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Medicaid's Role in the Delivery and Payment of Substance Use Disorder Services in Montana

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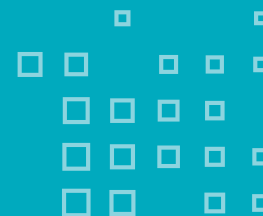
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I. Executive Summary

This report explores Medicaid's new role as the primary payer for substance use disorder (SUD) services in Montana as a direct result of the 2016 Medicaid expansion to cover most low-income adults in the State, and offers strategies that the Medicaid program may pursue in this new role to improve SUD service delivery in the State. Even as Congress and the Administration consider broad changes to healthcare reforms implemented under the Affordable Care Act (ACA), including elimination of Medicaid expansion and deep cuts to federal Medicaid funding, Montana's Medicaid program has a unique, point-in-time opportunity to make meaningful progress in SUD delivery system and payment policy to improve the health, wellbeing and lives of Montanans.

The State of Montana is grappling with a serious and growing public health problem in substance use disorders—including alcoholism, methamphetamine use and opioid abuse and overdose—as well as the related, profound economic and social consequences of these conditions. Montanans have particularly high rates of alcohol dependence and abuse, and more than 90 percent of those with alcohol or drug problems do not receive treatment. The number of children in Montana's foster care system due to abuse or neglect related to parental substance abuse has nearly doubled since 2010, and more than half of Montana's prison inmates are receiving or are in need of SUD treatment. Across the State, alcohol and drug abuse consistently top the list of health concerns identified in community assessments, indicating

widespread agreement about the urgent need to address these issues.

Prior to implementation of Medicaid expansion, SUD services in Montana were funded through a patchwork of federal grant dollars and substantial State alcohol tax and general funds. Medicaid did not play a central role in funding these services because the program covered few adults (other than parents, pregnant women and the elderly and disabled) and only limited SUD services for those adults. That changed in January 2016, when Montana expanded its Medicaid program to include most adults with incomes up to 138 percent of the federal poverty level (FPL). In the last year, the State has enrolled 71,000 Montanans in Medicaid, all of whom receive comprehensive health benefits including robust SUD services. As expansion

enrollment has grown, so too has Medicaid's role in financing SUD services because these services can now be funded with Medicaid dollars.

A key factor in Medicaid's major impact on SUD services funding is that Montana is receiving an enhanced federal match for its Medicaid spending on expansion adults—100 percent in 2016, 95 percent in 2017, and phasing down to 90 percent in 2020 and beyond. As Medicaid covers a larger share of SUD treatment costs, federal Medicaid dollars replace federal block grant and State dollars previously used to fund SUD services for uninsured Montanans. These funds are then "freed up" and may be reinvested in Medicaid (indeed a smart investment, as the State receives \$9 in federal matching funds for each \$1 in State funds spent on expansion adults), the SUD treatment and prevention system more broadly, and other State priorities. In State fiscal year (SFY) 2016 alone, after only six months of Medicaid expansion, Montana freed up approximately \$1.5 million in State general funds as SUD services for adults previously supported with non-Medicaid dollars were replaced by federal Medicaid funds. In each of SFYs 2018 and 2019, Governor Bullock has proposed freeing up nearly \$3 million in State general funds from the expanded availability of federal Medicaid funds for SUD.

Aside from the State fiscal benefits of its new role as a key payer for SUD services, Montana Medicaid has an opportunity to use its purchasing power to improve access, quality and efficacy for Medicaid enrollees with addiction and myriad co-occurring physical and mental health issues. Simply put, Medicaid can tackle long-standing issues and challenges in the State's SUD system that have historically impeded SUD service access and quality. Among those discussed in this report are included delivery system capacity issues such as a significant reliance on costly inpatient and residential treatment settings; capacity limitations with regard to outpatient treatment and recovery services; and lower-than-average use of medication-assisted treatment (MAT) and one of the nation's lowest rates of buprenorphine treatment capacity for individuals who are opioid dependent. These delivery system capacity issues are compounded (and in some cases perhaps exacerbated) by an antiquated methodology for setting SUD payment rates, along with coverage policies and reimbursement levels that in some cases may not pay appropriately for benefits, professionals and settings that would advance the State's goals with respect to improving both access to high-quality care and patient outcomes.

