

# Behavioral health campaign updates

## Campaign overview


The Health Care Authority's (HCA) Division of Behavioral Health and Recovery (DBHR) has worked on several successful campaigns during the last year. A prevention campaign, Washington Listens, and the on-going Starts with One campaign. The prevention campaign focused on wellness and protective factors related to substance use and mental health. The campaign targeted young adults 18-20 and parents of children 25 and younger. The goals were to encourage parents to prioritize their own wellness and remind them that they can positively influence their kids' choices and for young adults to prioritize their wellness and reduce their risk of substance use disorders. The Washington Listens campaign started in June and continues to receive funding. Printed materials, ad-buys, and social media helped the average call volume for Washington Listens increase to 600 calls per month. We continue to work on accessibility for the deaf and hard of hearing as well as equity and inclusion. The Starts with One campaign includes a pharmacy pilot project, the addition of messaging around stimulants, and a focus on BIPOC populations.

## Prevention campaign

- Programs
  - Start Talking Now
  - Not a Moment Wasted
  - Prevention toolkit
- Creative assets (young adult)
  - Digital animated banner ads (6 versions)
  - YouTube
  - Instagram and Snapchat
  - Digital radio spot for Spotify/Pandora
  - Website update
  - Toolkit update
- Creative assets (parents)
  - Facebook
  - Digital radio for Pandora
  - Pre-roll video for YouTube and programmatic video platforms
- Additional assets
  - Organic social
  - Posters
- Updated printed materials

## Behavioral health campaign updates

December, 2020


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- Media buy
    - Social media
    - Digital radio
    - YouTube
    - Digital media

### **Washington Listens campaign**

- Creative assets
  - TV/Radio Scripts
  - Printed materials
  - Banners/posters for Washington Listens locations
  - Website
- Media buy
  - Social media
  - Streaming networks
  - TV
  - Radio

### **Starts with One campaign**

- Pharmacy program
  - ✚ People picking up any prescription for an Opioid are asked if they lock up their meds. If they say no, they are offered a locking bag and asked to make a pledge to lock up their meds.
    - We have 11 warm leads of pharmacy contacts that may be potential fits for this year's program.
    - We have started mapping out the layout of the landing page and on the integration mechanics for pharmacies who will be entering data for us through the page. Plan for this to be up and running in early to mid-January.
    - We are looking at how to keep the program sustainable after the grant timeline ends.
- Creative assets
  - TV/Radio Scripts are in final stages and are ready for testing.
  - Two new for young adults, two new for parents of young adults, two new for older adults. Commercials focus on [spreadthefaxrx.com](http://spreadthefaxrx.com) and [takeback.org](http://takeback.org).
  - All assets translated in Spanish.
- Media buy
  - We have a Superbowl and Olympics buy placed, fingers crossed. We also have a contingency plan if needed.
  - TV, Digital Radio, SnapChat, Instagram, YouTube, HULU, Dating aps, TikTok, Spotify, Pandora.

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- Special populations
    - We have scheduled focus groups and key informational interviews in LatinX/BIPOC (HCA equity workgroup, DBHR DEI workgroup, and providers of color).
    - We have a [live work plan](#) that can be viewed at any time, it's currently updated through April 2021.
  - Tribal program
    - Dear Tribal letter has been released
    - DH is setting up two sessions with the informal advisory group to review the development of new creative assets (one for prevention, one for treatment).
    - The focus will be on medication refusal, resilience, connecting with cultural community, challenging stigma, and deflection strategies.
    - We will be working with a new production company this year for creative assets: [Counting Coup](#). They are a tribally owned production company that will bring the cultural lens to the work
  - Creative assets
    - Two PSA's (Treatment :15, :30, :60 and Prevention :15, :30, :60)
    - Update tribal photography to update creative assets as needed.
    - Microsite maintenance and develop a new page to include stimulants.
  - Media buy
    - Statewide digital targeting (Pre-roll and OTT, Display ads, Facebook, Instagram).
    - Geofencing tribal land (Display banner ads, Pre-roll video ads, Snapchat).
    - Tribally owned/operated media (Tribally owned/operated newspapers).

# Psychiatry Consultation Services for Washington State Healthcare Providers

## Psychiatry Consultation Line (PCL)

for prescribing providers with adult psychiatry and/or addictions questions

877-WA-PSYCH (877-927-7924) | [pclwa@uw.edu](mailto:pclwa@uw.edu)

Staffed 24/7

[www.pcl.psychiatry.uw.edu](http://www.pcl.psychiatry.uw.edu)

## Partnership Access Line (PAL)

for primary care providers with child and adolescent psychiatry questions

866-599-7257 | [paladmin@seattlechildrens.org](mailto:paladmin@seattlechildrens.org)

8am - 5pm, Monday - Friday (excluding holidays)

[www.seattlechildrens.org/PAL](http://www.seattlechildrens.org/PAL)

## PAL for Moms

for providers with behavioral health questions related to pregnancy and postpartum

877-PAL4MOM (877-725-4666) | [ppcl@uw.edu](mailto:ppcl@uw.edu)

9am - 5pm, Monday - Friday (excluding holidays)

[www.mcmh.uw.edu/ppcl](http://www.mcmh.uw.edu/ppcl)

## Psychiatry & Addictions Case Conferences (UW PACC-ECHO)

for providers interested in didactic presentations and case-based learning

[uwpacc@uw.edu](mailto:uwpacc@uw.edu)

12:00-1:30 pm, Thursdays

[ictp.uw.edu/programs/uw-pacc](http://ictp.uw.edu/programs/uw-pacc)



# UW Psychiatry Consultation Line (PCL)

For prescribers caring for adults with mental health and/or substance use conditions

AVAILABLE 24/7 | ☎ 877-927-7924 (877.WA.PSYCH) | ✉ PCLWA@UW.EDU



**QUESTIONS  
ABOUT TREATING  
A PATIENT'S  
MENTAL HEALTH?**

**Call the UW Psychiatry Consultation Line.**  
Free, fast, on-demand consultations connecting prescribing providers to psychiatrists  
at the University of Washington.

**877.WA.PSYCH (877-927-7924) PCLWA@UW.EDU**

- Questions answered about:
  - ✓ Assessment
  - ✓ Diagnosis
  - ✓ Treatment planning
- Staffed by adult & addiction psychiatrists
- Available 24 hours a day, 7 days a week
- Free to the caller and the patient
- Written recommendations provided

[pcl.psychiatry.uw.edu](https://pcl.psychiatry.uw.edu)

# PAL for Moms

For providers caring for pregnant/postpartum patients

WEEKDAYS 9:00 – 5:00PM | ☎ 877-725-4666 (PAL4MOM) | ✉ PPCL@UW.EDU



- Questions answered about:
  - ✓ Assessment, diagnosis, treatment planning
  - ✓ Pregnancy loss, complications, or difficult life events
  - ✓ Local resources & referrals
- Staffed by UW perinatal psychiatrists
- Free to the caller and the patient
- Written recommendations provided

[mcmh.uw.edu/ppcl](https://mcmh.uw.edu/ppcl)

Funded by:

Washington State  
Health Care Authority

# Psychiatry Consultation Services for Washington State Health Care Providers

## Our psychiatry consultation lines and ECHO programs:

- Connect you to adult, child, perinatal and addictions psychiatrists at the University of Washington and Seattle Children's Hospital
- Provide expert, timely advice on assessment, diagnosis and treatment planning
- Include written recommendations
- Are free for you and your patient



### **Psychiatry Consultation Line (PCL)**

for prescribing providers with adult psychiatry and/or addictions questions

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**Staffed 24/7**

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The Psychiatry Consultation Line (PCL), Partnership Access Line (PAL), Partnership Access Line for Moms (PAL for Moms), and Psychiatry and Addictions Case Conference (PACC) series are funded by the State of Washington.



STARTS WITH  
**one**

**Pharmacy Pilot Program  
Research Findings**

2020 Pharmacy Safe Storage Program



# Safe Storage Program Background

In 2020, the Washington State Health Care Authority piloted a pharmacy-based program to test whether making a personal commitment to lock up medications would influence consumer behavior.

Kirk's Pharmacy locations in Puyallup and Eatonville participated in the pilot program.

Pharmacists asked patients who received an opioid prescription if they had a way to lock up their medications, asking for their commitment to do so and offering a free locking bag if the customer needed one.

383 people were talked to about the Safe Storage program, 352 people pledged to lock up their medications and 270 locking bags were distributed over a three-month period.

The results underscore the power pharmacies have to encourage safe medication storage and return.

**382**

**PEOPLE**

people were talked to about the Safe Storage program

**352**

**PEOPLE**

pledged to lock up their medications

**270**

**LOCKING BAGS**

were distributed over a three-month period



**I PLEDGE TO LOCK UP MY MEDICATIONS**  
**TO STOP OPIOID MISUSE START AT HOME**

**75%** 75% of opioid misuse starts with someone taking medication that wasn't prescribed for them – usually taken from a friend or family member.<sup>2</sup>

Ending opioid misuse in your community begins in your home. Locking up opioid medications help to keep your family and community safe.

**TIPS FOR SAFE STORAGE**

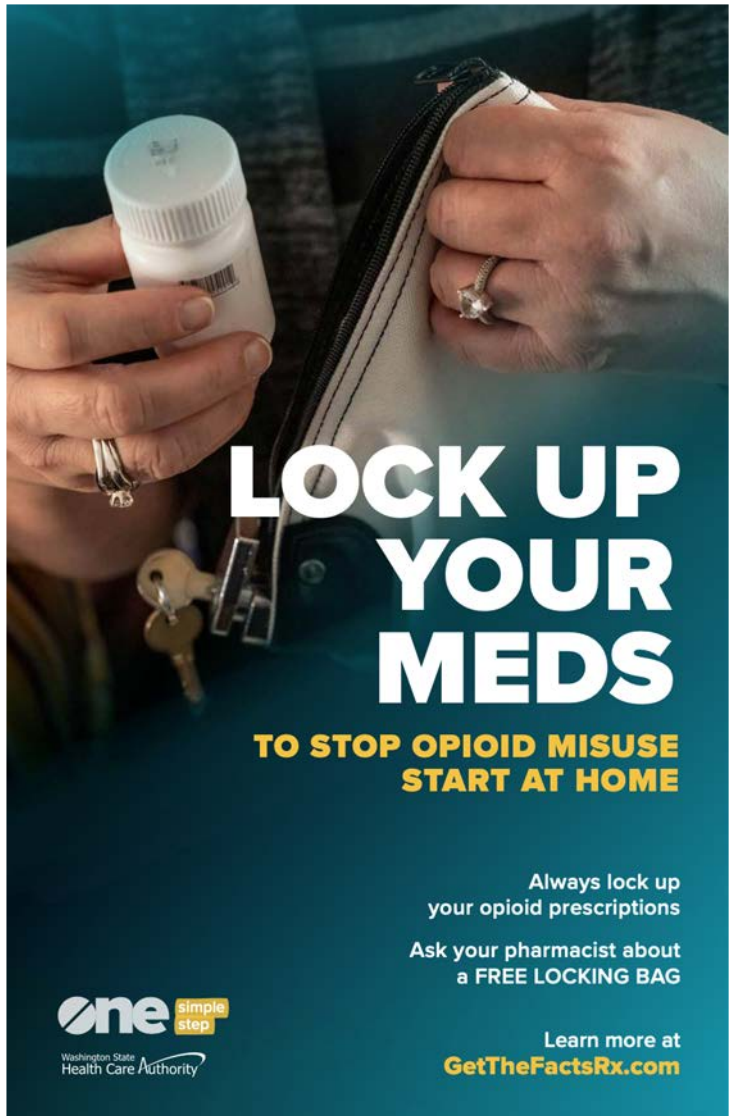
- Don't store your medications in your bathroom.
- Keep opioid medications in a
  - locking cabinet.
  - safe.
  - locking bag.
- Keep the key or combination to your locking device in a different location from your prescriptions to discourage theft and misuse.
- Find safe storage devices online or at hardware stores or drug stores.

**one simple step** Washington State Health Care Authority

**I LOCK UP MY MEDS**

**TO PROTECT MY FAMILY AND COMMUNITY**

**one simple step** Washington State Health Care Authority



**LOCK UP YOUR MEDS**

**TO STOP OPIOID MISUSE START AT HOME**

Always lock up your opioid prescriptions

Ask your pharmacist about a **FREE LOCKING BAG**

**one simple step** Washington State Health Care Authority

Learn more at **GetTheFactsRx.com**

# Evaluation Methodology

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## Sample

\*83 interviews with chronic and acute opioid patients who opted into the Safe Storage Program survey residing in Puyallup and Eatonville, Washington.

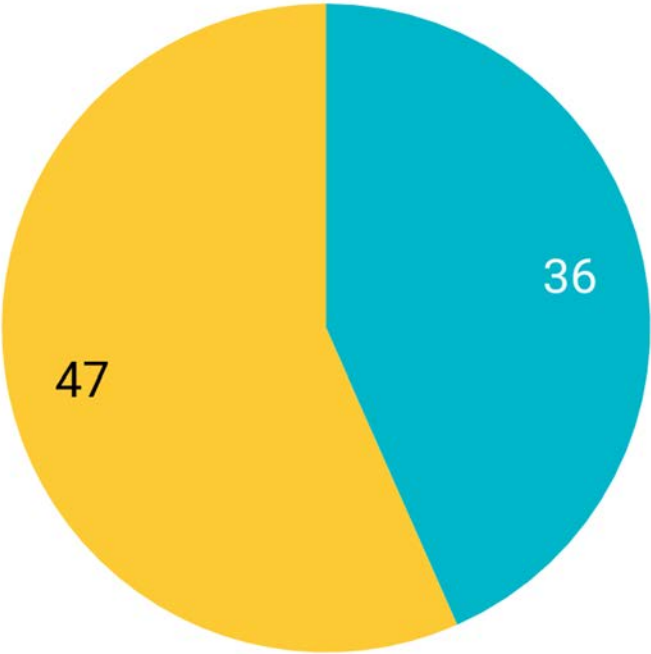


## Method

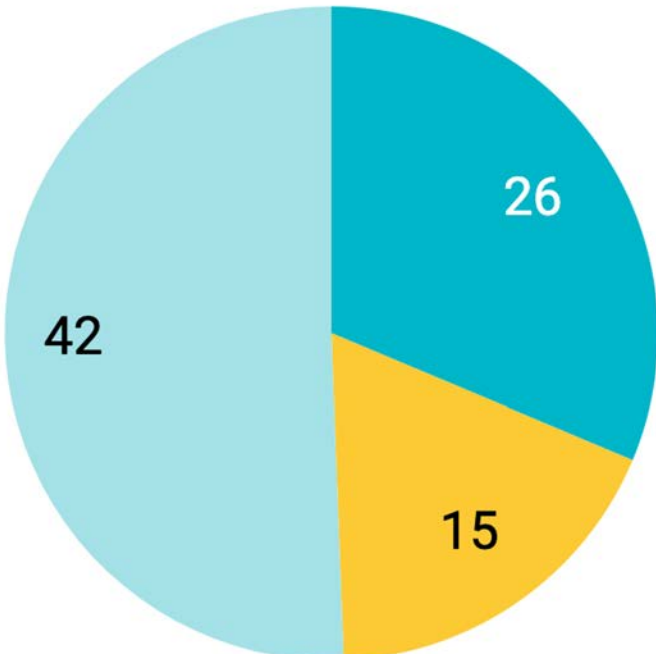
Live telephone interviews conducted between May – June 2020.

\*Survey results provide a saturation of the total population that participated in the Safe Storage program. Percentages are representative of this smaller sample size.

