know and appreciate that a lot of the breakdowns in financing happen at the interface of multiple systems. The key policy recommendation is about making the funding model work, so that the consumer doesn't feel like they're getting tugged between these oppositional systems.**

- Brendan Saloner, PhD, Associate Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health

**PRINCIPLE 7 POLICY IN ACTION** **Spotlight on Kentucky**

The Kentucky Legislature authorized and funded a four-year behavioral health conditional dismissal pilot program, beginning in October 2022, to divert eligible individuals away from incarceration to treatment for behavioral health disorders, including SUD. One of the core tenets of the pilot is to engage with counties that will divert people to Medicaid-eligible providers for screening, also increasing access to MOUD. In addition to promoting access to SUD treatment, the program offers a wide range of non-clinical supports including educational, vocational, counseling, and recovery housing supports. If the eligible individual chooses to participate, charges against them would be temporarily deferred and dismissed upon successful program completion.<sup>136</sup>

**Following is an initial set of potential state policy actions:**

PRINCIPLE 7 POLICY ACTION	STATE EXAMPLES
Leverage state grant funds to cross-train SUD treatment staff and staff from social service agencies.	In <a href="#">California</a> , a nonprofit serving individuals with developmental disabilities also supports area SUD treatment professionals through cross-training efforts focused on better supporting these individuals.
Implement policies that aim to connect people who are arrested for non-violent drug-related offenses with treatment programs which offer MOUD.	<a href="#">Kentucky</a> established a four-year behavioral health conditional dismissal pilot program to divert eligible individuals away from incarceration to treatment for behavioral health disorders, including SUD.
Provide family-based support to keep parent-baby dyads together (e.g., drug testing, other reporting approaches).	In <a href="#">Massachusetts</a> , Bill S.64 eliminates mandatory reporting requirements for substance exposed newborns. This proposed change can support decreasing the stigma and fear pregnant people may face when navigating SUD treatment options.
Deliver services across locations in which older adults receive care (skilled nursing facilities, assisted living centers, and adult day programs).	In <a href="#">New York State</a> there is an outpatient substance use program with a focus on older adults. The program considers accessibility and medical comorbidities in service design and is led by professionals with expertise in geriatric SUDs.
Use Title IV-E foster care funding for family-based facilities that treat SUDs.	<a href="#">Utah</a> leverages the Family First Prevention Services Act to support keeping a child with their parent/caregiver in licensed family-based residential substance use treatment programs.
Build partnerships between correctional facilities and local SUD treatment providers.	The <a href="#">Rhode Island</a> Department of Corrections partners with a community opioid treatment program, <a href="#">CODAC Behavioral Health</a> , to provide all three forms of MOUD, which include buprenorphine, naltrexone, and methadone, to its entire corrections population.

PRINCIPLE 7 POLICY ACTION	STATE EXAMPLES
<p>Encourage alignment of policies between drug court programs and jail systems to promote equitable access to services, including MOUD.</p>	<p><a href="#">New York State</a> passed a law in 2015 that states drug treatment courts cannot violate a defendant’s terms of release for participating in a program that prescribes MOUD. It specifically promotes the use of MOUD in drug courts by stating, “While the legislature has the utmost respect for judicial discretion, it is evident that prohibiting the use of methadone and buprenorphine...or requiring its use merely as a ‘bridge to abstinence’ is contrary to established best practice and hinders the recovery process.” <a href="#">Guidance from the U.S. Department of Justice</a> also notes how the Americans with Disabilities Act can protect people with OUD from discrimination. Jail systems, like Bernalillo County in New Mexico, are also promoting MOUD. <a href="#">Bernalillo County</a> partners with a community opioid treatment program that operate a medication unit in the jail.</p>

## PRINCIPLE 8

### Use Data to Drive Effective, Equitable Care, and Outcomes

States can use a variety of strategies to leverage local, state, and federal data — as well as patient-reported outcome measures — to make informed decisions about their SUD treatment system.



#### Barriers to Effective SUD Care Financing and Quality

Robust data collection and analysis can help policymakers gain insights into SUD treatment, service trends, and disparities in care.<sup>137</sup> While state policymakers may have access to a variety of SUD-related data sets including individual claims, administrative and programmatic data, patient satisfaction data, and de-identified state and federal data sets, there are several challenges in collecting, understanding, and applying data across distinct systems to more comprehensively guide decisions on improvements to the SUD treatment system.

- **One of the primary challenges in state data collection efforts related to SUD is the lack of standardized data collection methods across state agencies.** This lack of standardization includes inconsistencies in definitions, coding systems, and overall reporting procedures. Since Medicaid beneficiaries with OUD and other SUDs may receive services from several systems (such as social service systems, criminal legal, and child welfare), it is important for states to have access to a wide range of data sets.<sup>138</sup> Although data-sharing across systems is often a highly complex and regulated process, data-sharing across agencies is a critical opportunity to support states in better understanding the effectiveness of the treatment system, disparities in access, utilization trends, outcomes, and identifying possible intervention points before negative outcomes (such as incarceration, child removal, and fatal overdose).
- **Privacy concerns surrounding sensitive health information pose challenges in data collection and sharing.** The confidentiality of SUD information under 42 CFR Part 2 currently imposes different requirements for SUD treatment records than HIPAA, which creates barriers to systematic information sharing for patients, providers, and payers.<sup>139</sup> This limits opportunities for care coordination and effective treatment, and creates an array of compliance challenges. It can be very complex for states to promote data sharing across providers and systems while adhering to patient privacy restrictions and standards.
- **SUD treatment lags in quality improvement.** As of May 2019, while over 4,000 CMS quality measures were in use, none were in use for addiction treatment programs.<sup>140</sup> Many quality measures currently available focus on process and are related to service delivery and there continues to be a critical need for outcomes-based measures.<sup>141</sup> Routine data collection of patient outcomes data and subsequent analysis and sharing of findings with payers, patients, and providers is key to facilitating quality improvement among SUD services and treatment.