There is no "silver bullet" solution to ensuring that the right services are provided at the right time and place for Medicaid enrollees with SUD. Rather, the strategies highlighted in this report are drawn from best practices among state Medicaid agencies nationally, all of which recognize that the Medicaid program is a most potent weapon in combatting the addiction crisis. Strategies being pursued by these states and offered as options for consideration by Montana Medicaid can be summarized at a high level as follows:

- Improving identification of individuals with SUD and ensuring their access to a full range of SUD treatment services, potentially including recovery services such as peer supports;
- Promoting integration of SUD screening and intervention in primary care settings;
- Using prior authorization and other utilization management techniques to ensure that all Medicaid enrollees receive the care that best meets their needs and, conversely, removing prior authorization requirements that impede access to essential services like MAT;

- Enhancing delivery system capacity by allowing State-licensed addiction counselors to enroll in and bill Medicaid directly for services provided to all Medicaid enrollees, and pursuing elimination of statutory limits to State approval of SUD facilities as proposed in pending State legislation;
- Modernizing payment methodologies and levels to support and incentivize State priorities—for example, services for pregnant women that can directly affect infant

health and children's long-term development—and ensure that Medicaid is purchasing quality, cost-effective care;

- Targeting outreach to and enrollment of justice-involved populations to improve access to treatment for this high-need population; and,
- Pursuing innovative approaches to improving SUD coverage, service delivery and payment through a Section 1115 waiver that could, for example, allow coverage of services in SUD facilities with more than 16 beds (which are otherwise

subject to a prohibition on federal funding) or certain SUD services for individuals prior to their release from jail or prison.

By investing in and adopting some of these practices, Montana Medicaid can leverage its critical role as a primary purchaser of SUD treatment and recovery services to shape a delivery system that improves the health and wellbeing of its residents while efficiently and effectively administering limited State and federal dollars.

II. Introduction

In January 2016, Montana extended Medicaid coverage to adults with incomes up to 138 percent of the FPL (\$16,394 for a single adult). As of February 2017, 71,000 adults have gained coverage under the Medicaid expansion.¹ With limited exceptions, expansion adults with incomes above 50 percent of the FPL receive their benefits through Blue Cross and Blue Shield (BCBS) of Montana, the third-party administrator (TPA) for the State; all other enrollees receive their benefits through Standard Medicaid administered by the Montana Department of Public Health and Human Services (DPHHS). With expansion, all Medicaid enrollees have access

to comprehensive benefits, including SUD services. And, Medicaid is rapidly becoming the largest funding source for SUD services in Montana.

This report was commissioned by the Montana Healthcare Foundation (MHCF) in conjunction with its work to improve access to high-quality, effective SUD prevention and treatment, and focuses on substance use disorders in Montana and particularly on Medicaid's role in providing coverage and care. The focus is timely. Montana has high rates of substance use (both alcohol and drugs), and the impact of SUD is felt in communities throughout the State, as well as in its jails,

prisons and foster care system. With the expansion of Medicaid in 2016, most low-income Montanans now have access to comprehensive coverage, and the State has a new and powerful weapon in its battle against SUD.

The report begins with a brief overview of the impact of SUD in Montana, then reviews Medicaid's growing role in the SUD system, specifically in the delivery of and payment for SUD services. The report concludes with options the State Medicaid program may consider to most efficiently and effectively deliver and pay for Medicaid services for beneficiaries with SUD. With the expansion of Medicaid, the program is assuming a new and

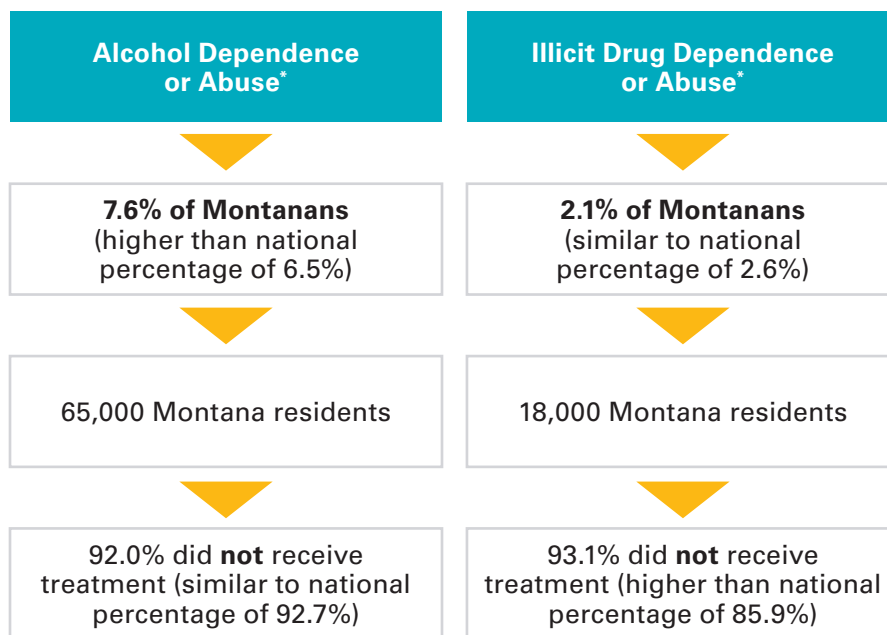
far more significant role in SUD service delivery; this report is intended to provide information and analysis to enable the State to strategically deploy its resources.