# Survey Participant Demographics

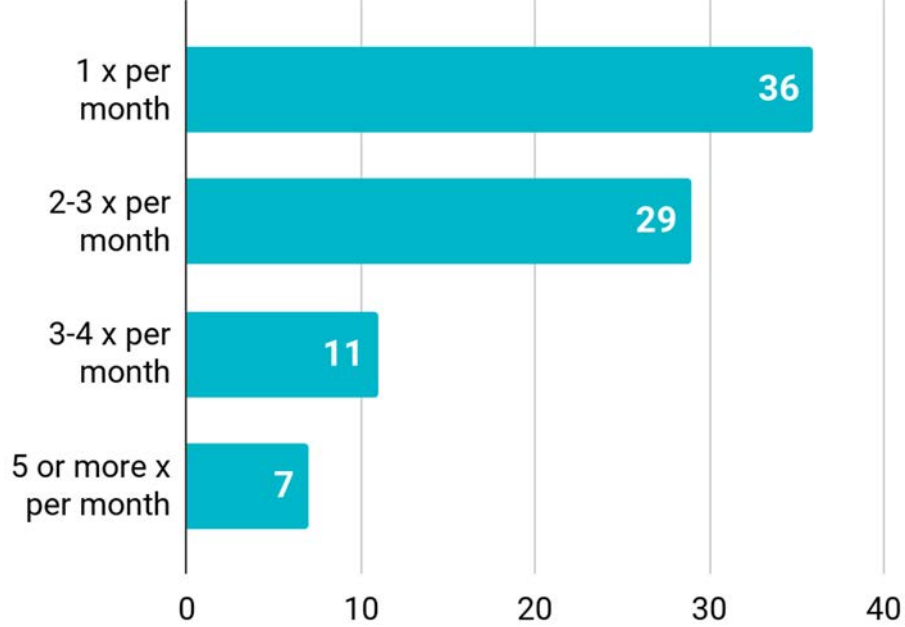


● Male ● Female



● 65 or older ● Ages 25-44  
● Ages 45-64

Frequency of Pharmacy Visits

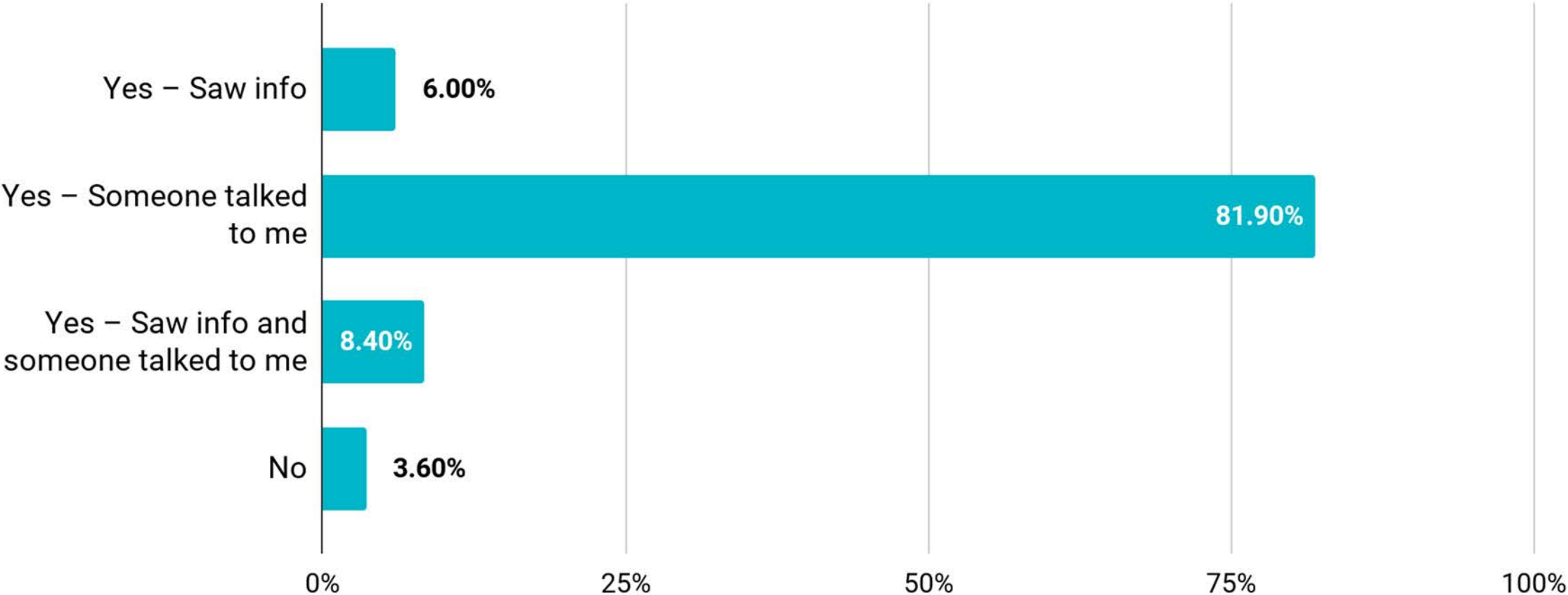


A photograph of two men in suits and ties standing outdoors, possibly in a park or garden. The man on the left is wearing a dark flat cap and is looking down at something in his hands. The man on the right is looking towards him. The entire image is overlaid with a semi-transparent teal color. The text 'Survey Results' and 'Sample Size = 83 Participants' is centered on the teal overlay.

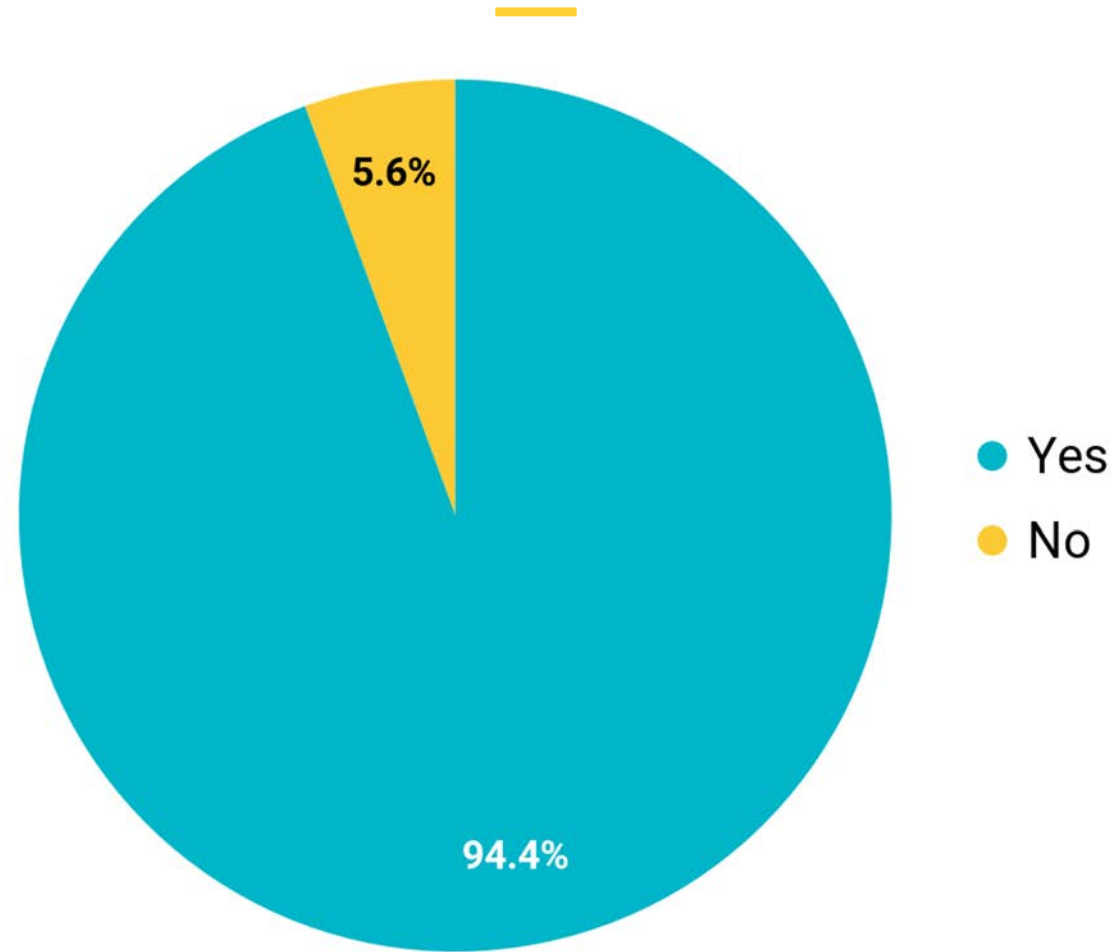
# Survey Results

Sample Size = 83 Participants

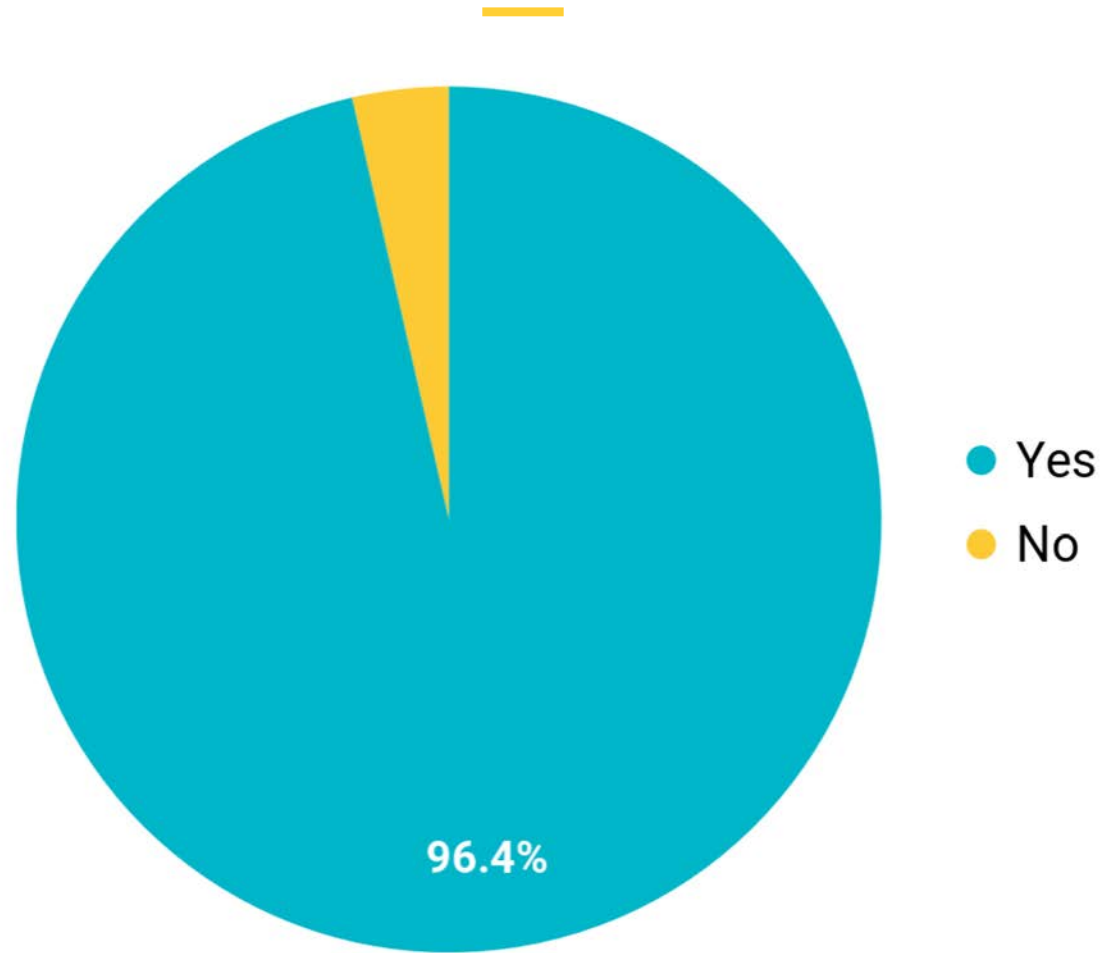
Q4. Kirk's Pharmacy is hosting a pledge for customers to commit to locking up their medications. Do you remember seeing information about this or talking with anyone at Kirk's Pharmacy about this?



Q5. Were you invited to participate in the pledge?

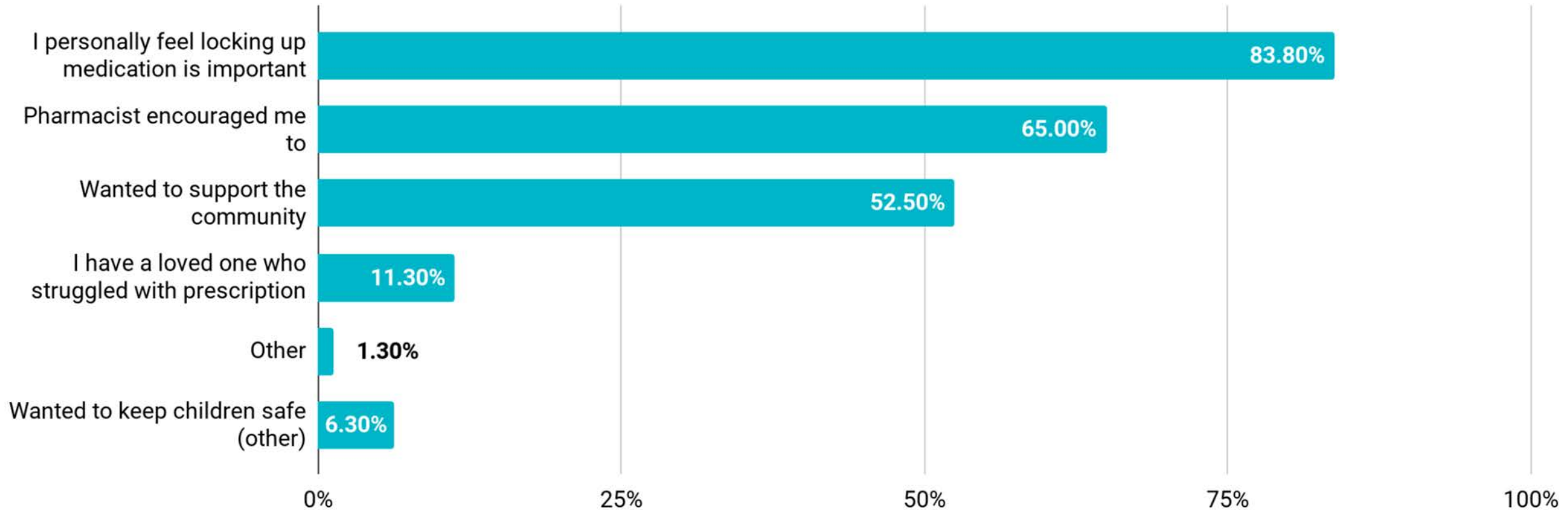


Q6. Did you pledge to lock up your medication?

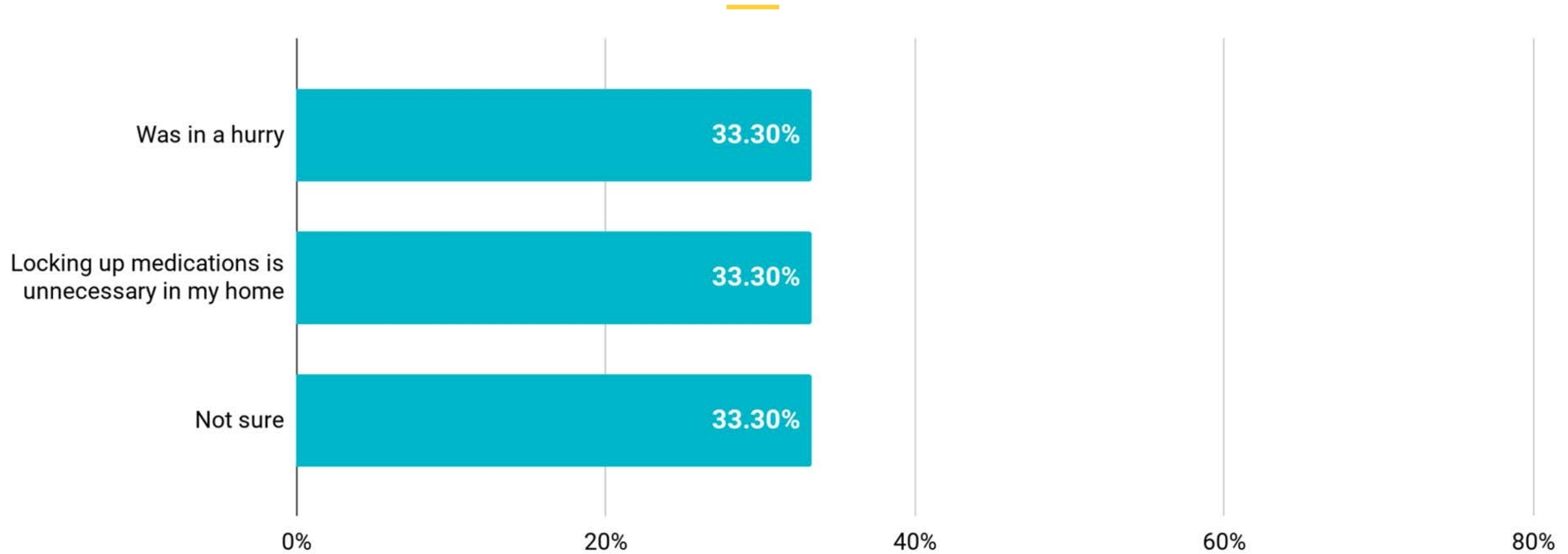




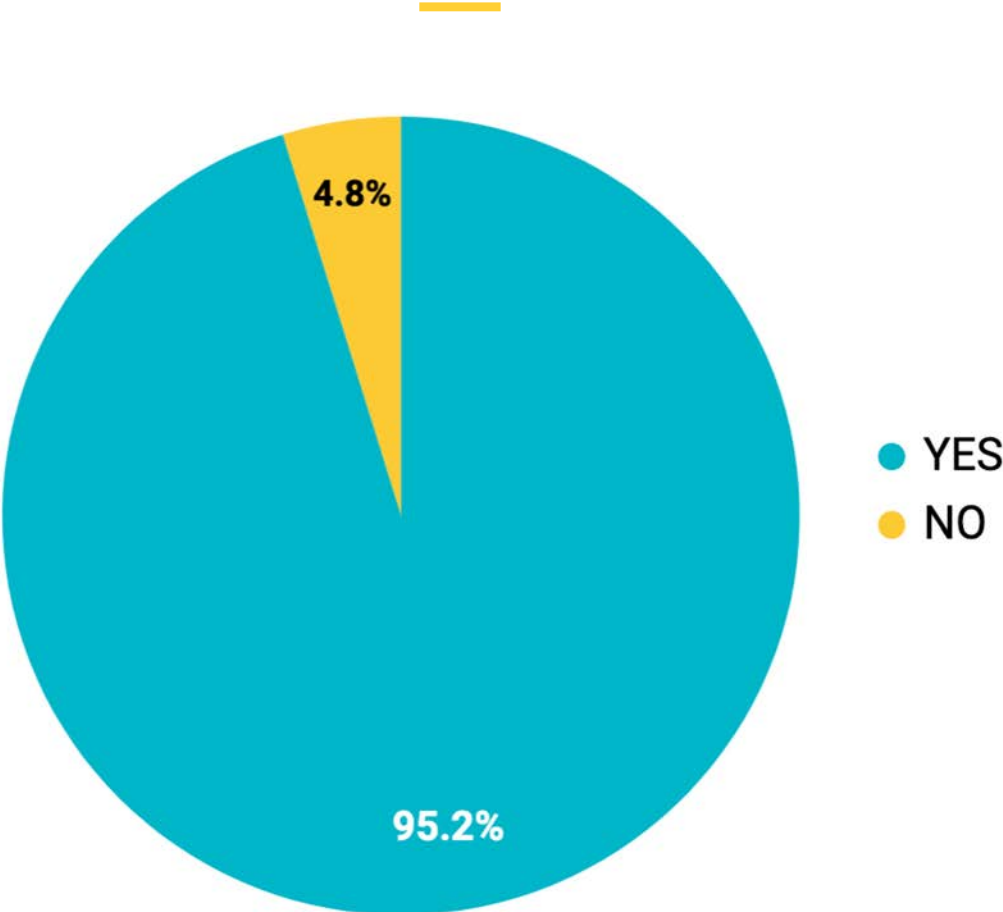
## Q6a. Why did you choose to make the pledge?