## Principle 8: Potential Policy Actions

Robust data collection and analysis efforts can play a pivotal role in supporting evidence-based health care decision-making, developing effective prevention strategies, improving patient care, and allocating health care resources efficiently.<sup>142</sup>

States should leverage available public health data across sectors to drive health care service delivery and support patients in more effectively accessing equitable care and achieving equitable outcomes.

Select policy actions include:

- ✓ **Leverage data use agreements (DUAs) to promote data-sharing across agencies.**

DUAs can clearly define and articulate how providers collect data as well as how state agencies will analyze, use, and share the data. DUAs often outline the broader goals of data sharing, how it will support future policy development, detail the responsibilities of all associated agencies and organizations, and specify related procedures and timelines.<sup>143</sup> Additionally, regular review and analysis of SUD systems data can support system evaluation and planning efforts to identify possible intervention points, and subsequent policy or programmatic actions before negative outcomes occur (such as incarceration, child removal, and fatal overdose).

- ✓ **Invest in data infrastructure that allows for real-time capture of critical events, such as fatal overdoses, through leveraging flexible federal funding opportunities, such as the SUPTRS Block Grant and opioid settlement funds.**

A well-developed data infrastructure can facilitate more robust ongoing monitoring and surveillance of substance use related outcomes. Bolstering the data infrastructure capabilities of state agencies can support the collection of more comprehensive and accurate data. Timely and accurate data allows for the detection of emerging trends, identification of high-risk populations, and evaluation of the effectiveness of prevention efforts. It enables health care systems to respond more promptly to crises and adapt strategies to address changing patterns of substance use. Data should also be used to prioritize resource allocation toward individuals, communities, and geographic areas that demonstrate the greatest need.

- ✓ **Stratify data by race, ethnicity, gender identity, language preference, sexual orientation, and location to examine and address disparities in care.**

In conjunction with investment in data infrastructure states can enact policies to promote access to and utilization of this data by care entities capable of rapid care and intervention deployment including emergency medical technicians and community-based outreach workers.



**Having some sort of infrastructure to provide consistent data, definitions, and guidance around outcomes would make the data collection better and easier. If a state says, ‘this is how we’re going to collect this’ and follows up with investment in terms of good definitions and good data dictionaries, that would be a good place to start.**

- Caroline Bonham, MD, Vice Chair, Community Behavioral Health Policy, Department of Psychiatry and Behavioral Sciences, University of New Mexico

**PRINCIPLE 8 POLICY IN ACTION** **Spotlight on Wisconsin**

The state of Wisconsin conducted a mapping assessment to examine existing gaps in the OUD treatment and services system. The assessment incorporated indicators including opioid overdose deaths, opioid overdose hospitalizations, suspected opioid overdose ambulance runs, and newly reported cases of hepatitis C in people aged 15 to 29. These indicators, alongside the inventory of available treatment and prevention resources through the state, supported officials in identifying gaps in services and areas of need. This data was then used to inform and prioritize funding allocation efforts.<sup>144</sup>

**Following is an initial set of potential state policy actions:**

PRINCIPLE 8 POLICY ACTION	STATE EXAMPLES
Leverage DUAs to promote data-sharing across agencies.	<a href="#">California’s</a> Health and Human Services Data Exchange Framework is a statewide data-sharing agreement between health care entities, government agencies, and social service programs that seeks to allow providers to access necessary information safely and securely.
Invest in data infrastructure that allows for real-time capture of critical events, such as fatal overdoses, through leveraging flexible federal funding opportunities, such as the SUPTRS and opioid settlement funds.	<a href="#">Pennsylvania’s</a> Senate Bill 1152, established the Overdose Information Network, <a href="#">which requires law enforcement to report all overdoses</a> (fatal and nonfatal) into a shared database within 72 hours of the overdose to assist public officials with tailoring intervention strategies.
Stratify data by race, ethnicity, gender identity, language preference, sexual orientation, and location to examine and address disparities in care.	In 2013, <a href="#">Oregon</a> passed a law requiring standardized collection of race, ethnicity, language, and disability data across the Department of Human Services and the Health Authority.
Create the infrastructure to regularly review and act on the data across systems to prioritize investments in treatment, recovery, and harm reduction services.	<a href="#">Wisconsin</a> conducted a mapping assessment to examine existing gaps in the OUD treatment and services system. The data was then used to inform and prioritize funding allocation efforts.
Develop and promote use of a standard Release of Information form to establish patient-level consent for data sharing in compliance with 42 CFR Part II.	The <a href="#">Legal Action Center</a> offers downloads of sample patient consent forms to release SUD records, which comply with HIPAA and recent updates to 42 C.F.R. Part 2.
Include patient-reported outcome measures (including patient satisfaction) in SUD treatment system planning efforts.	<a href="#">North Carolina’s</a> Department of Health and Human Services administers an annual perceptions of care survey for mental health/SUD clients.