The information contained in this report was gleaned from:

- A review of existing literature and data on SUD at both the State and national levels;
- An analysis of policy documents and data supplied by DPHHS on SUD providers, services and spending in Montana;
- Key informant interviews and meetings with Montana SUD providers and State officials; and
- A review of federal guidance and lessons learned from other states.

III. Substance Use Disorders in Montana

Exhibit 1. Montana SUD Population Snapshot



Substance use disorders are a nationwide problem. In Montana, residents have a higher rate of alcohol dependence or abuse than the national average and a higher rate of untreated illicit drug dependence or abuse. Among Montanans who do receive SUD treatment, more than half receive care for both alcohol and drug issues, a much higher percentage than for the nation as a whole (Exhibit 1).² Given this data, it is not surprising that alcohol and drug abuse consistently top the list of health concerns identified in communities across the State.³

Rates of Alcohol Abuse and Related Deaths Are High in Montana

Only a handful of states have rates of alcohol dependence or abuse exceeding that of Montana.⁵ More than 13 percent of deaths among individuals age 20 to 64 in the State are due to excessive drinking—one of the highest rates in the nation, with approximately 390 alcohol-attributable deaths in Montana

Among Montanans in SUD treatment:**

51.8% receive treatment for both alcohol and drug abuse (national average = 42.7%)	28.6% receive treatment for alcohol abuse only (national average = 17.4%)	19.6% receive treatment for drug abuse only (national average = 39.4%)
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*As of 2013-2014 (abuse percentages) or 2010-2014 (treatment percentages), for individuals ages 12 and older.

**As of 2013.

Source: Substance Abuse and Mental Health Services Administration.⁴

annually.⁶ Relative to the United States overall, both adults and youth in Montana have higher rates of binge drinking (18.9 percent for adults and 20.7 percent for high school students, versus national averages of 16.0 and 17.7 percent). Alcohol use starts early for many Montanans, with a higher than average share of high school students having tried at least one drink ever (69.9 percent versus national average of 63.2 percent) or before age 13 (19.6 percent versus national average of 17.2 percent). In adulthood, a higher than average share of Montanans are heavy drinkers (7.5 percent versus national average of 5.9 percent).⁷

Opioid, Methamphetamine and Other Drug Use Is a Cause for Concern

Although alcohol abuse is more prevalent in Montana, illicit and prescription drugs are a cause for concern as well. About 11 percent of Montanans report illicit drug use in the past month (similar to the U.S. average), with about 10 percent using marijuana (higher than the U.S. average) and about 2 percent using other illicit drugs (lower than the U.S. average).⁸ Drug overdoses account for nearly 250 deaths in Montana each year,⁹ and prescription drug overdoses were responsible for an average of about 2,500 inpatient hospital admissions and emergency department visits annually during

2010-2012.¹⁰ Opioids (primarily prescription pain relievers and heroin) are the main drugs associated with overdose deaths nationally, and while Montana's overall death rates from overdose have recently trended lower than the national average, its opioid-related death rates have been similar to the national average.¹¹ In addition, the State has a growing methamphetamine problem. Montana's rate of SUD treatment admissions for this drug exceeds the U.S. average (as with many western states),¹² and the percentage of admissions with methamphetamine as the primary substance of abuse has steadily increased in recent years (from 5.8 percent in 2009 to 13.3 percent in 2013) after having dropped sharply (from 18.1 percent in 2005).¹³

SUD Commonly Co-Occurs with Mental and Physical Health Problems

This report focuses on SUD in Montana; previous MHCF work has discussed the fact that SUD, mental health and physical health diagnoses are often linked.¹⁴ These linkages have implications for both healthcare costs and outcomes. Nationally, about 39 percent of adults with a past-year SUD also have a mental illness, and about 18 percent of adults with a past-year mental illness also have a SUD.¹⁵ With regard to costs, an analysis of data on youth in Montana receiving

publicly funded SUD services illustrates the higher spending associated with co-occurring conditions, finding that those with a mental health diagnosis had SFY 2014 expenditures more than eight times higher than those without (\$18,900 versus \$2,300).¹⁶ And while people with mental health conditions and substance use disorders are more likely to report poor physical health and more likely to be smokers,¹⁷ they are less likely than individuals in the general population to receive preventive care (such as immunizations, cancer screenings and smoking cessation counseling) and more likely to receive lower quality of care across a range of services.¹⁸