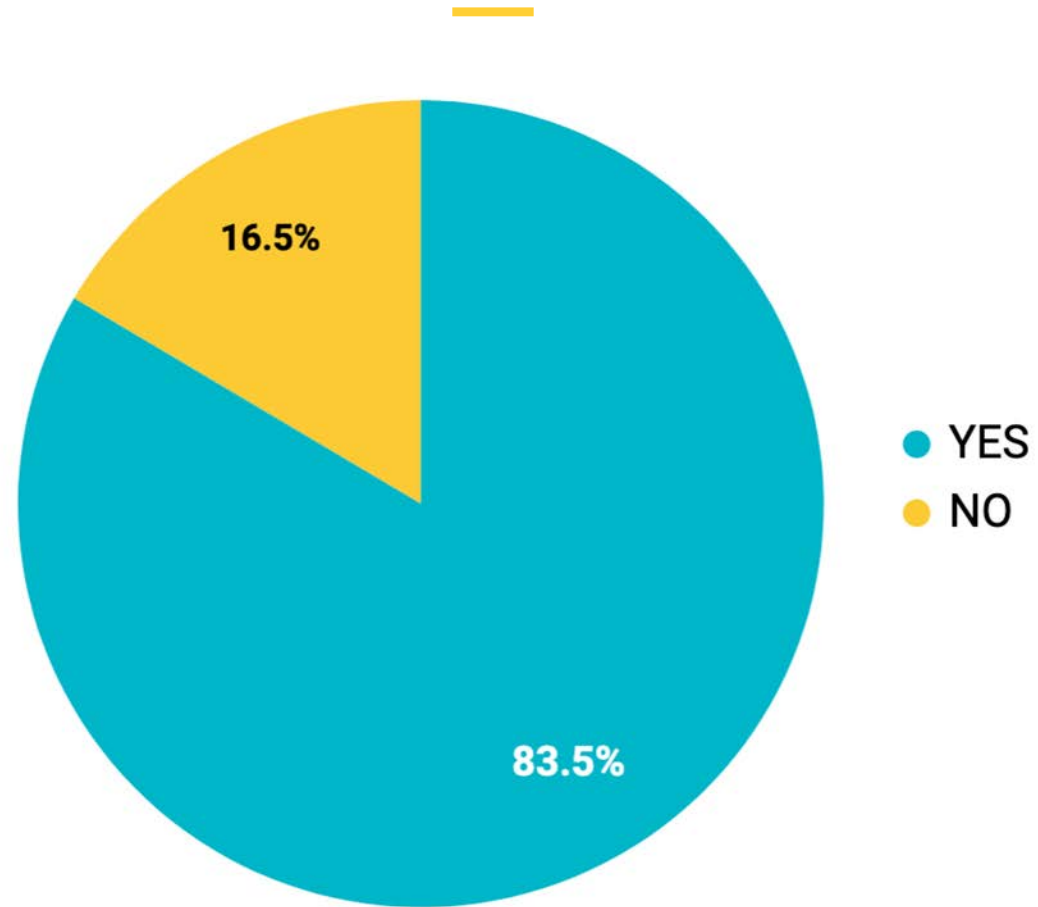
## Q6b. Why not?



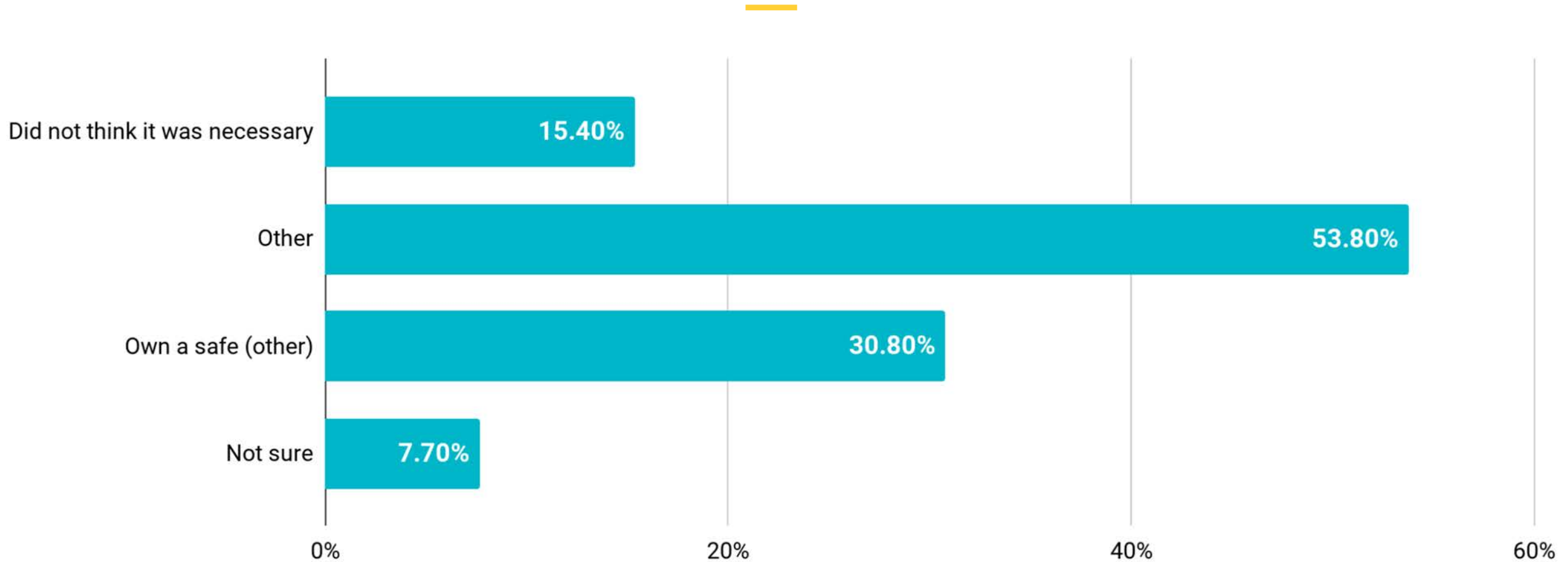
Q7. Were you offered a free locking bag to lock up your prescription medications?



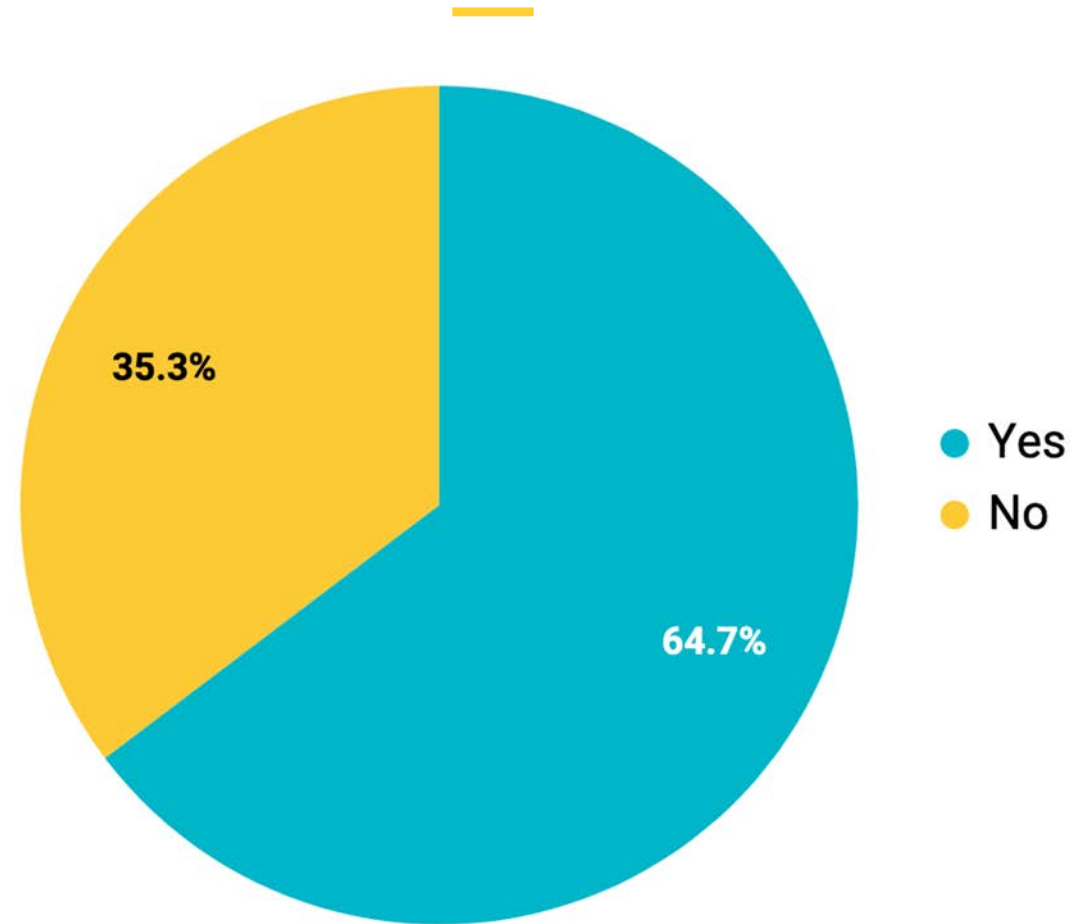
Q7a. Have you used the locking bag to store your medication? (79 answered)



## Q7b. If you chose no, why not? (13 answered)



Q8. Did the information you saw, or conversation you had at Kirk's Pharmacy, have any impact on how you store your medications at home?



## Feedback from those who cited that the information from Kirk's pharmacy about this program **did have an impact** on how they store medications

We put them in the locked bag in a safe for security.	I feel I'm doing the right thing since I have a young grandson that visits.
Usually use bag when I'm out.	I made me feel more secure as I have grandchildren here all of the time.
By having the bag meant that medications wouldn't be just sitting out.	The pharmacist showed me how to use the bag, and I thought that it was a very good idea.
Now I can lock up my pain pills in the bag when kids have friends over.	I chose to do this because I have a lot of respect for Kirk's even though I'm home alone the majority of the time.
It made me more aware of the necessity of keeping medications in a locked place.	I like using the bag because it is easier to access rather than getting into the safe.
It made me aware of keeping addictive drugs under lock and key.	It called my attention to keep drugs put in a secure place.
We now use the locking bag for drugs.	I felt like it was a good thing and there was no charge which was nice.
It actually made us go through our drugs and see what we had, and which ones needed to be stored.	It was nice for the pharmacy to do this, so I feel good about having that extra bit of peace of mind.

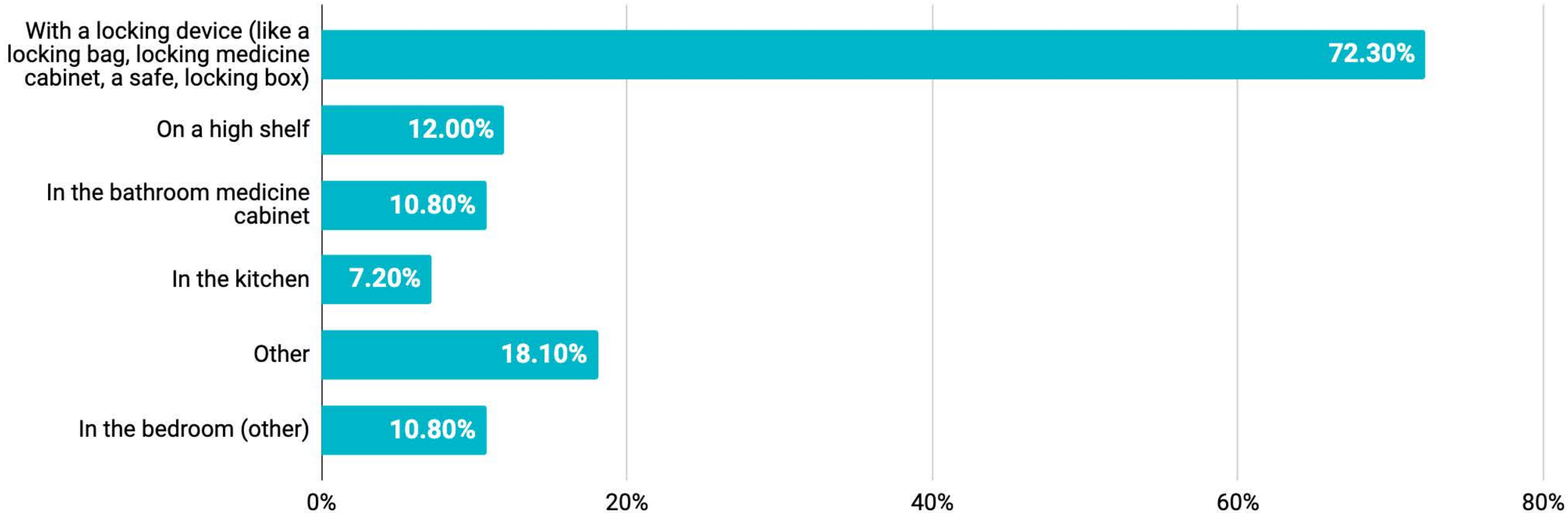
Feedback from those who cited that the information from Kirk’s pharmacy about this program **did not have an impact** on how they store medications.



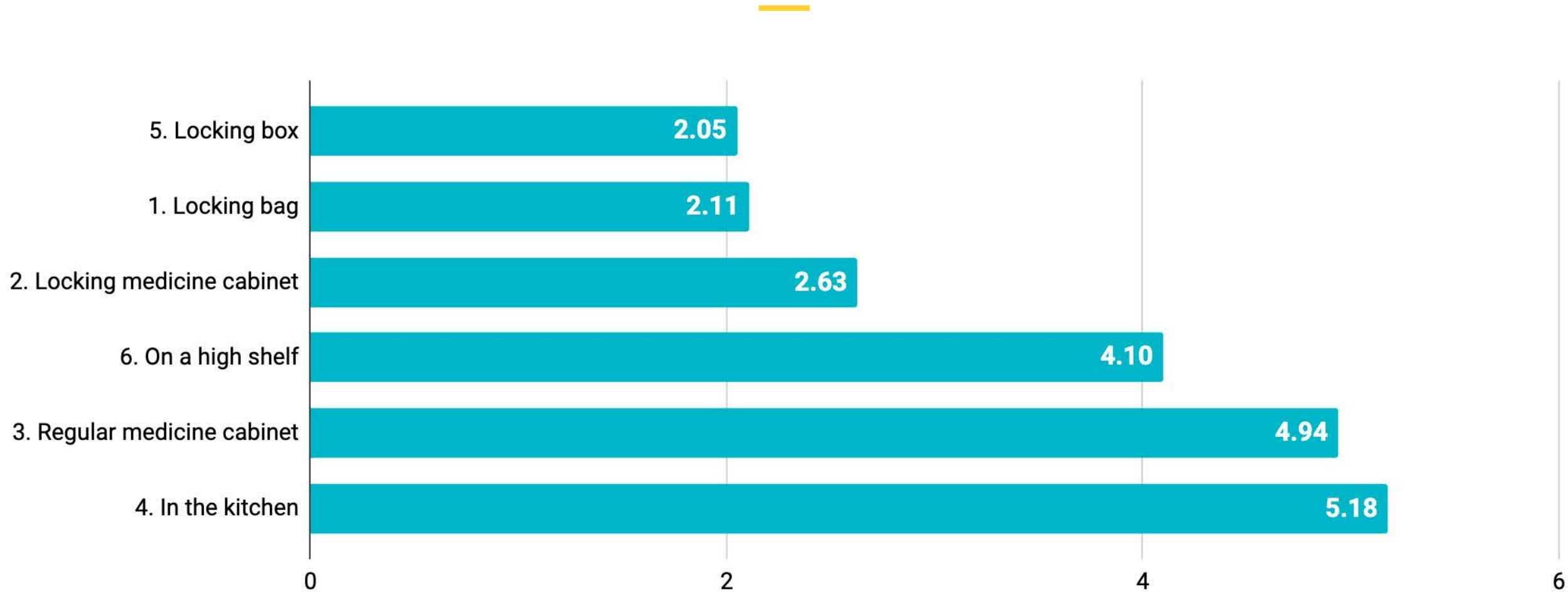
I was already storing the medication in a safe.	We are living alone, and we don't need to put to away.
The only time I would lock it is when we have the grandkids over.	Nobody home to need to lock.
By using the bag rather than going upstairs to the safe, it is easier for me to access my medications.	I have lots of friends and teenage girls in the house, so I've always locked the medications in the safe.
I just have one medicine that is a controlled substance.	I like where I keep my meds.
I live alone and will use the locked bag if I have visitors or workers that are coming to my apartment.	I have always kept the medication in the locked gun safe and only needed the locking bag for vacation.
We have always locked our medication and will only use the bag when traveling.	Since we have little kids running around here, we've always been careful about locking up our medications.
I have always kept my medications hidden.	