PRINCIPLE 8 POLICY ACTION	STATE EXAMPLES
<p>Provide consistent definitions and guidance through the development of data dictionaries and technical assistance efforts for mandated data collection efforts.</p>	<p><b>Louisiana's</b> Department of Health created a manual that outlines the standards, procedures, data sets, file structures, data elements, data definitions, formats, method, schedule, and means by which client level data should be reported to the Office of Behavioral Health.</p>
<p>Use the OUD Cascade of Care framework to organize data and identify areas of the treatment system where improvement is needed. More broadly, use quality measures to assess the performance of treatment providers and develop quality improvement initiatives.</p>	<p><b>Alabama's</b> Department of Mental Health published the Core Opioid Treatment Metrics, developed by The Pew Charitable Trusts, on an online publicly accessible dashboard. These metrics are based on the OUD Cascade of Care framework.</p>
<p>Improve data collection in state and local correctional systems. Promote data exchange with community-based providers to identify the mental health/SUD health care needs of people upon entry into corrections, during incarceration, and upon reentry.</p>	<p><b>Massachusetts</b> passed a law requiring the state Medicaid agency, the prescription drug monitoring program, the all-payer claims database, the public safety agency, the office of patient protection, and the state courts to share data with the department of public health so this data can be used to analyze the treatment and criminal justice history of people who died of an overdose.</p>
<p>Provide funds to support EHR adoption among SUD providers.</p>	<p><b>New Jersey's</b> Department of Health and Department of Human Services allocated funding to support behavioral health providers in adopting EHRs in their facilities.</p>
<p>Engage people with lived experience to interpret data and develop plans to act on findings.</p>	<p><b>Oregon</b> Health Policy Board established a Behavioral Health Committee, which includes members with lived experience, to direct the work of the Oregon Health Authority. The committee has broad goals of enhancing the quality of behavioral health services through focusing on improved outcomes, metrics, and incentives.</p>
<p>Incentivize positive performance on defined behavioral health metrics and encourage MCOs to focus quality improvement projects on targeted improvements in SUD care and outcomes.</p>	<p>In <b>Oregon</b>, coordinated care organizations (CCO, Oregon's term for MCOs) can earn incentives based on their performance on a set of quality metrics, including SUD measures.</p>



**PRINCIPLE 9**

## Require Specialty Substance Use Treatment Providers to Provide Evidence-Based Treatments, Particularly MOUD

Given that evidence-based, life-saving medications exist for people with SUD, states can use policy levers to require specialty SUD providers to offer evidence-based treatment, including MOUD. States can offer technical assistance and other on-ramping supports to providers to facilitate MOUD expansion efforts.



### Barriers to Effective SUD Care Financing and Quality

Opioids, both synthetic and non-synthetic, are largely responsible for drug overdose related deaths, accounting for approximately 75% of all drug overdose deaths in 2020.<sup>145</sup> Many of these deaths can be prevented through a number of mechanisms, including by connecting patients with evidence-based treatment for OUD. There are evidence-based medications available to treat patients with OUD, often referred to as MOUD. Research has demonstrated that MOUD treatment is clinically effective, reduces overdose and serious opioid-related acute care use, improves patient survival rates, and increases retention in treatment.<sup>146</sup> While MOUD has been widely recognized as the gold standard of care for treating opioid addiction, only about one in four patients with OUD report MOUD use.<sup>147,148</sup>

- **Barriers to treating patients with OUD.** Stigma among providers, including concerns about patients with OUD negatively impacting staff and provider perception of patients with OUD as being difficult or not trustworthy, is often reported as a barrier to prescribing MOUD.<sup>149</sup> Many providers also report concerns around competency to offer medication and inadequate professional education and training as some of the key barriers in prescribing MOUD.<sup>150</sup> A 2020 research study reports that only 29% of residential programs that offer treatment for OUD offer Opioid Agonist Therapy (OAT), a type of MOUD, and many providers actively discourage OAT use to potential patients who call in for additional information.<sup>151</sup>
- **Organizational and structural barriers to broader MOUD use.** Providers cited staff capacity, the need for prior authorization before MOUD can be prescribed, and the lack of integration between OTP providers and the traditional physical health care system as key resource, regulatory, and logistical limitations to increased prescribing of MOUD.<sup>152</sup> Until early 2023, providers also had to obtain an X-Waiver to prescribe buprenorphine, a large structural barrier for many providers. However, an X-Waiver is no longer required and any practitioner with a current U.S. Drug Enforcement Administration (DEA) registration that includes Schedule III authority, may prescribe buprenorphine to treat OUD.<sup>153</sup> A 2023 research study reports that structural factors among both patients and providers, including low levels of trust from patients about the effectiveness and safety of MOUD, patient belief that MOUD treatment is not warranted or needed, and provider bias, create stark disparities in the receipt of MOUD, particularly for Black and Hispanic populations.<sup>154</sup>

## Principle 9: Potential Policy Actions

State policymakers and state Medicaid programs are well positioned to address the rising opioid-related overdose deaths through implementing several upstream policy actions.