SUD Disproportionately Affects American Indians

Montana is home to approximately 78,000 people of American Indian heritage, which is more than 6 percent of the State's total population. The majority of these individuals come from Montana's 12 tribal nations and nearly 60 percent reside on one of Montana's seven Indian reservations, though not all are enrolled members of a tribe.¹⁹ In a recent report on the health of Montanans, DPHHS documented severe health disparities for this population, finding that American Indian people have lifespans about 20 years shorter than white residents of the State. Median

ages at death are 56 and 62 for American Indian men and women in Montana; in comparison, the figures are 75 and 82 for white men and women in the State. This disparity in mortality holds true across many causes of death, with American Indian residents having significantly higher mortality rates than white residents from cardiovascular disease, cancer, respiratory disease, vehicle and other injuries, suicide and homicide.²⁰

Financial and geographic disparities affecting health are unequally distributed by race in Montana, with half of white residents but nearly two-thirds of American Indian residents living in medically underserved counties. More than three times as many American Indian as white residents are unemployed or live in poverty.²¹ Nationally, American Indians have SUD rates about twice that of the overall U.S. population, with 16.0 percent reporting dependence or abuse of alcohol or illicit drugs in 2014, compared to 8.1 percent of the overall population.²² While state-specific SUD estimates are less readily available for the American Indian population, data from a 2001 study of adults living on Montana's reservations found that 26 percent of individuals had alcohol dependence or abuse, and 9 percent had drug dependence or abuse.²³

SUD Among Pregnant Women Is Growing and Presents Unique Access Challenges

In Montana, the percentage of infants under age 1 enrolled in Medicaid with evidence of perinatal drug exposure increased from 3.7 percent in 2010 (less than 200 affected infants) to an estimated 12.3 percent in 2016 (more than 500 affected infants).²⁴ A small but growing number of Montana newborns (96 in 2013) are diagnosed with neonatal abstinence syndrome (NAS), which is a collection of clinical findings associated with physical dependence on drugs and subsequent withdrawal that is most often seen with opioid exposure. During 2009-2013, average hospital charges for Montana newborns with NAS were \$34,000 versus \$6,800 for those without NAS.²⁵ Available data may not fully reflect the extent of the problem, as pregnant women with SUD often have difficulty finding treatment options or avoid seeking prenatal care for fear of being reported to the authorities.²⁶ Some providers may be hesitant to record SUD diagnoses during pregnancy in light of these issues. In addition, variation in hospital policies regarding testing of women in labor and their newborns for substance exposure may also lead to inconsistent data collection and reporting.²⁷

Social Consequences of SUD in Montana Extend Beyond the Healthcare System

SUD prevalence clearly affects health outcomes and spending, but there are notable social consequences as well for Montana's children and families, and for state programs and services outside of healthcare. The number of children in Montana's foster care system due to abuse or neglect related to parental substance abuse—often methamphetamine—grew from 851 in 2010 to 1,658 as of April 2016.²⁸ In addition, while the short-term effects of prenatal alcohol and drug exposure on infants (e.g., withdrawal symptoms) may be managed with medical treatment, a variety of studies document the negative effects of exposure on long-term behavior, cognition, language and achievement.²⁹ Financial costs associated with prenatal substance exposure beyond those incurred at birth are difficult to quantify,³⁰ but one study estimates that the lifetime costs for an individual born with fetal alcohol syndrome exceeds \$2 million—including medical, special education, juvenile justice and other services, as well as lost productivity.³¹ The estimated costs of excessive alcohol use in Montana are also high, totaling nearly \$900 million in 2010 and consisting of reduced workplace productivity, law enforcement and criminal

justice expenses, costs for motor vehicle crashes and costs for treatment of alcohol-related health problems.³²

SUD and mental health problems are a major issue for individuals with a criminal justice history. Nationally, 56 percent of state prisoners, 45 percent of federal prisoners and 64 percent of jail inmates are affected by a mental health problem, while fully two-thirds of those in state prisons or

jails meet the medical criteria for substance dependence or abuse.³³ In Montana, the Department of Corrections operates State-funded pre-release centers and treatment facilities that include a variety of SUD and other services for certain offenders (e.g., those who are newly sentenced and in need of treatment, or are referred by a probation officer in the community due to continued substance use while on supervision).³⁴ A 2007 study

found that more than half of inmates at the Montana State Prison were in SUD treatment or on a waiting list for these services,³⁵ and the State spent more than \$1.7 million on SUD treatment for prison inmates in SFY 2014.³⁶ Montana's drug courts provide an alternative to incarceration in some cases, with more than 500 active participants as of October 2014. Treatment costs for drug court participants are financed from various sources.³⁷