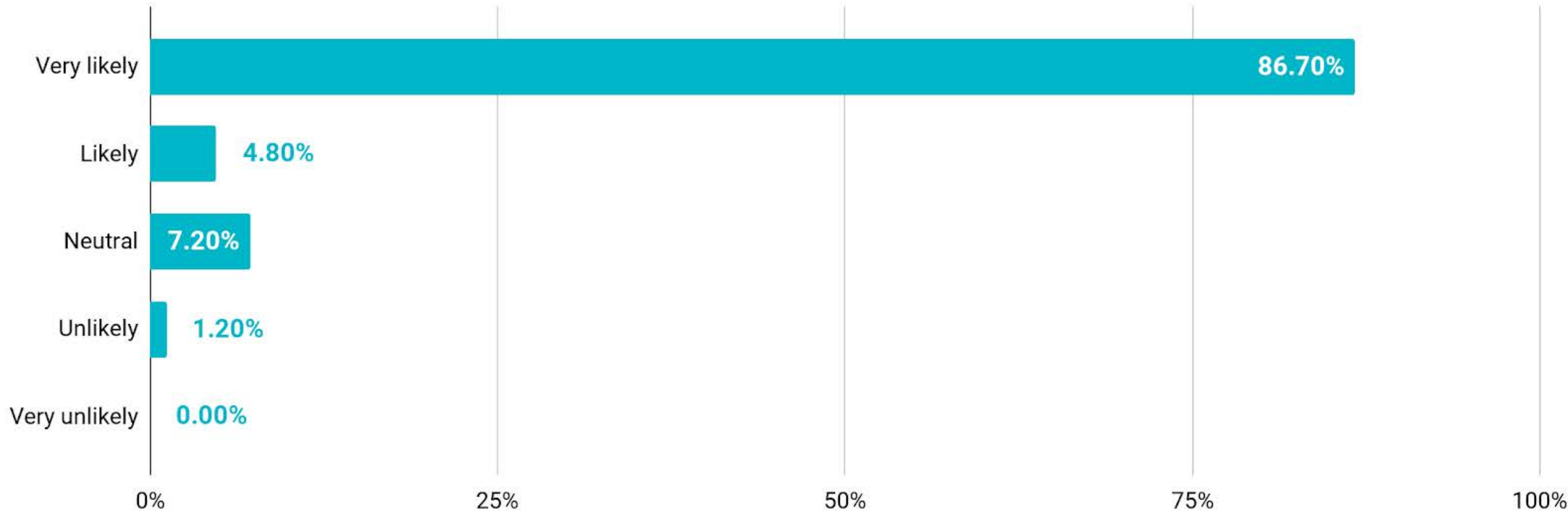
## Q9. How do you usually store prescription medication in your home?



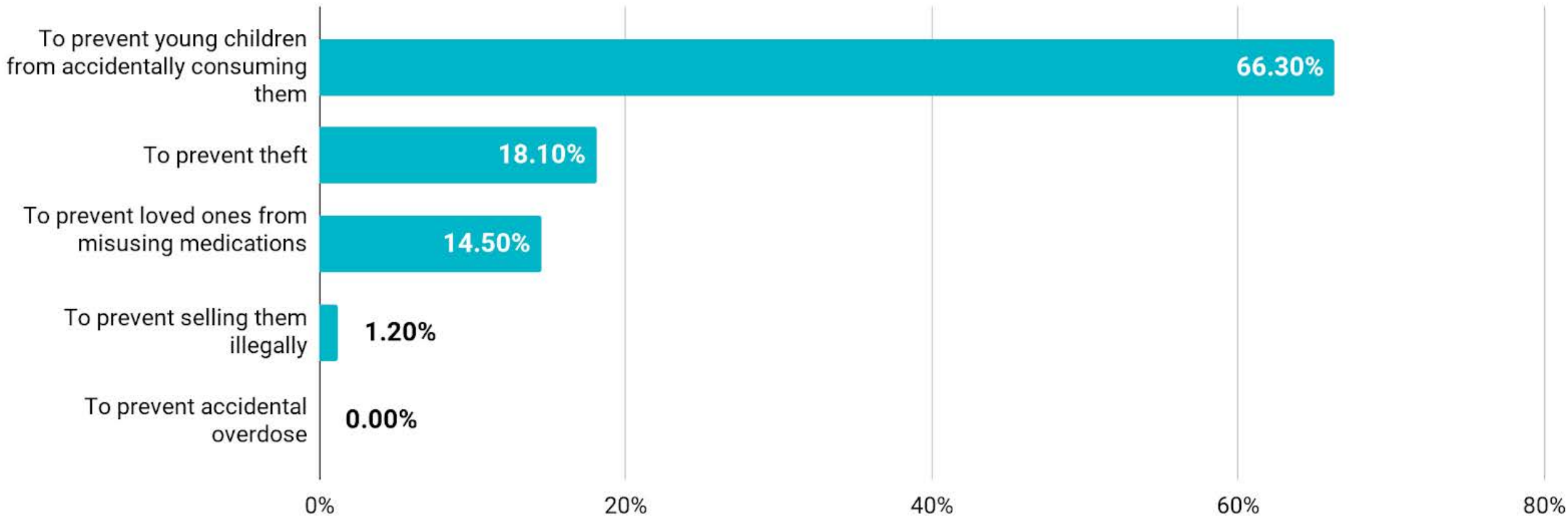
Q10. Next, I'm to read six places to store medications. I will read all six and then ask you to rank what you think are the safest from most safe, a one, to the least safe a 6. 6 pt. scale: (1=Most safe, ... 6=Least safe) Shown in descending order, ranked highest to lowest.



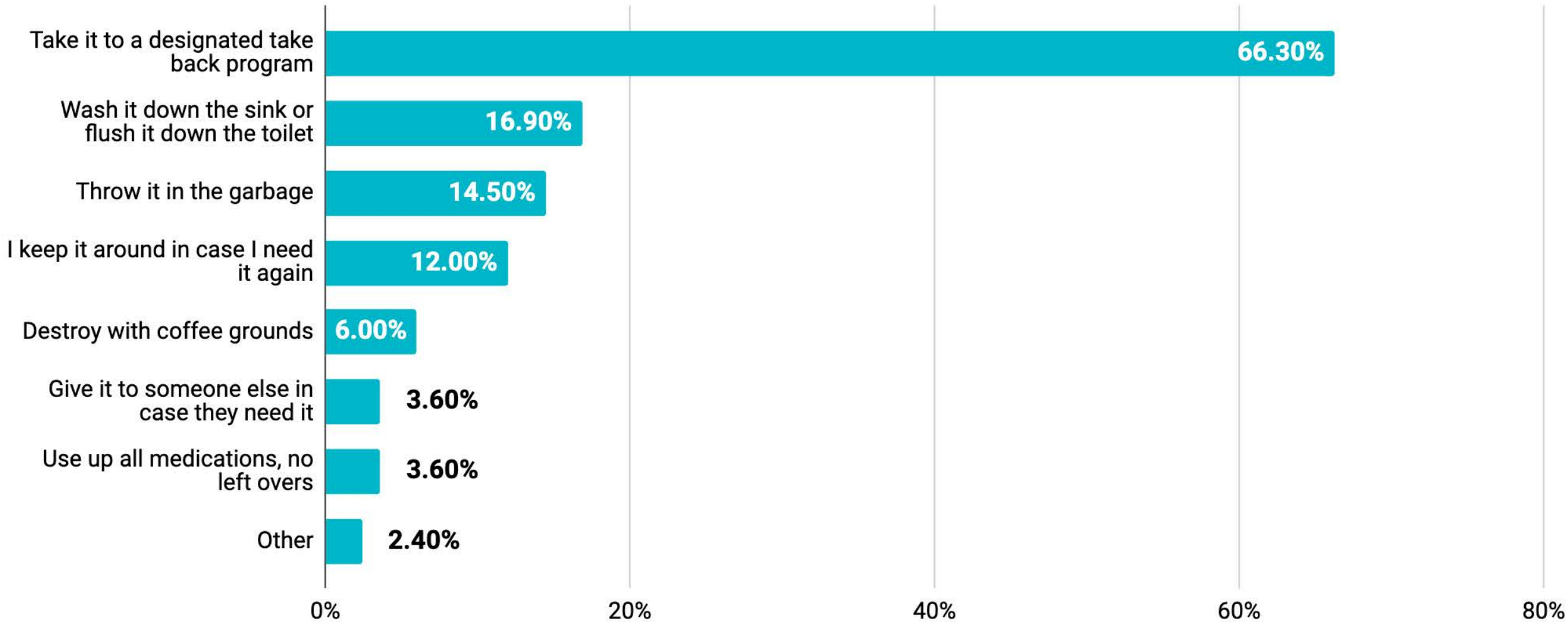
Q11. How likely are you to lock up your medications? Very likely, likely, neutral, unlikely, or very unlikely?



# Q12. What do you think is the most important reason someone would lock up their medications?



# Q13. When you are no longer using a prescription, how do you dispose of unused medication? ALL RESPONSES



# Takeaways

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- Customers were very willing to participate in the program.
- Pilot pharmacy felt it was a win-win and that implementing the program was very manageable.
- Pharmacists asking customers to make a personal commitment positively impacted safe storage behavior.
- Locking bags removed a barrier to safe storage.
- With more and more pharmacies becoming take back locations; this program can help drive safe storage AND safe disposal as social norms.

# What's Next

## Pharmacies across Washington can now participate in this free program!

The Washington State Health Care Authority has developed free materials for participating pharmacies to use, including:

- A supply of free locking bags for patients who receive opioid medications.
- Promotional materials including posters, informational rack cards, social media posts, eNews content and pledge forms.
- Promotion of your involvement in your market area through media relations and social media.
- Ongoing support to help pharmacies implement the program.





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**SHO# 20-005**

**RE: Mandatory Medicaid State  
Plan Coverage of Medication-  
Assisted Treatment**

December 30, 2020

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance about section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. No. 115-271). To increase access to medication-assisted treatment (MAT) for opioid use disorders (OUD), section 1006(b) of the SUPPORT Act requires states to provide Medicaid coverage of certain drugs and biological products, and related counseling services and behavioral therapy.<sup>1</sup> This State Health Official Letter (SHO Letter) also describes available opportunities for increasing treatment options for substance use disorders (SUD) generally. CMS encourages states to consider these opportunities when implementing the mandatory MAT coverage under section 1006(b) of the SUPPORT Act. The new required benefit is limited to the use of MAT for the treatment of OUD, and thus this SHO Letter is generally focused on that topic, not on treatment services for other SUDs, including alcohol use disorders.

### **Background**

Section 1006(b) of the SUPPORT Act, signed into law on October 24, 2018, amends section 1902(a)(10)(A) of the Social Security Act (the Act) to require state Medicaid plans to include coverage of MAT for all eligible to enroll in the state plan or waiver of state plan. Section 2601 of the Continuing Appropriations Act, 2021 and other Extensions Act, Pub. L. No. 116-159, amended the SUPPORT Act to specify that the rebate requirements in section 1927 shall apply to any MAT drug or biological described under the mandatory benefit to the extent that the MAT drug or biological is a covered outpatient drug. (More information on section 2601 is in the section below entitled, “MAT Drug Coverage and Section 1927 Manufacturer Rebates.”) Section 1006(b) also adds a new paragraph 1905(a)(29) to the Act to add the new required benefit to the definition of “medical assistance” and to specify that the new required benefit will be in effect for the period beginning October 1, 2020, and ending September 30, 2025.

In addition, section 1006(b) adds section 1905(ee)(1) to the Act to define MAT, for purposes of the new required coverage, as:

. . . all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section

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<sup>1</sup> SUPPORT for Patients and Communities Act, Pub. L. No. 115–271 (2018), <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>.

351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and[,] . . . with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

CMS interprets section 1905(ee)(1) of the Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MAT to treat OUD. Currently, the FDA has approved the following drugs used for MAT to treat OUD: methadone, buprenorphine, and naltrexone.<sup>2</sup> Only those formulations of drugs or biologicals that are approved or licensed by the FDA for MAT to treat OUD must be covered under the new mandatory Medicaid benefit. There are currently no FDA-licensed biological products to treat OUD.<sup>3</sup>

### **Medication-Assisted Treatment**

While states are required to cover all drugs and biologicals approved or licensed by the FDA used for MAT to treat OUD under the new mandatory benefit, various considerations affect which medication should be provided to a particular patient.<sup>4</sup>

- Methadone is a long-acting synthetic opioid agonist medication with a long history of use in treatment of OUD in adults. Methadone is indicated for the detoxification treatment of opioid addiction as well as maintenance treatment of opioid addiction in conjunction with appropriate social and medical services.<sup>5</sup>

Methadone for treatment of OUD must be administered by an Opioid Treatment Program (OTP). Currently, solid (non-dispersible) and dispersible tablets, as well as the liquid concentrate, are labeled for use in such outpatient OUD therapy. These products cannot be dispensed from a pharmacy for the purpose of treating OUD. OTPs must have a current, valid certification from the Substance Abuse and Mental Health Services Administration (SAMHSA) and be accredited by an independent, SAMHSA-approved accrediting body.<sup>6</sup> Effective January 1, 2020, the Medicare program began covering and reimbursing OUD treatment services furnished by an OTP.<sup>7</sup>

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<sup>2</sup> U.S. Food and Drug Administration (FDA). Information about Medication-Assisted Treatment (MAT). FDA web site. <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat>; Substance Abuse and Mental Health Services Administration (SAMHSA). Medication-Assisted Treatment.

SAMHSA website. <https://www.samhsa.gov/medication-assisted-treatment>

<sup>3</sup> “Information about Medication-Assisted Treatment (MAT),” U.S. Food and Drug Administration, last modified February 14, 2019, <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat>.

<sup>4</sup> SAMHSA. Office of the Surgeon General. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington (DC). U.S. Department of Health and Human Services. 2016 Nov. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK424859/>.

<sup>5</sup> FDA. Dolophine Highlights of Prescribing Information. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2018/006134s0451bl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/006134s0451bl.pdf)

<sup>6</sup> SAMHSA. Certification of Opioid Treatment Programs. SAMHSA website. <https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs>.

<sup>7</sup> SUPPORT Act, Section 2005, Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs. See also CMCS Informational Bulletin, “Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020” (Dec. 17, 2019), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib121719.pdf>

- Buprenorphine is a synthetic opioid medication that acts as a partial agonist, blocking and only weakly activating the opioid receptor, thus blunting the euphoric effects of other opioids for the treatment of OUD.<sup>8</sup>

Buprenorphine is currently available in several dosage forms, including an oral dissolvable film, sublingual tablet, and injection. It is available as a single ingredient or in combination with naloxone, an antagonist (or blocker) of opioid receptors to prevent attempted misuse by injection. For more information on the FDA approved medications for treatment of OUDs, see SAMHSA’s Treatment Improvement Protocol 63 as well as the FDA web site:

<https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm>.<sup>9</sup>

Long-acting buprenorphine injections are a route of administration that may help to improve patient adherence, may reduce the risk of accidental exposures, theft, or deliberate misuse, and may reduce risks associated with office visits during the COVID-19 pandemic.<sup>10</sup> Sublocade is a once-monthly injection designed to deliver buprenorphine at sustained levels of medication throughout the month.<sup>11</sup>

- Naltrexone is a synthetic opioid antagonist – it blocks opioids from binding to receptors and is FDA-approved for the prevention of relapse to opioid dependence, following opioid detoxification. Naltrexone is well-tolerated following detoxification. It has no potential for abuse, and it is not addictive.<sup>12</sup> Long-acting injectable naltrexone is FDA-approved with recommended dosing once every four weeks<sup>13</sup> for maintenance of abstinence.<sup>14</sup> Naltrexone can be prescribed by any clinician who is licensed in the state to prescribe medications.<sup>15,16</sup>

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<sup>8</sup> FDA. Subutex Highlights of Prescribing Information.

[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2018/020732s018lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/020732s018lbl.pdf)

<sup>9</sup> SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020.

<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006>

<sup>10</sup> Volkow ND. Collision of the COVID-19 and Addiction Epidemics. *Ann Intern Med.* 2020; 173(1):61-62.

doi:10.7326/M20-1212

<sup>11</sup> Crist, Richard C et al. Pharmacogenetics of Opioid Use Disorder Treatment. *CNS drugs.* 2018; vol. 32 (4): 305-320. doi:10.1007/s40263-018-0513-9.