Select policy actions include:

- ✓ **Prioritize allocation of public funding and resources to providers offering evidence-based treatment options for people with SUDs, such as MOUD.** Section 1006(b) of the SUPPORT Act requires states to cover MOUD under Medicaid.<sup>155</sup> States can directly leverage Medicaid funds to increase access to MOUD.

Additionally, several other federal funding opportunities including STR grants, SOR grants, Tribal Opioid Response grants, and Section 1115 waivers can be leveraged toward these efforts.<sup>156</sup> By prioritizing allocation of these funds for providers who prescribe MOUD, states can support infrastructure needs of providers already offering MOUD, while also incentivizing providers who do not currently offer MOUD to begin building capacity to be eligible to receive public funding. These efforts would support increasing overall provider availability, strengthening the specialty SUD treatment provider network, and increasing the availability of MOUD for patients.

- ✓ **Enact policy that requires specialty SUD providers to offer MOUD within a transitional time period.** States can consider requiring providers to offer at least two forms of MOUD, specifically buprenorphine and naltrexone, and work with providers to build a comprehensive on-ramping support strategy. Buprenorphine and naltrexone have been specifically recommended due to the complexities of becoming licensed as a SAMHSA-certified Opioid Treatment Program, which is required of providers who dispense methadone.<sup>157</sup> However, given that methadone is often disproportionately provided to BIPOC populations,<sup>158</sup> states should consider how to expand access to methadone as part of equity considerations. States can provide a reasonable window of time for providers to meet new requirements before ending state funding for providers who do not meet them. Several states are actively implementing MOUD expansion strategies and have provided robust and diverse forms of technical assistance including statewide hotlines to provide clinical consultative support, case conferencing opportunities, identifying provider champions to serve as mentors to new providers, and establishing provider collaboratives.<sup>159</sup>



**Acknowledging that there are many ways people can find recovery, while also uplifting evidence-based approaches, is important. If a provider, particularly a specialty SUD provider, is treating patients with OUD, they should offer MOUD as a treatment option to those patients.**

- Ricky Bluthenthal, PhD, Associate Dean for Social Justice, Professor of Population and Public Health Sciences, Institute for Health Promotion & Disease Prevention, Keck School of Medicine at the University of Southern California

- ✓ **Expand evidence-based strategies and treatment across the range of SUDs, including polysubstance use.** It is also important to acknowledge the evolving nature of the opioid epidemic and the large impact psychostimulant misuse and illicitly manufactured synthetic opioids, including fentanyl, have recently had on drug overdose deaths in the U.S.<sup>160</sup> Contingency management has been demonstrated to be an effective treatment option for patients with a range of SUDs, but particularly with stimulant use disorder.<sup>161</sup> In draft clinical practice guidelines on the management of stimulant use disorder, the ASAM recognized contingency management as the current standard of care. As states and SUD providers respond to the evolving nature of the crisis, it remains important to expand evidence-based strategies and treatment across the range of SUDs prevalent within a state and to consider how policy and funding can be leveraged to support patients with polysubstance use given high rates of co-occurring SUD in adults with OUD.<sup>162</sup>

**PRINCIPLE 9 POLICY IN ACTION** **Spotlight on Vermont**

In [Vermont’s Hub and Spoke program](#), the state contracted with the Dartmouth-Hitchcock Medical Center to coordinate and implement regional learning collaboratives for Office Based Opioid Treatment (OBOT) programs.<sup>163</sup> Through this training initiative, the state supported increasing OBOT programs’ capacity to offer quality, evidence-based services, including MOUD. Implementation of this program resulted in significant increases in Vermont’s OUD treatment capacity. In fact, Vermont now has the highest capacity to treat people with OUD in the entire United States.

**Following is an initial set of potential state policy actions:**

PRINCIPLE 9 POLICY ACTION	STATE EXAMPLES
Prioritize allocation of public funding and resources to providers offering evidence-based treatment options for people with SUDs, such as MOUD.	<a href="#">Arizona’s</a> Targeted Investment Program leverages state-directed payments to offer incentives to providers for adding specified capacities, including around prescribing MOUD and meeting MAT guidelines.
Enact policy that requires specialty SUD providers to offer MOUD within a transitional time period.	<a href="#">Louisiana’s</a> legislature passed a law requiring residential facilities, licensed as behavioral health services providers, to offer MOUD. Providers were given time to prepare for the requirement and technical support from the state licensing agency to meet the new regulations.
Expand evidence-based strategies and treatment across the range of SUDs, including polysubstance use.	<a href="#">California</a> is the first state to receive federal approval of contingency management, an evidence-based treatment for individuals with stimulant use disorder, as a benefit in the Medicaid program through <a href="#">CalAIM 1115 Demonstration &amp; 1915(b) Waiver</a> .