<sup>12</sup> National Institute on Drug Abuse. (2018, January 17). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies>.

<sup>13</sup> FDA. ReVia Highlights of Prescribing

Information. [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2013/018932s017lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf)

<sup>14</sup> Tanum L, Solli KK, Latif ZE, Benth JS, Opheim A, Sharma-Haase K, Krajci P, Kunøe N. Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial. *JAMA Psychiatry.* 2017 Dec 1;74(12):1197-1205. doi:

10.1001/jamapsychiatry.2017.3206. Erratum in: *JAMA Psychiatry.* 2018 Mar 14;75(5):530. PMID: 29049469; PMCID: PMC6583381.

<sup>15</sup> SAMHSA. Naltrexone. SAMHSA website.

<https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone>.

<sup>16</sup> We note that in addition to the MAT drugs listed here that are required to be covered for management of opioid dependency under the new benefit at section 1905(a)(29) of the Act, states that provide optional coverage of prescribed drugs under section 1905(a)(12) must do so consistent with sections 1902(a)(54) and 1927, which require coverage of all drugs and biologicals that satisfy the definition of a covered outpatient drug at sections 1927(k)(2)-(4), if the manufacturer has a national drug rebate agreement in effect. In that some medications not defined as MAT

To address the full scope of patients' treatment needs, section 1905(ee)(1) defines the required MAT benefit as including counseling services and behavioral therapy related to the drugs and biologicals covered under the new mandatory benefit. While states have flexibility to specify which counseling services and behavioral therapy they will include in the new mandatory benefit, states that already cover MAT successfully often cover a range of effective behavioral health services for beneficiaries with OUD receiving MAT, including the following:

- **Individual/Group Therapy** generally helps patients identify treatment goals and potential solutions to problems that cause emotional stress; seeks to restore communication and coping skills; strengthens self-esteem; and promotes behavior change and optimal mental health. Cognitive behavioral therapy is a type of therapy that has been shown to be successful in treating individuals with OUD.
- **Peer Support Services** are typically understood to be services in which a qualified peer support provider (also called a recovery coach or peer recovery support specialist) assists individuals with their recovery from substance use disorders, including OUD. Peer support services can also be offered in relation to co-occurring mental disorders and OUD. Services can include counseling on coping with symptoms and navigating early stages of the recovery process; modeling appropriate behavior, skills, and communication; engagement with a supportive community of recovering peers; and helping the person access community resources. CMS has issued guidance that addresses requirements for peer support providers.<sup>17</sup>
- **Crisis Intervention Services** are typically provided to immediately reduce or eliminate the risk of physical or emotional harm. Services can include evaluation, triage, and access to services; and treatment to effect symptom reduction, harm reduction, and/or safe transition of individuals in acute crisis to the appropriate level of care for stabilization.

### **MAT Provider Landscape**

Section 3502 of the Drug Addiction Treatment Act of 2000<sup>18</sup> amended the Controlled Substances Act (CSA) to permit qualified physicians to receive a waiver of the CSA's separate registration requirements for prescribing and dispensing certain opioid medications, such as buprenorphine, to treat OUD. Because of concerns about the lack of access to OUD treatment, Congress expanded the types of practitioners who are eligible for a waiver to prescribe and dispense buprenorphine to treat OUD. The Comprehensive Addiction and Recovery Act of 2016 allowed nurse practitioners and physician assistants to qualify for a waiver.<sup>19</sup> Additionally,

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may be used to assist in short or long-term treatment success for beneficiaries with OUD, such as medications to treat opioid withdrawal symptoms, CMS would encourage states to focus on optimal patient outcomes in decisions that impact coverage and access.

<sup>17</sup> <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf>.

<sup>18</sup> Children's Health Act of 2000, Section 3501, Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (2000). <https://www.govinfo.gov/content/pkg/PLAW-106publ310/pdf/PLAW-106publ310.pdf>.

<sup>19</sup> Comprehensive Addiction and Recovery Act of 2016, Section 303, Medication-assisted Treatment for Recovery from Addiction, Pub. L. No. 114-198, 130 Stat. 69, (2016). <https://www.congress.gov/114/plaws/publ198/PLAW-114publ198.pdf>

section 3201 of the SUPPORT Act<sup>20</sup> extends eligibility for prescribing buprenorphine for the treatment of OUD to clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives until October 1, 2023.

Section 3201 of the SUPPORT Act also expands the eligibility of certain physicians and other qualifying practitioners to treat up to 100 patients in the first year of waiver receipt if they satisfy one of the following two conditions found in regulation:<sup>21</sup>

- 1) The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology; or
- 2) The practitioner provides MAT in a “qualified practice setting.” A qualified practice setting is one that:
  - a. Provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
  - b. Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
  - c. Uses health information technology systems such as electronic health records in accordance with practice setting requirements;
  - d. Registers for their state prescription drug monitoring program where operational and in accordance with federal and state law; and
  - e. Accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

After one year at the 100-patient limit, physicians and qualifying other practitioners who meet the above criteria can apply to increase their patient limit to 275.<sup>22</sup>

### **Current MAT State Plan Coverage**

Currently, all state Medicaid programs cover some form of buprenorphine and extended-release naltrexone for treatment of OUD. In addition, most states also cover some form of the counseling and behavioral therapies that are necessary to provide evidence-based MAT. Methadone is indicated for use as part of an MAT protocol for treating OUD, but also for pain management. When used for treating OUD, methadone can only be administered by OTPs, which must be certified by SAMHSA and registered with the Drug Enforcement Administration (DEA).<sup>23</sup> OTPs must be licensed in the state in which they operate and accredited by a

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<sup>20</sup> SUPPORT Act, Section 3201, Allowing for More Flexibility with Respect to Medication-Assisted Treatment for Opioid Use Disorders.

<sup>21</sup> 21 U.S.C. 823(g)(2)(B)(II)(bb) – (cc); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610, 42 C.F.R. 8.615.

<sup>22</sup> 21 U.S.C. 823(g)(2)(B)(II)(dd); Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. 8.610 – 655.

<sup>23</sup> We note that in contrast, when methadone is used for the treatment of pain, it can be dispensed from pharmacies, which are not able to dispense methadone for OUD unless they are also certified as OTPs.

SAMHSA-approved accrediting body.<sup>24</sup> Additionally, federal regulations at 42 C.F.R. part 8 impose standards governing, for example, required services, staff credentials, patient admission criteria, and patient confidentiality criteria.<sup>25</sup> In a report on the use of medications to treat OUD in the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, SAMHSA found that methadone is covered for MAT to treat OUD by Medicaid in 42 of the 53 states and territories included in the report.<sup>26</sup>

### **Institution for Mental Diseases (IMD) Exclusion**

Frequently, MAT-related counseling and behavioral therapy are provided on-site at clinics and health centers where buprenorphine and/or naltrexone are dispensed. Primary care providers who prescribe MAT drugs often partner with local substance use disorder treatment or mental health care agencies to connect individuals to counseling. Federal regulation requires patients who receive treatment in an OTP to receive access to<sup>27</sup> medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication.<sup>28</sup> Medications for MAT, as well as the counseling and behavioral therapies, can also be furnished in inpatient and residential settings such as psychiatric hospitals, inpatient units, or residential treatment programs, including in IMDs, but Medicaid coverage is generally not available unless the setting is not an IMD or an exception to the IMD exclusion applies, as discussed below.

An IMD is defined in section 1905(i) of the Act as a “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual under age 65 who resides in an IMD. This is commonly known as the “IMD exclusion.” The IMD exclusion applies to any care or services provided inside or outside of the facility or hospital to a Medicaid beneficiary residing in an IMD, unless an exception to the IMD exclusion applies. As specifically relevant here, MAT and counseling and behavioral therapies provided in an IMD would not be covered by Medicaid unless an exception to the IMD exclusion applies.

Currently, there are several exceptions to the IMD exclusion and other authorities that permit short-term stays in IMDs. First, Medicaid payment is permitted for inpatient hospital services, nursing facility services, and intermediate care facility services provided in IMDs to individuals age 65 and older.<sup>29</sup> Second, Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the “psych under 21 benefit,” furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a “Psychiatric Residential Treatment Facility.”<sup>30</sup>

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<sup>24</sup> SAMHSA. Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose. HHS Publication No. SMA-18-5093, page 39.

<sup>25</sup> 42 C.F.R. 8.12.

<sup>26</sup> SAMHSA. HHS Publication No. SMA-18-5093, page 39. Published November, 2018

<sup>27</sup> SAMHSA, Treatment Improvement Protocol: Medications for Opioid Use Disorder, May 2020.

<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006>

<sup>28</sup> 42 C.F.R. 8.12(f)

<sup>29</sup> 42 C.F.R. 440.140

<sup>30</sup> 42 C.F.R. 440.160

Third, section 1012 of the SUPPORT Act, entitled “Help for Moms and Babies,” added a new limited exception to the IMD exclusion. For more information, see the CMCS Informational Bulletin, “State Guidance for the New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women, July 26, 2019.”<sup>31</sup> Fourth, section 5052 of the SUPPORT Act, entitled, “State option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases,” amended the IMD exclusion and established a new section 1915(*l*) of the Act. This provision permits states to cover a state plan option to provide services to Medicaid beneficiaries age 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD. The period of this state plan option is from October 1, 2019 through September 30, 2023. For more information, see State Medicaid Director Letter (SMDL) # 19-0003, Re: Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(*l*) of the Social Security Act, November 6, 2019.<sup>32</sup>

Other authorities that permit short-term stays in IMDs include section 1115 demonstrations. CMS announced a section 1115 demonstration initiative where states can receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids or other substances, including services provided to beneficiaries residing in IMDs. For more information, see section 1115 SUD Demonstrations, SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017.<sup>33</sup> Finally, states may receive FFP for monthly capitation payments for beneficiaries age 21 through 64 receiving SUD treatment in an IMD for a short-term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the managed care regulation are met.<sup>34</sup>

### **SUPPORT Act Section 1006(b) Coverage**

Section 1006(b) of the SUPPORT Act requires states to begin implementing MAT as a mandatory Medicaid state plan benefit for categorically needy populations for the 5-year period beginning October 1, 2020. Under the definition of the new mandatory benefit at section 1905(ee)(1) of the Act, states are required to cover all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat OUDs. CMS interprets the statute to require coverage of all forms of the drugs and biologicals that the FDA has approved or licensed for treatment of OUD. States are also required to cover counseling services and behavioral therapies associated with provision of the required drug and biological coverage.

### **Exception for Provider Shortage**

Section 1905(ee)(2) of the Act provides that states may be excused from the mandatory coverage requirement if, before the requirement takes effect on October 1, 2020, the state “certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of

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<sup>31</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf>.

<sup>32</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf>.

<sup>33</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

<sup>34</sup> 42 C.F.R. 438.6(e)

a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3).”

In CMS’s view, the purpose of the new requirement is to increase access to MAT to treat OUD for Medicaid beneficiaries, and this can only be accomplished by increasing the enrollment in Medicaid of OTPs and other MAT providers and practitioners. CMS therefore expects states to conduct provider outreach and enrollment as they prepare to meet the new requirements. As discussed above, because methadone for treatment of OUD can only be provided in OTPs, states that do not already enroll OTPs as Medicaid providers will be expected to take action to do so. Additionally, if a state has MAT providers operating in the state that are not currently enrolled in the Medicaid program, states are expected to permit any willing and qualified provider to become a Medicaid provider for the newly required MAT benefit, so that beneficiaries may receive these services from the qualified and willing provider of their choice, consistent with section 1902(a)(23) of the Act and 42 C.F.R. 431.51.

CMS expects a state seeking the exception under section 1905(ee)(2) to document in its exception request that it has made a good faith effort toward enrolling providers of MAT for the Medicaid fee-for-service program, Medicaid managed care organizations (MCOs), and primary care case managers (PCCMs). Such documentation would include information about state review of MCO demonstrations of adequate capacity to furnish services under 42 C.F.R. 438.207; state standards for uniform credentialing policies that MCOs must use in accordance with 42 C.F.R. 438.214(b); and MCO policies and procedures for credentialing and re-credentialing network providers, required under 42 C.F.R. 438.214. A state requesting an exception should conduct a detailed accounting of the current MAT providers in the state, both those that are enrolled in the Medicaid program and those that are not, and should detail in its exception request the process that the state has undertaken to contract with MAT providers (and/or to encourage that MAT providers contract with the state’s Medicaid MCOs and/or PCCMs) and the reasons why the providers are not willing to enroll.

We recognize that there may be state-specific administrative challenges with providing CMS with the information necessary for the Secretary to determine that the state has satisfactorily certified to the existence of a shortage of providers, especially in light of the fact that this guidance is being issued after October 1, 2020, the effective date of the new MAT coverage requirement. Therefore, CMS will not require states seeking this exception to have submitted a request for the exception before October 1, 2020. Instead, CMS will accept state requests for this exception on or before January 14, 2021. The request for the exception should be submitted at the same time as a request for flexibility under section 1135 of the Act with respect to state plan amendment (SPA) submission and notice timelines (as described further below). If a state is not granted an exception based on a shortage of providers or facilities, then the state will need to submit a SPA, and requesting flexibility with respect to SPA submission and notice timelines could help the state to safeguard a SPA effective date of October 1, 2020 if the exception request is denied. For further detail, please refer to the “SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines” section below.



CMS remains committed to providing technical assistance to states and other stakeholders in understanding the mandatory MAT benefit and developing implementation approaches that result in the provision of Medicaid services in a manner compliant with program requirements.

States that seek an exception based on a shortage of providers or facilities should submit their request on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new “One CMS Portal,” the request for the exception based on a shortage of providers or facilities should be submitted via the portal. The information detailed below should be included with the request, which should include the state’s certification that it cannot come into compliance with the new requirement due to a shortage of providers. States may, but are not required to, use the following format.

\_\_\_\_\_ [Insert name of state] certifies that implementing the MAT benefit specified in section 1905(a)(29) of the Act is not feasible due to a shortage of qualified providers or facilities that will enroll in the state Medicaid program or contract with a Medicaid managed care organization (MCO) or Primary Care Case Manager to furnish one or more of the required MAT benefit components, and requests an exception from the requirement to provide this benefit for this reason.

The state’s request should include all of the following information:

- a. A description of the state’s current qualified provider and facility status, including the number, type, and location of qualified providers and facilities that furnish MAT.
- b. A brief description of the process that the state has undertaken to contract with all qualified MAT providers and facilities and reasons why the providers did not contract with the state or a managed care organization or Primary Care Case Manager.
- c. For all Medicaid MCOs in the state, the written policies and procedures for selection and retention of network providers required by 42 C.F.R. 438.214, and copies of the assurances of adequate capacity and supporting documentation required by 42 C.F.R. 438.207(b), along with the state’s certification and supporting documentation required by 438.207(d).
- d. A description of the unmet need caused by the shortage of qualified providers or facilities among eligible children and adults whom the state identifies as individuals with OUD who could benefit from MAT.
- e. A description of the state’s plan to enroll additional qualified providers or facilities to ensure that all individuals eligible for MAT under the state plan (or a waiver of the state plan) are able to access it, and the date when the state thinks it will resolve the qualified provider or facilities shortage.

All exceptions approved under section 1905(ee)(2) will be for the full five-year period that the new MAT benefit is required. However, if a state decides to come into compliance with the MAT benefit requirement after receiving an exception under section 1905(ee)(2), CMS will be available to provide technical assistance to the state.

**Extension of Compliance Deadline Due to Legislative Delay**

Section 1006(b)(4)(B) of the SUPPORT Act (which was not codified in any provision of the Social Security Act) provides for an “exception” to the October 1, 2020 effective date of the new MAT benefit “for state legislation.” Essentially, this provision provides for an extension to the required start date of the new coverage requirement if the only reason the state cannot come into compliance by October 1, 2020 is due to lack of state legislation that is needed to meet the requirement. Not all states will be able to seek this extension, because it depends on the timing of the state’s first regular legislative session that began after the date of enactment of the SUPPORT Act (October 24, 2018). If the Secretary of Health and Human Services determines that state legislation is needed to bring the state plan into compliance with the new coverage requirement, the Secretary will not consider the state to be out of compliance with the new coverage requirement solely on the basis of a failure to enact the required state legislation before the first day of the first calendar quarter beginning after the close of the first regular session of the state’s legislature that begins after October 24, 2018. If a state’s first regular legislative session beginning after October 24, 2018 was the calendar year that began on January 1, 2019 and ended on December 31, 2019, the state would not be able to seek this extension because it would have had only until December 31, 2019 to enact any required legislation, and the first day of the first calendar quarter that begins after that date is January 1, 2020 – well before October 1, 2020.

If, however, a state’s first regular legislative session beginning after October 24, 2018 does not end until on or after October 1, 2020, and the Secretary determines that legislation was necessary to meet the new coverage requirement, but the necessary legislative authorization was not obtained, the state could seek to delay compliance with the new coverage requirement until the first day of the first calendar quarter after the legislative session ends. Such a state is expected to come into compliance with the new coverage requirement by the first day of the first calendar quarter after the end of the legislative session, unless the exception in section 1905(ee)(2) applies. If a state has a two-year legislative session, each year of the session shall be considered to be a separate regular session of the state legislature for purposes of this extension. This means that a state would not have a longer extension if it has a two-year legislative session; such a state is treated like a state with a one-year legislative session, and any applicable extension ends on the first day of the first calendar quarter following the end of the first year of the two-year session.