PRINCIPLE 9 POLICY ACTION	STATE EXAMPLES
<p>Build a comprehensive on-ramping support strategy and provide a reasonable window of time for providers to meet new requirements before ending state funding for providers who do not meet new requirements.</p>	<p><a href="#">Virginia</a> implemented a provider training initiative in alignment with new MOUD coverage and payment policies as a part of their MOUD expansion efforts. The provider training initiative included online and in-person trainings for prescribers and support staff, development of hotlines to provide clinical consultation to providers, case conferring opportunities, as well as the identification of providers already delivering MOUD to serve as mentors to new MOUD providers.</p>
<p>Consider an array of strategies to meet requirements such as formal partnerships to organizations which provide MOUD, leveraging telehealth services and reduced face-to-face prescriber requirements, and partnering with mobile medication units.</p>	<p><a href="#">New Jersey</a> leveraged funding through SOR and SUPTRS grants to award contracts to opioid treatment providers to increase mobile access to medication and case management and recovery support services.</p>
<p>Strengthen the specialty SUD treatment provider network and increase provider availability and capacity to offer evidence-based treatment options, through leveraging public funding opportunities including STR grants, SOR grants, Tribal Opioid Response grants, the SUPPORT Act, and utilization of Section 1115 waivers.</p>	<p><a href="#">Nevada's</a> Division of Health Care Financing and Policy leveraged funding from the SUPPORT Act to expand the capacity of specialty SUD Medicaid providers through ongoing needs assessments, recruitment and training, and improved reimbursement for SUD and OUD treatment and recovery services.</p>
<p>Invest in public campaigns to address stigma around MOUD where prescribing providers and patients highlight their positive experiences.</p>	<p>The University of <b>Michigan</b> Injury Prevention Center and the Michigan Department of Health and Human Services developed a <a href="#">safer prescribing toolkit</a> that includes content on addressing stigma across patients and providers.</p>

**PRINCIPLE 10**

## **Bolster the Substance Use Treatment and Recovery Support Service Network for Children and Youth**

Because early substance use correlates to substance use problems later in life, and parent/family experience of an SUD can lead to poor outcomes for the child, promoting access to and strengthening the substance use treatment and recovery support service network for children and youth is critical.



### **Barriers to Effective SUD Care Financing and Quality**

The impact of SUD on children and youth is complex and multifaceted. There are concerning rates of substance use among youth, with approximately 11% of eighth graders, 22% of tenth graders, and 33% of twelfth graders reporting using illicit drugs in the past year.<sup>164</sup> Early substance use places youth at a higher risk for psychosocial and behavioral problems as well as long-term health risks.<sup>165,166</sup> It is also important to note the high rate of co-occurring mental health conditions among youth with an SUD, with approximately 90% of youth under age 15 with an SUD also reporting at least one mental health condition.<sup>167</sup> While children and youth face the negative impacts of their own substance use, they can also be highly impacted by family substance use. Approximately one in eight children, age 17 or younger, live in a household with at least one parent with an SUD.<sup>168</sup> Parent or family experience of an SUD can have profound impacts on children and youth, affecting their physical, emotional, and social well-being. Research has consistently demonstrated that children growing up in households with parental substance use face a higher risk of adverse outcomes including developmental delays, academic difficulties, behavioral problems, mental health issues, and disrupted family dynamics.<sup>169</sup>

Additionally, parents with an SUD frequently encounter a range of difficulties, including financial, housing, employment instability, food insecurity, chaotic living conditions, domestic violence, social stigma and isolation, facing incarceration, as well as elevated levels of stress.<sup>170</sup> These additional factors can exacerbate risk to children and youth. Children and youth with parents who have SUD are also at an increased risk of developing substance use problems themselves.<sup>171</sup> Given that approximately a third of the children in the U.S. are insured through Medicaid or the Children’s Health Insurance Program (CHIP), Medicaid/CHIP programs are well positioned to strengthen the existing substance use treatment and recovery support service network for children, youth, and families.<sup>172</sup>

- **Accessing quality substance use treatment and recovery support services can be challenging for youth with an SUD.** There are several evidence-based substance use treatment approaches that have proven effective in youth; however, many studies demonstrate an underutilization of these services by children and youth.<sup>173</sup> Additionally, there is a lack of school-based services to support children and youth with an SUD, this is of particular importance to note given that youth spend such a significant part of their lives in a school setting.<sup>174</sup> A 2020 study reports that only one in 54 youth who experience an overdose receive pharmacotherapy and less than one-third receive behavioral health services — rates that are far lower than for adults.<sup>175</sup> Given that nearly 17% of adults who experience an overdose receive pharmacotherapy and roughly 43% receive behavioral

health services, this demonstrates a clear treatment gap for youth. A lack of pediatric clinician familiarity in treating opioid overdose and SUD, lack of capacity within schools to provide substance use services and supports, and limited access to specialty SUD providers all contribute to this treatment gap.

- **Family-centered treatment options are limited.** Research demonstrates that family-centered treatment approaches are most effective in serving families where the parent/caregiver has an SUD, but traditional SUD treatment and recovery services focus only on the individual patient. A family-centered approach to SUD treatment connects patients with clinical treatment and social support services that extend outside the SUD treatment system including parenting programs, children’s developmental and therapeutic services, and attachment-based family therapeutic services. This type of approach not only meets the needs of the individual with an SUD but improves overall outcomes for the family as well.<sup>176</sup>

## Principle 10: Potential Policy Actions

There are several policy mechanisms states can leverage to strengthen the substance use treatment and recovery support service network for children, youth, and families.

Select policy actions include:

- ✓ **Strengthen network adequacy requirements within Medicaid for pediatric specialists to increase access to care for children.** States can leverage contract language with MCOs/ACOs to operationalize network adequacy standards through defining and requiring representation of specific pediatric medical specialties within the plan’s network and enacting requirements around geographic standards to ensure that pediatric enrollees have access to a provider within a reasonable distance.
- ✓ **Leverage the Family First Prevention Services Act (FFPSA) to expand outpatient and residential family-focused treatment options, with access to supportive housing when possible.** Funding available through FFPSA creates an opportunity for states to use Title IV-E funds for enhanced support services for children and families that focus on keeping children in their home and avoiding foster care placements.<sup>177</sup> Eligible services must be rated as promising, supported or well-supported by the [Title IV-E Prevention Services Clearinghouse](#) to receive Title IV-E reimbursement.<sup>178</sup> There are several types of programs and services within the Clearinghouse that are eligible for reimbursement including programs focused on preventing and treating both parent/caregiver and youth substance use.<sup>179</sup>



**What are Medicaid and other state agencies doing around youth? There are so many intersections between SUD, mental health, behavioral health, and developmental disabilities. It is important to have transparent and accessible information about this work. It would be great to begin identifying how various funding streams for substance use are being directed toward youth services at the state level. If they aren't, how can they be incentivized to do so.**

- Alexa Eggleston, Founder, Audacia Consulting

**PRINCIPLE 10 POLICY IN ACTION** Spotlight on New Jersey

In 2021, the New Jersey legislature passed [Senate Bill 3000](#) that establishes network adequacy standards for pediatric primary and specialty care in the state’s Medicaid program. The bill leverages contract language with MCOs to require that plans have a sufficient number of pediatric primary care physicians, pediatric oncologists, and developmental and behavioral pediatricians within specified geographic standards. The bill also outlines a range of pediatric medical specialties that must be represented within the plan’s network. MCOs that are not able to meet these requirements face severe financial penalties and are asked to meet standards within 30 days of notification.

**Following is an initial set of potential state policy actions:**

PRINCIPLE 10 POLICY ACTION	STATE EXAMPLES
Strengthen network adequacy requirements within Medicaid for pediatric specialists to increase access to care for children.	<a href="#">New Jersey</a> uses contract language with MCOs to require plans to maintain specific pediatric network adequacy standards. If plans do not meet the standards, they face financial penalties.
Leverage the FFPSA to expand residential family-based treatment options and outpatient family-focused treatment options with access to supportive housing when possible.	<a href="#">Utah</a> leverages the FFPSA to support keeping a child with their parent/caregiver in licensed family-based residential substance use treatment programs.
Leverage Medicaid’s pediatric benefit, Early and Periodic Screening Diagnostic and Treatment (EPSDT), to cover screenings and medically necessary treatment for children with an SUD.	In <a href="#">California</a> , Medi-Cal managed care plans are required to provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SBIRT) services and beneficiaries under age 21 are entitled to receive all medically necessary SUD services under 42 U.S.C. § 1396d(a), regardless of whether the services are in the state plan.
Build connections between adult Medicaid and youth-specific benefit streams, including Title IV-E Foster Care Maintenance, Temporary Assistance for Needy Families, Title IV-E Prevention Services, and The Child Abuse Prevention and Treatment Act, to best support the service needs of children and families, while incorporating considerations around preventing the pipeline to foster care.	<a href="#">Ohio</a> leveraged FFPSA to invest in prevention services, embedding guidance from FFPSA to create an updated case flow process which captures eligibility, assessment of safety and risk, service planning and review (including a prevention services case category).

PRINCIPLE 10 POLICY ACTION	STATE EXAMPLES
<p>Address variability in reporting substance exposed newborns, which in some states requires child welfare reporting for babies born to people treated with MOUD.</p>	<p><a href="#">Bill S.64</a> was introduced in the <a href="#">Massachusetts</a> legislature that eliminates mandatory reporting requirements for substance-exposed newborns. This proposed change can support decreasing the stigma and fear pregnant people may face when navigating SUD treatment options.</p>
<p>Pursue family-based policy actions and approaches, such as Safe Harbor legislation to facilitate access to treatment for pregnant people, reforming drug testing and reporting requirements, and facilitating connections to services for this population.</p>	<p>In <a href="#">Vermont</a>, the <a href="#">CHARM collaborative</a> is made up of 11 organizations that provide comprehensive care coordination and SUD treatment services to pregnant people with OUD. Information sharing between the organizations is allowed under Vermont’s Statute Title 33, Section 4917, that allows a group of professionals to “share relevant, client-specific information with one another for the purpose of protecting child safety.”</p>

## Next Steps

Despite increased opportunities for states to use public funds for SUD treatment systems in the last decade — including opportunities through Medicaid, flexible federal funds, and the opioid settlement funds — there remains a need for states to direct these dollars more strategically to increase access to evidence-based treatment services and address inequities.

States across the U.S. continue to be hit hard by the overdose crisis, and too many people — particularly those from under-resourced communities and certain racial groups — lack the SUD care they need. State policymakers can take action by considering how to align these principles for financing substance use care, treatment, and support services to the unique context of their states and work to apply select policy actions (detailed under each principle), using the state examples presented as a concrete guide for moving forward.