CMS will grant an extension based on legislative delay only if a legislative delay is the only reason that a state cannot meet the requirement, and only when the first regular legislative session that began after October 24, 2018 ends on or after October 1, 2020, as discussed above. States should submit requests for the legislative delay extension on or before January 14, 2021 to the Regional SPA/Waiver mailbox that is currently used for Medicaid SPA submissions. If the state is participating in the pilot for the new “One CMS Portal,” the request for the legislative delay extension should be submitted via the portal. The request should include documentation to support that the state’s first regular legislative session that began after October 24, 2018 did not end until on or after October 1, 2020, that state legislation is needed to come into compliance with the new coverage requirement, and that the legislative delay is the only reason the state cannot come into compliance as of October 1, 2020. States are encouraged to submit a request for flexibility under section 1135 of the Act with respect to SPA submission and notice timelines,

as discussed below under “SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines,” at the same time as the request for the legislative delay extension, in order to help safeguard a SPA effective date of October 1, 2020 if the state’s request for a legislative delay extension is not granted. States may, but are not required to, use the following format for their legislative delay extension submission:

\_\_\_\_\_ [Insert name of state] requests an exception based on the need for legislative authority to cover the benefit described in section 1905(a)(29) of the Social Security Act, and submits documentation to support that the state’s first regular legislative session that began after October 24, 2018 will not end until on or after October 1, 2020. [Describe the documentation that is attached or that accompanies the request and include information about the state’s legislative calendar so CMS can determine the state’s compliance date.]

States that are granted an extension due to legislative delay will still need to follow the SPA submission requirements below and submit a SPA consistent with the extended compliance deadline.

**SPA Submission Requirements and Opportunity to Request Section 1135 Flexibility With Respect to SPA Submission and Notice Timelines**

SPA effective date requirements outlined at 42 C.F.R. 430.20 provide for an effective date retroactive to the first day of the quarter in which the SPA was submitted. In addition, the public notice requirements at 42 C.F.R. 447.205 require states to publish notice of proposed changes in methods and standards for setting payment rates for services before the proposed effective date of the change. Accordingly, under these rules, states have only until December 31, 2020 to submit a SPA establishing coverage or payment for the new MAT benefit that would take effect October 1, 2020. Additionally, any SPA setting payment rates for the new benefit could take effect only after the state issues public notice of the proposed payment changes. Thus, states would have had to publish notice of their payment rate changes by September 30, 2020, for changes to take effect October 1, 2020.

CMS is aware that most states have been unable to submit a SPA for the new MAT benefit that meets these submission and notice timing requirements because they have had to focus almost exclusively on responding to the COVID-19 pandemic throughout much of 2020. At the same time, the opioid crisis has only been exacerbated by the COVID-19 pandemic. During the COVID-19 public health emergency (PHE), disruptions in treatment have resulted in a resurgence of relapses and fatal overdoses among individuals with OUD.<sup>35</sup>

Consequently, in order to help ensure that beneficiaries can access coverage for the new MAT benefit effective retroactively to October 1, 2020, CMS is giving states the opportunity to request that CMS exercise its section 1135 authority to modify the regulatory deadlines associated with SPA submission and public notice for coverage and payment SPAs for the new MAT benefit while the COVID-19 PHE is still in effect.<sup>36</sup> CMS strongly recommends that states submit these

<sup>35</sup> <https://qz.com/1889798/covid-19-is-making-the-opioid-crisis-much-worse/>

<sup>36</sup> Section 1135 authority permits the Secretary to temporarily waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements during a PHE, in order to ensure, to the maximum extent feasible, that sufficient health care items and services are available to meet the needs of individuals enrolled in those programs.

requests on or before January 14, 2021. Specifically, if responding to the COVID-19 pandemic has delayed a state's ability to submit a coverage or payment SPA for the new MAT benefit or provide public notice of payment rate changes related to the new MAT benefit under the time frames set forth at 42 C.F.R. 430.20 and 447.205, the state may request flexibility regarding the timing of the SPA public notice and submission process for these SPAs, so that it can submit SPAs adding coverage and payment for the new mandatory MAT benefit at section 1905(a)(29) of the Act in the first quarter of 2021 that would be effective October 1, 2020. If a state does not submit a request for section 1135 flexibility as described herein and submits a SPA after December 31, 2020 to add the new mandatory MAT benefit, then the SPA's effective date would be on (or sometime after) January 1, 2021, beneficiaries might not be able to access all available MAT coverage before that date, and the state would not be in timely compliance with the new coverage requirement.

CMS will provide states with this flexibility only if they meet the following conditions. First, all state requests for modification of the deadlines for MAT SPA submission and public notice under section 1135 must be submitted and approved during the COVID-19 PHE, and all MAT SPAs must be submitted on or before March 31, 2021. Second, states must solicit and should consider public comments and comments received through tribal consultation before finalizing the SPAs that will take effect. States must conduct tribal consultation if required under section 1902(a)(73)(A) before submission of their MAT SPAs, even if CMS approves a modification under section 1135 of the 42 C.F.R. 447.205 notice timelines. Additionally, CMS strongly recommends that states conduct any public notice required under 42 C.F.R. 447.205 before submitting their MAT SPAs, even if CMS approves a modification under section 1135 of the timeline for that notice. If states have had to put in place interim coverage or rate policies for the new MAT benefit while preparing their SPAs for submission and finalizing them for approval, they would be expected to give effect to the rates and coverage policies that are ultimately approved retroactive to the effective date of October 1, 2020. States seeking these section 1135 flexibilities should submit a letter to Jackie Glaze at [Jackie.Glaze@cms.hhs.gov](mailto:Jackie.Glaze@cms.hhs.gov) by January 14, 2021. In addition to a statement explaining that the state's response to the COVID-19 pandemic has delayed its ability to submit coverage and/or payment SPAs for the new MAT benefit according to the regulatory SPA submission and notice timelines, the letter should include the following language (as applicable):

#### Request for Modifications under Section 1135

Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of SPA submission requirements at 42 C.F.R. 430.20, in order to submit a SPA implementing section 1905(a)(29) of the Act by March 31, 2021 that would take effect on October 1, 2020.

Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, the state Medicaid agency requests modification of the public notice time frames set forth at 42 C.F.R. 447.205, in order to obtain an effective date of October 1, 2020 for its SPA implementing statewide methods and standards for setting payment rates for the benefit described at section 1905(a)(29) of the Act. The state will issue public notice as soon as possible, and in no event later than February 28, 2021.

With respect to SPA submissions related to coverage and payment for the new MAT benefit, states should take the following steps.

States should submit an amendment to their Medicaid state plans (including to Alternative Benefit Plans, if applicable), no later than December 31, 2020 (or March 31, 2021, if CMS has approved section 1135 flexibility as discussed above) after having conducted public notice and tribal consultation, as needed, to cover, under the new mandatory benefit at section 1905(a)(29) of the Act, all FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, as well as all forms of the drugs and biologicals approved or licensed by the FDA for MAT to treat OUD, and associated counseling services and behavioral therapies. States should submit their SPAs to the Regional SPA/Waiver mailbox that is currently used for other Medicaid SPA submissions. If a state is participating in the pilot for the new “One CMS Portal,” the SPA should be submitted via the portal.

States that already use existing Medicaid authorities to cover items and services that will now be covered under the new mandatory MAT benefit, including FDA-approved or licensed drugs and biologicals used for MAT to treat OUD, and associated counseling services and behavioral therapies, are expected to submit a SPA to move their coverage of these items and services to a new page in their Medicaid state plans for the new mandatory benefit at section 1905(a)(29) of the Act.

In addition to submitting SPAs to add the mandatory MAT benefit to the state plan, states will need to propose associated changes to the payment section of the state plan. States will need to submit a new Attachment 4.19-B page for the mandatory benefit at section 1905(a)(29) that describes the rate-setting methodology used to pay for the services covered under the mandatory MAT benefit. The rate-setting methodology for the new MAT benefit must be consistent with section 1902(a)(30)(A) of the Act, which requires Medicaid payments to be “consistent with efficiency, economy, and quality of care” and to be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” States may include all medical service costs associated with furnishing the MAT benefit services to Medicaid beneficiaries (such as salaries, fringe benefits, supplies, and equipment) in their rate-setting methodology for the new MAT benefit, and the methodology must be a comprehensive description within the state plan consistent with 42 C.F.R. 430.10. As states have a variety of options to choose from in how they pay for MAT services, CMS is available to provide assistance to states as they develop SPA proposals. We encourage states to reach out to their state lead in the Medicaid and CHIP Operations Group for technical assistance.

As with any SPA submission, CMS expects states to comply with all SPA requirements that are not waived or modified, including those found in 42 C.F.R. 440.200, et seq., and to provide information on the source of the non-federal share of the service payments and information on the rate-setting methodology. Specific guidance related to SPA submission procedures may be found on the Medicaid.gov web page.

### **MAT Drug Coverage and Section 1927 Manufacturer Rebates**

CMS interprets section 1905(ee)(1) of the SUPPORT Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the FDA has approved or licensed for MAT to treat OUD. More specifically, under the new mandatory MAT benefit, states are required to cover such FDA approved or licensed drugs and biologicals used for indications for MAT to treat OUD.

Statutory amendments were made to the original language at sections 1905(a)(29) and 1905(ee) by Section 2601 of the Continuing Appropriations Act, 2021 and Other Extensions Act (Pub. L. No. 116-159) to specify that the rebate requirements in section 1927 shall apply to any MAT drugs or biologicals described under the mandatory benefit at section 1905(ee)(1)(A), that are furnished as medical assistance under sections 1905(a)(29) and section 1902(a)(10)(A), and are covered outpatient drugs, as that term is defined at section 1927(k)(2). In determining whether such a MAT drug or biological satisfies the definition of a covered outpatient drug, such MAT drugs or biologicals are deemed prescribed drugs for such purposes. More specifically, these amendments ensure that MAT drugs and biologicals can be included in the Medicaid Drug Rebate Program (MDRP). Additionally, for MAT drugs or biologicals that are also covered outpatient drugs, the amendments also ensure a state's ability to seek section 1927 rebates and apply drug utilization management mechanisms (such as preferred drug lists and prior approval), and establish a manufacturer's obligation to pay appropriate rebates and comply with all applicable drug product and drug pricing reporting and payment of rebates. The change in law is effective as if included in the enactment of the SUPPORT Act, which was October 24, 2018.

CMS expects that most manufacturers of MAT drugs and biologicals currently have in effect a rebate agreement with the Secretary and pay rebates to states for all drugs and biologicals that meet the definition of covered outpatient drug (COD) in section 1927(k) of the Act, and if not, that manufacturers of these drugs and biologicals will likely enter into a rebate agreement with the Secretary and pay rebates to states. Should an FDA-approved MAT drug or biological for OUD not meet the definition of a covered outpatient drug, or if the drug is a covered outpatient drug, but the manufacturer does not have a rebate agreement in effect with the Secretary, the state would still be required to cover the drug or biological under the MAT mandatory benefit, and the drug or biological would be eligible for FFP, but not rebates. States could subject MAT drugs or biologicals that are not covered outpatient drugs to prior approval or other utilization management mechanisms under 42 C.F.R. 440.230 as described below, including in order to prioritize coverage of those drugs that are covered outpatient drugs, but the state still must provide coverage for MAT drugs that are not covered outpatient drugs if they are medically indicated for the beneficiary, consistent with 42 C.F.R. 440.230(b).

### **State Use of Utilization Management Mechanisms**

As a reminder, states may use utilization management controls to promote the efficient delivery of care and to control costs.<sup>37</sup> States can use the Section 1927 utilization management mechanisms for MAT drugs used for OUD that are covered outpatient drugs, such as

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<sup>37</sup> Medicaid and CHIP Payment and Access Commission's (MACPAC) October 2019, Report to Congress: Utilization Management of Medication-Assisted Treatment in Medicaid, <https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf>

encouraging the use of generic products, creating a preferred drug list, or choosing to implement prior authorization to manage drug classes that may require additional monitoring.

For MAT drugs that are covered outside of a rebate agreement, or would be covered outpatient drugs, except that they are subject to the limiting definition at section 1927(k)(3) (e.g. those that are paid as part of a bundle), states may use the utilization management mechanisms authorized under 42 C.F.R. 440.230. In these cases, states may propose limits on the amount, duration, and scope of these drugs under the MAT benefit, including to encourage the use of the most cost-effective MAT drugs and biologicals.

### **Support to States for Increasing SUD Treatment Options**

Well-supported scientific evidence demonstrates that treatment for substance use disorders – including inpatient, residential, and outpatient treatment – is cost-effective compared with no treatment.<sup>38</sup> Existing Medicaid authorities, as well as new opportunities afforded by the SUPPORT Act, are available to help states expand their SUD service continuum, which can include MAT.

Section 1115 demonstration projects – In November 2017, CMS announced a section 1115 initiative that affords states the opportunity to receive federal financial participation (FFP) for expenditures on the continuum of services to treat SUD, including expenditures on treatment while Medicaid enrollees are residing in residential treatment facilities that are IMDs. Such expenditures can generally not be federally matched under Medicaid due to the IMD exclusion. As part of this initiative, states may develop innovative approaches to inpatient and residential care for individuals with SUDs that are expected to supplement and coordinate with community-based care to provide a robust continuum of care in the state. Participating states are required to ensure residential settings included in these demonstrations are either offering beneficiaries access to MAT on-site or facilitating beneficiaries' access to MAT off-site.<sup>39</sup>

Section 1003 of the SUPPORT Act – Section 1003 requires the Secretary to conduct a demonstration project to increase Medicaid SUD provider capacity. In 2019, CMS awarded planning grants to 15 states to conduct an assessment of SUD treatment and recovery needs of the state. The planning grants may also support activities to recruit, train, and provide technical assistance for providers; to improve reimbursement; and to expand the number or treatment capacity of Medicaid providers. Up to five of the states that received planning grants will be selected to implement demonstrations and receive enhanced federal reimbursement for increases in Medicaid SUD treatment and recovery services expenditures. For more information on this demonstration project, and the 15 states that were awarded planning grants, see the Medicaid.gov web page.<sup>40</sup>

Section 1006(a) of the SUPPORT Act – Section 1006(a) of the SUPPORT Act permits CMS to extend, at state request, the period of 90% federal match from eight to 10 fiscal year quarters for

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<sup>38</sup> Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016. Chapter 4, Early Intervention, Treatment, and Management of Substance Use Disorders. <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

<sup>39</sup> SMDL # 17-003, Re: Strategies to Address the Opioid Epidemic, November 1, 2017, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

<sup>40</sup> <https://www.medicaid.gov/medicaid/benefits/bhs/support-act-provider-capacity-demos/index.html>

health home services provided to SUD-eligible individuals under a SUD-focused Medicaid health home SPA approved on or after October 1, 2018. The Medicaid health home state plan option (authorized under section 1945 of the Act) promotes coordination of primary and acute physical and behavioral health services and long-term services and supports. Specific guidance related to the health home Medicaid state plan option, including guidance on health home services, health home providers, state reporting, and developing payment methodologies, can be found on the Medicaid.gov web page.<sup>41</sup> Information on section 1006(a) of the SUPPORT Act is also available in the policy guidance tab on the Medicaid.gov web page.<sup>42</sup>

Section 7181 of the SUPPORT Act – Section 7181 of the SUPPORT Act reauthorized and modified the “State and Tribal Response to the Opioid Crisis” grants established under section 1003 of the 21st Century Cures Act. Section 7181 requires the grants to be awarded to Indian tribes in addition to states and territories. This provision also expands the types of activities that grants may support to include the establishment of prescription drug monitoring programs and training for health care practitioners in preventing diversion of controlled substances. It also emphasizes flexibility with use of funds by permitting resources to be directed “in accordance with local needs related to substance use disorders.”<sup>43</sup>

Section 7181 authorizes \$500 million for each of Fiscal Years 2019-2021, which would remain available until expended. It authorizes a set-aside of up to 15% for states with the highest age-adjusted rate of drug overdose death based on the ordinal ranking of states according to the Centers for Disease Control and Prevention (CDC)<sup>44</sup>. SAMHSA will provide state agencies and Indian tribes with technical assistance on grant application and submission procedures, award management activities, and enhancing outreach and direct support to rural and underserved communities and providers in addressing the opioid crisis.

Telehealth – HHS developed materials to help clarify how clinicians can use telemedicine as a tool to expand buprenorphine-based MAT for OUD treatment under current DEA regulations. This information includes a clinical practice example that is consistent with applicable DEA and HHS administered authorities. It is hoped that the materials help expand providers’ ability to prescribe MAT to patients, including remote patients under certain circumstances. This information can be found on the HHS.gov web page.<sup>45</sup>

Telehealth could be especially helpful in supporting access to buprenorphine in rural areas, where there may be a smaller number of waived providers able to prescribe buprenorphine for the treatment of OUD in settings other than federally regulated opioid treatment programs.<sup>46</sup>

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<sup>41</sup> <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>.

<sup>42</sup> CMCS Informational Bulletin, [Guidance for States on the Availability of an Extension of the Enhanced Federal Medical Assistance Percentage \(FMAP\) Period for Certain Medicaid Health Homes for Individuals with Substance Use Disorders \(SUD\)](#), May 7, 2019, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib050719.pdf>.

<sup>43</sup> <https://www.govinfo.gov/content/pkg/PLAW-115publ271/html/PLAW-115publ271.htm>

<sup>44</sup> <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

<sup>45</sup> <https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf>.

<sup>46</sup> U.S. Department of Health and Human Services. Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder. DHHS web site. September 2018. <https://www.hhs.gov/blog/2018/09/18/using-telemedicine-combat-opioid-epidemic.html>.



CMS also released a State Medicaid Director Letter (SMDL) in June 2018, “Leveraging Medicaid Technology to Address the Opioid Crisis,”<sup>47</sup> that includes a section on how states can leverage telehealth technologies to improve access to SUD treatment. This SMDL also discusses the potential availability of enhanced federal funding to support telehealth-enabling technologies. Additionally, consistent with section 1009(b)(1) of the SUPPORT Act, CMS issued guidance on federal Medicaid reimbursement for services to treat SUD furnished via telehealth, including in School-Based Health Centers.<sup>48</sup> Services discussed in this guidance include assessment, MAT, counseling, medication management, and medication adherence with prescribed medication regimes.

### **Conclusion**

MAT is an effective, comprehensive, and evidence-based treatment that is integral to addressing the nation’s opioid crisis. Section 1006(b) of the SUPPORT Act amended the Social Security Act to require states to cover MAT for all eligible to enroll in the state plan or waiver of state plan. The new mandatory MAT benefit includes all FDA-approved drugs and licensed biologicals used for MAT to treat OUD, as well as associated counseling and behavioral therapies. CMS interprets the statute to require coverage of all forms of drugs and biologicals approved or licensed by the FDA for use as MAT to treat OUD. CMS is available to provide technical assistance and looks forward to working with states to ensure Medicaid beneficiaries with OUD receive the services they need. If you have any questions, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at [Kirsten.Jensen@cms.hhs.gov](mailto:Kirsten.Jensen@cms.hhs.gov).

Sincerely,

/s/

Anne Marie Costello  
Acting Deputy Administrator and Director

cc: State Mental Health Directors  
State Substance Use Directors  
State Opioid Treatment Authorities  
State Budget Officers  
State Pharmacy Directors  
National Association of Medicaid Directors  
National Association of State Mental Health Program Directors  
National Association of State Alcohol and Drug Abuse Directors  
Association of State and Territorial Health Officials  
National Association of State Budget Officers  
National Conference of State Legislatures

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<sup>47</sup><https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>.

<sup>48</sup> CMCS Informational Bulletin, April 2, 2020. Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth. <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf>

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# Interim Findings on Washington's Medicaid Transformation Project

In 2020, Washington State was midway through an ambitious five-year effort to transform its health system for Medicaid beneficiaries.

**Washington State's Medicaid Transformation Project (MTP) is a \$1.27 billion effort spanning 2017-2021 to transform health care delivery and payment and improve the quality of care for the state's Apple Health members.** MTP is a five-year agreement with the Centers for Medicare & Medicaid Services under a Section 1115 Medicaid demonstration waiver.

**The state of Washington engaged the Center for Health Systems Effectiveness at Oregon Health & Science University as an Independent External Evaluator (IEE) to conduct a comprehensive evaluation of MTP.** The purpose of this evaluation is to assess whether MTP accomplished its goals of transforming the delivery of the state's health systems and improving care for its Medicaid enrollees.

**This brief summarizes the Interim Evaluation Report, the second in a series of three major evaluation reports that assess the success of MTP and communicate lessons of the state's experience.** The results in this report reflect data through December 2019. *This period predates the first confirmed COVID-19 case in Washington State and results are unlikely to have been affected by the pandemic.*

Medicaid Transformation Project Evaluation: Interim Report. Center for Health Systems Effectiveness, Oregon Health & Science University, 2020.

[Access the full report](#)

## RECOMMENDATIONS

- Address factors driving disparities in access and quality for racial and ethnic minorities.
- Strengthen engagement of non-clinical partners in MTP and continue to assess ACH Health Improvement Projects with consideration for ACHs' roles in COVID-19 response.
- Support the recruitment and retention of key workers necessary for MTP success.
- Provide clear guidance regarding the state's vision for Community Information Exchange.
- Align MAC and TSOA benefits and eligibility criteria with participants' needs.
- Build on early positive results from the FCS Supported Employment program.
- Ensure the SUD waiver does not create incentives for unnecessary residential stays.
- Address challenges identified in MCO payments made to behavioral health and SUD treatment providers.

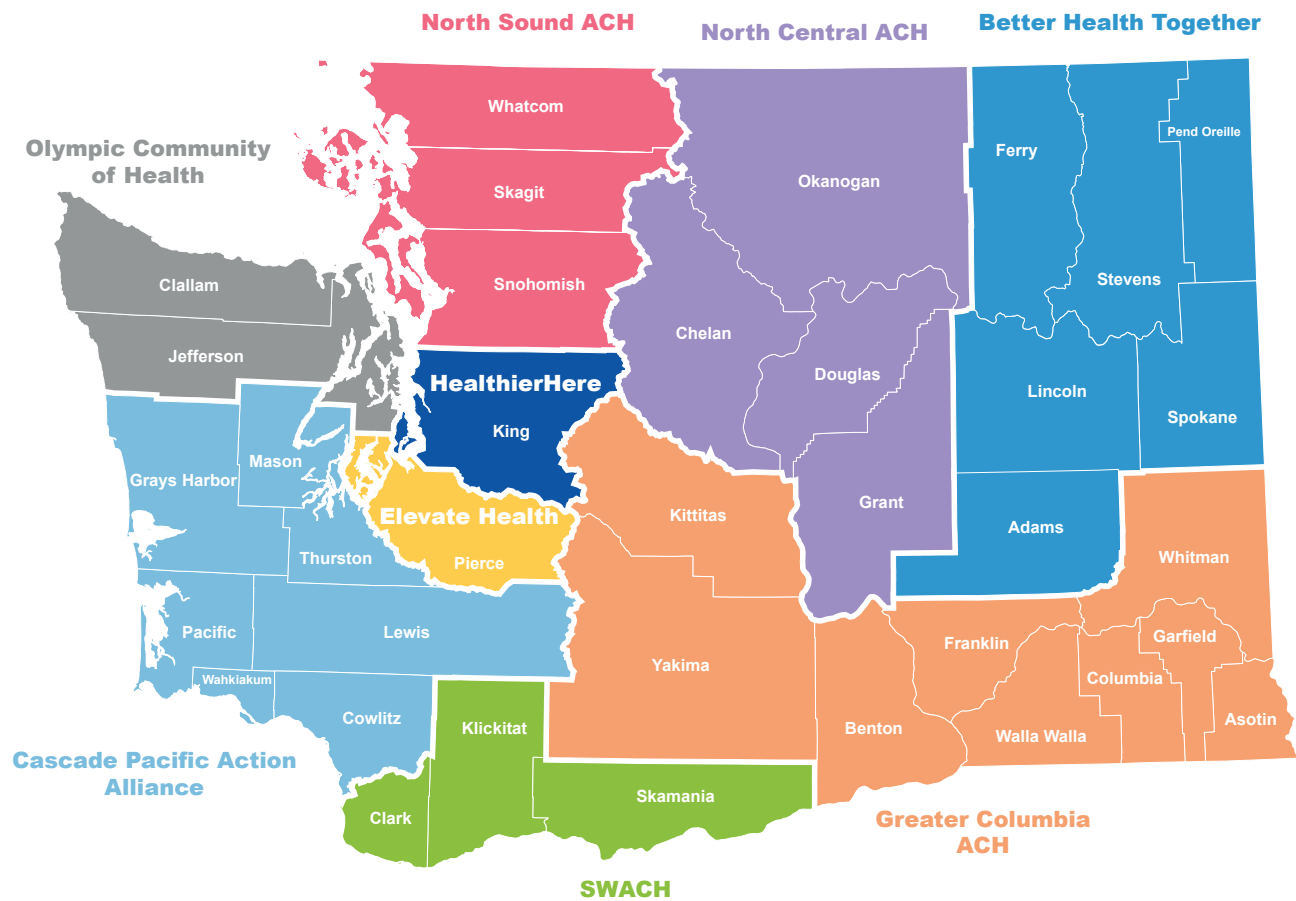


# Washington State's Medicaid Transformation Project

MTP consists of four initiatives:

- **Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program.** Establishes nine regional Accountable Communities of Health (ACHs) to collaborate with health and social services organization partners on a series of locally led health improvement projects (see Exhibit 1).
- **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).** Establishes new service options for older adults to remain in their homes and avoid the need for more intensive services.
- **Initiative 3: Foundational Community Supports (FCS).** Establishes a statewide network of organizations connecting vulnerable adults with supportive housing and supportive employment services.
- **Initiative 4: Substance Use Disorder (SUD) Amendment.** Expands options for federally funded treatment of substance use disorder in mental health and SUD facilities.

Exhibit 1. Washington State's Accountable Communities of Health



## Medicaid System Performance Midway Through MTP

**We found substantial improvements in measures related to substance use disorder and care for chronic conditions.** There were modest or no changes in other performance measure domains during this period.

### **Additional effort is needed to achieve equity in the state's transformation of care.**

Racial and ethnic disparities were evident. Black and American Indian/Alaska Native beneficiaries experienced less access and lower quality of care relative to Medicaid beneficiaries of other races. Asian and Hispanic beneficiaries also experienced lower quality of care on some measures compared to the state's Medicaid beneficiaries as a whole. However, these differences were less pronounced than for Black and American Indian/Alaska Native members.

In summary:

**Social Determinants of Health** measures were largely unchanged from prior years. High rates of homelessness persisted among people with serious mental illness and American Indian/Alaska Native and Black Medicaid beneficiaries.

**Access to Primary and Preventive Services** measures were mostly unchanged. Rates of access were similar for urban and rural areas but lower among Native Hawaiian and Pacific Islanders.

**Reproductive and Maternal Health Care** measures were stable, with the state demonstrating better access to prenatal care than the national average. Disparities in access to contraception were evident for Asian, Black, and Hawaiian/Pacific Islander beneficiaries.

**Prevention and Wellness** measures were also relatively stable, although the state's performance was below the national average for many measures. American Indian/Alaska

Native beneficiaries had lower rates of preventive screenings and well visits relative to other beneficiaries.

**Mental Health** measures demonstrated mixed performance. Some measures were slightly better than average for people with serious mental illness and rural residents compared to the average Medicaid beneficiary.

**Oral Health Care** measures were largely unchanged. Some populations, such as people in rural and high-poverty areas and American Indian/Alaska Native and Black beneficiaries, continued to be served at lower rates than the state as a whole.

**Care for People with Chronic Conditions** measures improved modestly from 2018 to 2019, although most measures remained below national averages. American Indian/Alaska Native and Black beneficiaries experienced significant disparities in the quality of care in this domain.

**Emergency Department (ED), Hospital and Institutional Care** measures increased slightly. These utilization measures were substantially higher for people with chronic conditions or serious mental illness, as well as for Black, American Indian and Alaska Native beneficiaries.

**Substance Use Disorder Care** improved meaningfully across the state for all performance measures. Quality measures were lower for most communities of color and for higher-poverty areas.

**Opioid Prescribing and Opioid Use Disorder Treatment** exhibited improvements across the state, including decreases in opioid prescriptions and improvements in access to treatment.

## Exhibit 2. ACH Health Improvement Projects

Domain 2: Care Delivery Redesign	Domain 3: Prevention and Health Promotion
<p><b>Bi-Directional Integration of Physical and Behavioral Health Care (Required):</b> Integrate behavioral health care into primary care settings and primary care into behavioral health settings.</p>	<p><b>Addressing the Opioid Public Health Crisis (Required):</b> Help achieve the state's goals of reducing opioid-related illnesses and deaths by implementing a variety of opioid prevention and misuse programs.</p>
<p><b>Community-Based Care Coordination:</b> Help Medicaid members with complex health and social needs access the services they need to improve their health.</p>	<p><b>Reproductive and Maternal or Child Health:</b> Ensure women of reproductive age, pregnant women, and mothers have access to high-quality reproductive health care.</p>
<p><b>Transitional Care:</b> Ensure Medicaid members have the right care through transitions between health care settings, such as acute care to home or jail to the community.</p>	<p><b>Access to Oral Health Care:</b> Increase access to oral health services by integrating oral health into primary care and providing dental care to school-age children using mobile dental units.</p>
<p><b>Diversion Interventions:</b> Direct Medicaid members who use emergency services for non-emergent conditions toward primary care and social services.</p>	<p><b>Chronic Disease Prevention and Control:</b> Improve care for people who have or are at risk for a chronic disease, such as asthma, diabetes, or cardiovascular disease.</p>

## Impact of ACH Health Improvement Projects

**Most ACH Health Improvement Projects (see Exhibit 2) were at an early stage of implementation at the time of this analysis.** ACHs focused on developing the partnerships, workforce, and HIT infrastructure necessary to support new interventions or workflows.

We observed a variety of improvements in outcome measures for target populations in projects 2A and 3A. There were fewer significant or detectable improvements in analyses of other HIPs. These results were based on data from the first year of implementation.

### Domain 2: Care Delivery Redesign Projects

**2A: Bi-Directional Integration of Physical and Behavioral Health Care.** All ACHs participated in Project 2A and we observed improvements in a number of measures related to mental health treatment in primary

care settings and prevention and treatment of substance use disorders.

**2B: Community-Based Care Coordination.** Six ACHs implemented Pathways Community HUBs to support care coordination and information exchange in their regions. Measures of mental health treatment penetration and follow-up after emergency department visits for substance use disorders improved in participating ACHs relative to non-participating regions.

**2C: Transitional Care.** Five ACHs participated in projects for people exiting from intensive or institutional care settings to their homes, supportive housing, or communities. Participating ACHs demonstrated poorer performance on some measures than those ACHs that did not select this project.

**2D: Diversion Interventions.** Three ACHs engaged in projects to redirect Medicaid beneficiaries from correctional settings or EDs to primary care, behavioral health, or SUD care when appropriate. Among high emergency department utilizers, rates of

mental health treatment improved and hospital readmissions declined in participating ACH regions. We observed few other differences across ACHs.

### **Domain 3: Prevention and Health Promotion Projects**

**3A: Addressing the Opioid Use Public Health Crisis.** All ACH regions participated in Project 3A to address opioid use disorder (OUD), emphasizing provider education, training in prescribing guidelines, and medications for OUD treatment. Opioid prescribing rates and OUD treatment rates improved during this period.

**3B: Reproductive and Maternal or Child Health.** Three ACHs participated in Project 3B, often focusing on providing technical assistance to providers to implement evidence-based programs for pregnant and postpartum women. We found no differences in outcomes between ACHs that did and did not participate in this project. Our analyses also revealed that stakeholders may have deprioritized some efforts such as reproductive health projects out of a belief that these projects would not substantially drive changes in performance measures.

**3C: Access to Oral Health Care.** Two ACHs participated in Project 3C. There were modest improvements in the utilization of some dental services in participating ACHs relative to non-participating ACHs. We observed small declines in performance for other selected measures.

**3D: Chronic Disease Prevention and Control.** All ACHs participated in Project 3D, promoting partner implementation of screenings and disease self-management programs. There were relatively few improvements in quality measures related to specific chronic diseases during this period. However, there were promising improvements in hospitalization rates and

emergency department utilization among people with chronic conditions.

### **Progress on Value-Based Payment**

**Washington State has demonstrated progress toward adoption of value-based payments (VBP), including:**

- Achieving targets for VBP participation by managed care organizations (MCOs); and
- Expanding participation in VBP arrangements by primary care practices.

**Washington's MCOs have made particular progress toward the adoption of shared savings and shared risk arrangements.**

According to a 2019 survey conducted by HCA, more than half of MCO payments to Medicaid providers in 2018 were made through arrangements that included shared savings and shared risk, compared with 20 percent of commercial payments and 8 percent of Medicare Advantage payments.

### **MTP's Impact on Health Care Workforce Capacity**

Several findings emerged from the interim evaluation related to Washington's workforce capacity under MTP.

**Workforce shortages were cited as one of the top challenges in implementing MTP initiatives.** Specific examples included psychiatrists or clinical social workers to support Health Improvement Project 2A (bi-directional integration), providers eligible to become certified to prescribe medications for addiction treatment in support of Project 3A (opioid interventions), and rural health care providers or first responders that ACHs could engage in implementing chronic disease interventions.

**ACHs devoted substantial effort to regional workforce development as part of health improvement project (HIP) work.** Planning and early implementation of HIPs often

required retraining existing workers for new clinical processes ACHs sought to promote, such as new screening protocols. ACHs also recruited new workers to serve in care coordination or patient navigator roles necessary for project implementation.

**Community health workers (CHWs) played an important role in ACH and regional progress toward HIP implementation.**

Regions with established CHW workforces at the beginning of the MTP demonstration experienced fewer challenges with projects such as care coordination hubs. Retention of CHWs was cited as a challenge that hindered implementation across multiple areas.

### MTP's Impact on Health Information Technology Use

These findings on health information technology (HIT) emerged:

**ACHs leveraged care coordination platforms developed for Project 2B (Community-Based Care Coordination) to support a wide range of health promotion activities,**

including all projects within Domain 2 (Care Delivery Redesign) and most projects in Domain 3 (Prevention and Health Promotion). Once in place, a shared HIT infrastructure could be leveraged to support mutually reinforcing activities that were applicable to most HIPs.