## Appendix A. Methodology

**I**n shaping the principles presented in this report, CHCS undertook a comprehensive process to understand the current SUD services and financing landscape and develop consensus among a group of stakeholders with expertise in SUD financing and/or experience accessing the SUD treatment system. The process was iterative, with multiple opportunities for stakeholders to review and offer additional insights, through interviews, a convening, and a convening poll. While a reliable consensus was achieved, it does not mean that all project stakeholders are in absolute alignment with the final wording of each principle. *(See page 4 for list of participating experts.)*

Activities are outlined below:

- ✓ **Background Research.** In Fall 2022, CHCS undertook a comprehensive review of more than 50 articles, including peer-reviewed and gray literature, to understand evidence-based strategies and/or promising practices for maximizing use of various public funding streams to support sustainable state behavioral health and public health initiatives, as well as identify lessons from relevant past or current efforts.
- ✓ **Key Stakeholder Interviews.** From October 2022 through February 2023, CHCS conducted 15 stakeholder interviews with a range of informants. Interviewees included state leaders with experience identifying opportunities to improve alignment and coordination across various behavioral health funding streams; policy and research experts who have explored innovative opportunities for improving access to substance use treatment services; and providers and individuals with lived experience who know the realities of accessing substance use treatment.
- ✓ **Convening.** In December 2022, CHCS brought together 14 stakeholders at a virtual convening to share key findings from background research and informant interviews and present the preliminary set of SUD financing principles for reaction and further refinement.
- ✓ **Participating Expert Poll.** Following the convening, CHCS administered an electronic poll in which participating experts rated their level of agreement for each principle on a 1-5 scale (1 = strongly agree and 5 = strongly disagree). Consensus was defined as all responses in the 1-3 range. For responses 4 or 5, participants suggested amendments, which were used to refine the principles.

## Appendix B. Key Components of the Continuum of Substance Use Care and Medicaid Coverage

People with SUD should have access to a continuum of care that offers a range of services and supports to address their varied and evolving needs. A continuum of care addresses the varying levels of service intensity (e.g., early intervention, outpatient, residential, and inpatient), though it should also include access to MOUD, recovery supports, and harm reduction. Some services along the continuum can be delivered concurrently. For example, a person receiving SUD treatment in a residential facility could simultaneously receive peer supports and MOUD.<sup>180</sup> More information about the continuum of care and how states are using Medicaid to expand access to these services is described below.

### Clinical Services

Many clinical SUD services are covered under Medicaid, but some states cover select services using non-Medicaid funding sources, such as SUPTRS. The below table, derived from a [2018 MACPAC report](#), provides a high-level summary of Medicaid coverage in states for clinical services along the SUD continuum of care.

To categorize the various services, the MACPAC report uses the nationally recognized American Society of Addiction (ASAM) criteria, which is a set of guidelines designed to support treatment planning for people with SUD. The ASAM criteria service categories range from less-intensive (e.g., outpatient) to more intensive (e.g., inpatient). The ASAM criteria also include an assessment to assist providers in determining the most appropriate placement, according to each person’s individualized treatment plan, with an understanding that regular assessments are necessary as treatment needs will change over time.

The MACPAC report found the most significant gaps in states’ Medicaid coverage were for partial hospitalization and residential services. The report indicated that gaps in partial hospitalization may be due to states designing Medicaid services after Medicare, which has limited SUD coverage, particularly for intermediary levels of care.<sup>181</sup> Gaps in residential services are likely related to the prohibition on Medicaid reimbursement in these settings, also known as Institutions for Mental Disease (IMDs), until a Section 1115 SUD demonstration waiver reversed this prohibition in 2017.

BROAD SERVICE CATEGORY	DESCRIPTION	MEDICAID COVERAGE*
<b>Early Intervention</b> (ASAM Level of Care 0.5)	Screening and educational services for people at-risk of SUD	<b>Various early intervention services covered in 42 states and DC.</b> Specific services can include: Screening, Brief Intervention, and Referral to Treatment (SBIRT), DUI programs, motivational interventions, individual/group counseling.
<b>Outpatient</b> (ASAM Level of Care 1.0)	Varying services and intensity of services for people with less severe SUD. Outpatient: < 9 hours/week; < 6 hours/week for adolescents	<b>Various outpatient services covered in 49 states and DC.</b> Specific services can include: MOUD, individual and group counseling, family therapy, motivational enhancement, etc.