**MTP required substantial effort from partnering organizations to participate in new HIT/HIE tools.**

Stakeholders noted that HIT/HIE platforms may be most easily adopted by physical health partners with prior experience with electronic health record systems or OneHealthPort. Behavioral health providers or human service organizations may bear a higher burden to join projects that involve information exchange. ACHs reported the need for community information exchanges or alternative HIT/E tools for these partners.

**Stakeholders expressed a desire for a statewide HIT/HIE strategy** to promote standardization and interoperability. The diversity of HIT/HIE platforms used across regions and between various types of partnering providers was identified as a challenge for regional coordination or implementation of closed-loop referral networks.

**There were concerns about the distribution of HIT/HIE costs and effort related to MTP.**

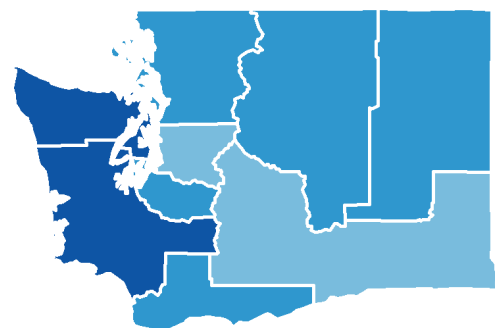
Behavioral health providers incurred new costs to acquire electronic health records and reporting systems to meet MCO billing requirements under integrated managed care (IMC). ACHs expressed concerns regarding the sustainability of the community information exchange (CIE) infrastructure developed for HIPs, citing a lack of renewable funding streams to support that work.

### Impacts of MAC and TSOA

We examined the impact of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) on older adults' need for and use of traditional Medicaid long-term services and supports (LTSS).

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**Exhibit 3. Some regions of Washington will have a larger proportion of older adults by 2030.** ACH regions are shaded to display the proportion of the population that will be age 55 or older in 2030. In the darkest shaded regions, at least 35 percent of the population will be age 55 or older.



Source: Population forecasts from U.S. Census Bureau data and Washington State Office of Financial Management forecasts.



**Enrollment in both MAC and TSOA ramped up slowly, but satisfaction in both programs was high.** There appears to have been more interest and incentive to enroll in TSOA than in MAC. Care recipients and their informal (unpaid) caregivers expressed high satisfaction with the two programs. Participants reported that the programs contributed to independence and were beneficial to physical and mental health.

**MAC and TSOA may have reduced the statewide utilization of traditional LTSS through December 2019.** Washington will experience a steady increase in demand for in-home services, assisted living facilities, and nursing facilities through 2030. MAC and TSOA may be able to offset some of the anticipated demand for traditional LTSS use.

**MAC participants had fewer adverse health outcomes following enrollment.** These changes were comparable to results for traditional in-home services users and reflected a relatively early period in the program's implementation. Only a small proportion of MAC and TSOA participants went on to use traditional LTSS within six months of MAC and TSOA enrollment, suggesting the program may have succeeded in deferring the need for more intensive services among participants.

**Roughly one-quarter of TSOA participants went on to enroll in Medicaid,** suggesting that the TSOA program has had mixed success in preventing participants from spending down assets to the point that they become eligible for Medicaid.

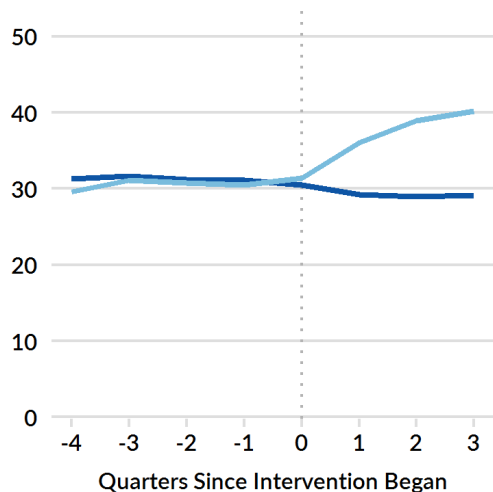
## Impacts of Foundational Community Supports

Our evaluation of the Foundational Community Supports program found:

**Washington has successfully established a statewide network of FCS providers, but gaps in services remain.** The network of FCS service providers has gradually increased since the program launched in 2018. However, engagement of service providers in rural areas has been challenging.

**FCS Supported Employment demonstrated progress increasing employment and reducing arrests.** Rates of employment increased strongly for Medicaid enrollees who participated in FCS Supported Employment, relative to a matched comparison group (see Exhibit 4). These changes were clearly evident in the months following receipt of FCS employment services.

**Exhibit 4. FCS Supported Employment participants saw strong improvements in employment.** Rate of employment among people enrolled in **Supported Employment** and a **comparison group**.



Source: Employment data from Washington Employment Security Department.

**The impact of FCS Supportive Housing is less clear.** Rates of homelessness did not improve for Medicaid enrollees who participated in FCS Supportive Housing, though arrest rate declined. Stakeholders noted that FCS housing services typically must be paired with other housing resources, and lack of affordable housing options limited FCS service providers' ability to connect participants with housing after they had enrolled in FCS.

**Engagement in primary care and SUD treatment improved for FCS participants who participated in both the housing and employment programs.** However, rates of homelessness and employment did not improve, and the positive finding could be a result of the small sample of these individuals. Nonetheless, this population may have unique service needs not well addressed by current program design.

**Measures of health care access and utilization improved for some beneficiary groups,** but these results were based on small sample sizes and should be interpreted with caution.

## Progress on SUD Waiver Amendment Implementation

Our assessment of the impact of the Medicaid Substance Use Disorder (SUD) amendment to Washington State's 1115 demonstration waiver found the following:

**Access to and quality of substance use disorder treatment improved in the first year of Washington's SUD waiver.**

For example, there were substantial improvements in measures of initiation of alcohol and other drug dependence treatment and access to preventive services for individuals with substance use disorders. The number of patients receiving substance use treatment increased.

**There was evidence of increased capacity** for providers authorized to prescribe

medications for opioid use disorders and increases in the number of institutions for mental disease (IMD) billing for substance use disorder treatment.

**Despite this progress, there were implementation challenges.** The transition to integrated managed care (IMC) appears to have created unintended consequences for SUD treatment providers, including negatively impacting the timeliness of payment for claims to behavioral health providers, and adversely affected provider organizations' financial stability.

**The IMC transition also created challenges for residential treatment facilities, including new prior authorization requirements.** As managed care organizations (MCOs) took on financial risk for residential services, disagreements emerged between payers and providers about the role of residential care in SUD treatment.

## Recommendations

Specific recommendations for Washington State and the Health Care Authority arising from this interim evaluation include:

- 1. Address health disparities.** Our analysis of Washington's Medicaid system performance through 2019 revealed progress on some measures, as well as persistent racial and ethnic disparities in access and quality of care. The state should further investigate structural factors that may be driving differences among specific groups. The state's managed care contracts may also present options to reduce health care disparities.
- 2. Strengthen engagement of non-clinical partners in MTP.** Stakeholders across MTP initiatives have struggled to expand beyond a clinical approach to population health promotion. Behavioral health, human services, and other community-based partners have faced particular challenges engaging in MTP.

Making progress on social factors – homelessness contacts with corrections, unemployment – may require greater collaboration between the state, Tribes, ACHs, MCOs, Foundational Community Supports providers, and community-based organizations. The state should also explore how to increase housing options for participants in the FCS Supportive Housing initiative.

**3. Support the recruitment and retention of key workers necessary for MTP success.**

Additional efforts may be needed to address workforce shortages. In rural areas, difficulty recruiting community health worker positions has limited ACH progress on health improvement activities.

**4. Provide clear guidance regarding Washington State’s vision for Community Information Exchange (CIE),**

including the desired financing mechanisms to support community information exchange platforms. The state should promote standardization and interoperability of HIT/HIE platforms across regions and sectors, focusing on lowering barriers to participation among behavioral health and SUD treatment providers.

**5. Continue to monitor progress on ACH Health Improvement Projects.**

ACHs’ early activities focused on developing the infrastructure and workforce necessary to implement new interventions or programs. A more extended period of observation and consideration of ACHs’ roles in COVID-19 response and recovery will yield more robust conclusions about the impact of ACH projects.

**6. Explore options to more strongly align MAC and TSOA benefits and eligibility criteria with participants’ needs.**

Stronger incentives may be needed to promote enrollment in MAC versus

traditional Medicaid in-home services. Additional supports may be needed for TSOA participants to avoid enrollment in Medicaid.

**7. Build on early positive results from the FCS Supported Employment program.**

The program may play an important role in employment recovery after the COVID-19 pandemic. Further investigation is needed for whether additional or different employment services are needed for FCS participants who enroll in both supported employment and supportive housing services.

**8. Continue to assess the entire system of substance use prevention, treatment, and recovery,**

and ensure that the SUD waiver does not create incentives for unnecessary residential stays for SUD treatment.

**9. Monitor challenges identified in MCO payments made to behavioral health and SUD treatment providers,**

including timeliness of payments and appropriateness of prior authorization requirements. Assess whether these challenges gradually resolve following the implementation of integrated managed care and the execution of new MCO contracts in 2021, or whether these challenges persist over time and warrant future changes to IMC.

## Next Steps for the Evaluation

Many of the findings in the interim report relate to early successes and challenges in implementation. Evaluation of MTP is ongoing, with additional data collection and analysis slated to occur. Interim findings will continue to be reported in quarterly Rapid Cycle Reports. A Final Evaluation Report planned in 2022 will present summative evaluation findings for the demonstration.

The COVID-19 outbreak had little to no effect on Washington's delivery system during the time period described in this report (through December 2019) as this period predates the first known case of the virus in the United States.

As Washington transitions to the final years of MTP, the full impact of the COVID-19 outbreak on the state's Medicaid population is not yet known. Understanding the effects of the pandemic on the Medicaid program and the state's progress in improving quality, controlling costs, and achieving equity will be important areas of focus for the final evaluation.

### CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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## Provider alert regarding increased concern of suicide risk in youth during COVID-19

### Actions Requested

- Screen patients for suicide risk, particularly children, teens, and young adults. See the **Screening** section below for more information.
- Share information and resources with patients and their families on crisis support, suicide warning signs, and suicide risk factors. See the **Resources** section below for more information.

### Background

A convergence of factors may be leading to an increased risk of suicide attempts, suicidal ideation, and psychological distress among youth in Washington, including:

- The extended *disillusionment phase*<sup>1</sup> of disaster for the COVID-19 pandemic, which is typically the disaster phase with the greatest behavioral health impacts.
- Other effects related to the pandemic, such as disruption of two academic years, economic impacts, and social isolation.
- Seasonal changes, such as reduced daylight hours and winter weather conditions.

Nationally, the Centers for Disease Control and Prevention (CDC) estimates that one in four people under age 18 have struggled with suicidal thoughts since the beginning of the pandemic.<sup>2</sup> Moreover, over twice as many adults reported having serious thoughts of suicide in the previous 30 days in June 2020 (10.7%) compared to the previous 12 months in 2018 (4.3%).<sup>2</sup> Rates were particularly high among certain populations, including young adult respondents aged 18–24 (25.5%), Hispanic respondents (18.6%), Black respondents (15.1%), and essential workers (21.7%).<sup>2</sup> As a result, the CDC recommends community-level intervention and prevention to address this concern.

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<sup>1</sup> For a description of each phase in the disaster timeline, refer to page 5 of the [COVID-19 Behavioral Health Group Impact Reference Guide](https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19BehavioralHealthGroupImpactReferenceGuide.pdf) (https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19BehavioralHealthGroupImpactReferenceGuide.pdf).

<sup>2</sup> Centers for Disease Control and Prevention. (2020, August 14). *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

## Screening

We recommend using the National Institute of Mental Health’s [Ask Suicide-Screening Questions \(ASQ\) Screening Tool](#) for patients ages 10–24.<sup>3</sup> For example, ask patients if they have:

1. **Current or recent suicidal ideation.**
  - a. Determine the frequency, intensity, and duration of suicidal thoughts.
2. **Past suicidal ideation or attempts.**
  - a. Assess historical patterns of behavior to help determine risk.
3. **A plan.**
  - a. Determine timing, location, and lethality.
4. **The means or access to carry out the plan.**
  - a. Ask about availability of means (i.e., types of harm) to complete suicide, such as drowning, cutting, poisoning, jumping, etc.
  - b. Ask about access to methods to complete suicide, such as medications, household materials (e.g., bleach, poisons, rope, or cleaning agents), or firearms.
5. **The intention to carry out the plan.**
  - a. Explore how they envision carrying out their plan, and to what degree they believe the plan to be lethal versus harmful.
6. **Protective factors.**
  - a. Ask about connectedness to family, friends, community, and culture.
  - b. Assess skills, including the ability to cope, problem solve, or engage in conflict resolution.
  - c. Determine access to medical and mental healthcare.

## Prepare for Screening and Supporting Patients and Families

Having information readily available and accessible will help providers advise young people who are struggling with suicidal thoughts or actions and their families. Parents may need counseling on safety planning and should be provided information and contact numbers on how to access crisis outreach, if needed. Contact information and resources for providers, patients, and families are listed on the following pages in the Resources section.

The COVID-19 pandemic has created difficulty in accessing behavioral health care, as behavioral health providers are seeing a surge in new patients. Parents should be counseled that it may take some time before their child can get into treatment, and it may be helpful to discuss interim planning with them. For example, an option can be offering follow-up appointments as a way of monitoring and supporting until the patient can begin behavioral health treatment.

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<sup>3</sup> National Institute of Mental Health. (2020). NIMH Ask Suicide-Screening Questions (ASQ) Toolkit. [https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening\\_tool\\_asq\\_nimh\\_toolkit\\_155867.pdf](https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf).

Sometimes young people in crisis may not agree to treatment. Parents should be provided information on how involuntary treatment works in Washington, including the need for a designated crisis outreach provider to assess and make the determination. Inform yourself about these processes and gather contact information for designated crisis responders. Additionally, provide counseling and information for parents on safety planning and actions for reducing access to methods of self-harm in their homes.

To help increase emotional health, we encourage everyone to work on building resilience. Whenever possible, encourage patients and clients to access their support network for assistance, and consider facilitating that connection with the patient's permission. For additional tips on building resilience, please see [The Ingredients of Resilience handout](#).

## Suicide Warning Signs

Everyone can play a role in suicide prevention. Know the [suicide warning signs](#):

- A history of suicide attempt(s)
- Current talk of suicide or making a plan
- Strong wish to die or a preoccupation with death
- Giving away prized possessions
- Signs of depression, such as moodiness, hopelessness, or withdrawal
- Increased alcohol and/or other substance use
- Hinting at not being around in the future or saying goodbye

## Suicide Risk Factors

Ask patients about the following risk factors for suicide:

- Unsecured firearms
- Recent loss or trauma
- Accessible medications or substances in the home
- Social isolation
- Hopelessness for the future

Although there is stigma around discussing suicide, research shows **it is best to ask about suicide directly**. Ask patients candidly if they have had thoughts or feelings about suicide and if they are a danger to themselves. **Asking about suicide does not increase risk** and, in fact, increases safety.

## Resources

### For Providers:

- **Seattle Children's Partnership Access Line (consultation about child patients):**  
Call 866-599-7257, or visit <https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/wa-pal/>.
- **Psychiatry Consultation Line (PCL) (consultation about adult patients):**  
Call 877-927-7924, or visit <https://psychiatry.uw.edu/clinical-care-consultation/provider-consultation/psychiatry-consultation-line-pcl-fags/>.

- **Seattle Children’s Safe Storage for Firearms:**  
<https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/prevention/firearm-safety/>
- **Training for Providers on Suicide Safety**  
<https://saferhomescoalition.org>
- **Local Options for Safe Temporary Firearms Storage**  
<https://hiprc.org/firearm/firearm-storage-wa/>
- **Suicide Prevention Lifeline – We Can All Prevent Suicide**  
<https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/>
- **Suicide Prevention Resource Center**  
<https://www.sprc.org/>
- **Department of Health – Behavioral Health Resources and Recommendations**  
<https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/BehavioralHealthResources>

### **For Patients and Families:**

- **Washington Mental Health Crisis Services**  
<https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines>
- **National Suicide Prevention Lifeline:** Call 800-273-8255 (English) or 1-888-628-9454 (Español).
- **Crisis Text Line:** Text HEAL to 741741.
- **Crisis Connections:** Call 866-427-4747.
- **TeenLink:** Call or text 866-833-6546.
- **Crisis Lines for Specific Groups**  
<https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/HotlinesTextandChatResources>
- **Washington Warm Line:** Call 877-500-9276.
- **WA Listens (support line for stress related to COVID-19):** Call 1-833-681-0211.
- **Washington Recovery Help Line (help line for substance use):** Call 1-866-789-1511 (24/7).
- **Washington State COVID-19 Response – Mental and emotional well-being webpage:**  
<https://coronavirus.wa.gov/information-for/you-and-your-family/mental-and-emotional-well-being>
- **Teens, Depression and Firearms Tips for Parents:**  
<https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/prevention/teens-depression-and-firearms/>
- **Safety Checklist for Homes:**  
<https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/prevention/home-checklist/>