BROAD SERVICE CATEGORY	DESCRIPTION	MEDICAID COVERAGE*
<b>Intensive Outpatient /Partial Hospitalization</b> (ASAM Level of Care 2.0)	Varying services and intensity of services for people with low or moderate severity SUD: <ul style="list-style-type: none"> <li>• Intensive Outpatient: ≥ 9 hours/week; ≥ 6 hours/week for adolescents</li> <li>• Partial Hospitalization: ≥ 20 hours/week but not 24-hour care for adults and adolescents</li> </ul>	<b>Various intensive outpatient and partial hospitalization services in many states, but only 29 states offer both outpatient and partial hospitalization services.</b> Specific services can include: MOUD, individual and group counseling, family therapy, motivational enhancement, etc.
<b>Residential or Inpatient</b> (ASAM Level of Care 3.0)	Varying services and intensity of services for people with low, moderate to severe SUD in clinically managed and structured residential settings, which are staffed 24-hours: <ul style="list-style-type: none"> <li>• Clinically managed low-intensity residential</li> <li>• Clinically managed population-specific high-intensity residential (for adults)</li> <li>• Clinically managed high-intensity residential</li> <li>• Medically monitored intensive inpatient</li> </ul>	<b>18 states cover all four sublevels of residential/inpatient care; 12 offer none.</b> Services can include: MOUD, individual/group counseling, family therapy, motivational enhancement, and other skilled treatment. Coverage pathways are: <ul style="list-style-type: none"> <li>• <b>In-lieu of service under managed care:</b> short-term IMD stays, no more than 15 days</li> <li>• Section 1115 demonstration for SUD care in IMDs: day limits vary under demonstrations</li> </ul>
<b>Medically Managed Intensive Inpatient</b> (ASAM Level of Care 4.0)	Hospital-based 24-hour care for people with very severe SUD	<b>43 states cover medically managed intensive inpatient services</b>

\* Based on MACPAC’s 2018 analysis of state plan authorities and approved Section 1115 SUD waivers.

**Sources:** Medicaid and CHIP Payment and Access Commission. “Chapter 2: Medicaid and the Opioid Epidemic.” June 2017. Available at: <https://www.macpac.gov/publication/access-to-substance-use-disorder-treatment-in-medicaid/>; E. McMullen. “Substance Use Disorder Continuum of Care and the IMD Exclusion.” Medicaid and CHIP Payment and Access Commission presentation, March 1, 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2018/03/Substance-Use-Disorder-Continuum-of-Care-and-the-IMD-Exclusion.pdf>.

## Medication for Opioid Use Disorder

MOUD is an essential part of the SUD continuum of care and can be available in many general medical settings, except for methadone which is only available in opioid treatment programs.

BROAD SERVICE CATEGORY	DESCRIPTION	MEDICAID COVERAGE
<b>MOUD (buprenorphine, methadone, and naltrexone)</b>	Evidence-based prescription medications that have been proven to reduce opioid use and overdose.	<b>Federally mandated Medicaid benefit:</b> Under the 2018 SUPPORT Act, MOUD is a Medicaid-covered service for people with OUD through September 2025. <ul style="list-style-type: none"> <li>• Methadone can only be offered in licensed and accredited opioid treatment programs.</li> <li>• Buprenorphine can be offered in general medical settings, by any practitioner with a DEA license (if allowable under state law), without any limits on the number of patients.<sup>182</sup></li> <li>• Naltrexone can be offered in any setting by any clinical practitioner with prescribing authority for any medications.</li> </ul>

## Non-Clinical/Recovery Supports

Non-clinical/recovery supports should be a part of any comprehensive SUD continuum of care. These services are designed for people in recovery from SUD (and mental illness) to promote resilience, foster wellbeing, and provide support with attaining life goals.<sup>183</sup> This chart, derived from a [2019 MACPAC report](#), provides a high-level summary of state Medicaid coverage for recovery supports. The MACPAC report found that increasingly more states are covering recovery supports under Medicaid in response to the opioid epidemic and because both behavioral health and rehabilitative services were defined as essential health benefits under Medicaid under the ACA. This MACPAC analysis reviewed state benefits under state plans (including the health home, rehabilitative, and Section 1915(i) state plan options), home- and community-based services waivers, Section 1115 demonstrations and Certified Community Behavioral Health Clinics.

BROAD SERVICE CATEGORY	DESCRIPTION	MEDICAID COVERAGE
<b>Comprehensive Community Supports</b>	Skill-based development services to address barriers to functioning independently in the community for people with significant functional impairments as a result of an SUD or co-occurring disorder	29 states
<b>Peer Support</b>	Recovery support services delivered by a person with lived experience of SUD or mental illness, or a family member of a person with this experience; can be delivered in a variety of settings including outpatient, inpatient, and mobile crisis teams, among others	38 states
<b>Skills Training and Development</b>	A wide range of life skills services to support someone with SUD or mental illness to achieve their best possible functioning across various areas (e.g., employment readiness, coping skills)	15 states
<b>Supported Employment</b>	Services delivered by an employment specialist to support a person with SUD or mental illness to obtain or maintain a job in the competitive job market	13 states
<b>Supportive Housing</b>	Housing assistance that includes wraparound supports for people who are chronically homeless or living with disabilities in obtaining and maintaining tenancy	4 states

**Source:** Medicaid and CHIP Payment and Access Commission. “Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder.” July 2019. Available at: <https://www.macpac.gov/publication/recovery-support-services-for-medicaid-beneficiaries-with-a-substance-use-disorder/>.

## Harm Reduction

Historically, Medicaid has not covered harm reduction services in the form of a unique harm reduction benefit, which includes core services and resources (e.g., sterile syringe distribution, overdose prevention counseling). However, Medicaid does cover a range of services that are typically offered in harm reduction settings, such as **HIV, STI, and viral hepatitis testing; wound care; and naloxone distribution**. Medicaid also recently began covering **sterile syringes** if prescribed by an eligible provider and obtained through a pharmacy.

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