IV. Coverage and Funding of SUD Prevention and Treatment

Consistent with national figures,³⁸ the majority of SUD treatment in Montana is publicly funded through Medicaid and a combination of non-Medicaid State and federal funding sources. Together, these public funding streams have historically covered about 70 percent of inpatient, residential and outpatient admissions to State-approved SUD facilities (see Box 2) in Montana.³⁹ (As noted in Section V, most individuals in SUD treatment obtain care at facilities that specialize in SUD, and there is limited utilization and spending data available for other settings, which include self-help groups and private offices staffed by independent practitioners.)

With implementation of the Medicaid expansion,⁴⁰ Medicaid's role in covering and financing SUD services is growing in Montana. It is expected that Medicaid will cover a significantly larger share of SUD treatment costs in the future, with the federal government financing at least 90 percent of the total costs for expansion enrollees who use Medicaid SUD services. Indeed, after the first six months of Medicaid expansion, Montana freed up approximately \$1.5 million in State general funds as SUD services for adults previously supported with non-Medicaid dollars were replaced by federal Medicaid funds.

Medicaid Was Not a Primary Funding Source for Montana SUD Services Prior to Expansion

Prior to Montana's January 2016 expansion of coverage to adults with incomes below 138 percent of the FPL,⁴¹ Medicaid did not play a central role in funding SUD treatment. Medicaid covered comprehensive SUD services only for those under age 21. For adults enrolled in Medicaid (primarily parents with incomes below 47 percent of the FPL and pregnant women up to 157 percent FPL), the SUD benefit was limited to outpatient treatment, which was added to the Medicaid benefit package for the first time in 2002,⁴²

and hospital-based inpatient detoxification. Most adults without dependent children were not eligible for Medicaid. As a result of Medicaid's limited reach prior to expansion, Montana's coverage of SUD treatment services was financed primarily through the following non-Medicaid sources:⁴³

- **Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars** are used to fund inpatient, residential and outpatient SUD services for individuals with incomes up to 200 percent FPL in Montana, which are provided by State-approved facilities (see Box 2) under contract with DPHHS. Block grant funds may be used for services similar to those allowed under Medicaid, but may also be used to pay for other SUD treatment services—such as room and board in residential facilities—that are not eligible for reimbursement under Medicaid. In addition to covering treatment services, a portion of SAPT block grant funds are allocated for prevention (20 percent) and administrative costs (5 percent).
- **State alcohol tax funds** have been earmarked for SUD treatment since 1977 and are used to support services at State-approved SUD facilities, including those that serve individuals with co-occurring mental illness (20 percent of the

earmarked funds are distributed to counties for this purpose, plus another 6.6 percent for co-occurring services); inpatient SUD treatment at the state-run Montana Chemical Dependency Center (MCDC); and part of the State share of spending on Medicaid SUD services. Funds that are distributed to counties for use by State-approved SUD facilities are allocated based on each county's share of the State's population (85 percent) and land area (15 percent).⁴⁴

- **State general funds** were appropriated for an expansion of residential SUD treatment beginning in 2007, as a response to the methamphetamine epidemic. Until that time, the State's publicly funded SUD treatment system had few inpatient and residential options. State general funds are also used for Department of Corrections (DOC) treatment costs and part of the State share of Medicaid SUD spending.⁴⁵ For the room and board costs of residential treatment, as well as the overall costs of SUD treatment provided by the DOC or in facilities with more than 16 beds that qualify as "institutions for mental diseases" (IMDs), State general funds may continue to be an essential source of funding, as Medicaid's ability to cover these costs is limited under federal law.⁴⁶

Medicaid SUD Coverage and Spending Is Growing Post-Expansion

Medicaid's role in the financing of SUD services is growing as a direct result of the State's decision to expand Medicaid and the concomitant decision, discussed below, to provide full SUD benefits to previously eligible adults as well as expansion adults. Although the income information reported for individuals receiving treatment at State-approved SUD facilities is incomplete, an analysis of the available data indicates that the majority have incomes at or below 138 percent FPL, making it highly likely that they are or would be eligible for Medicaid.⁴⁷

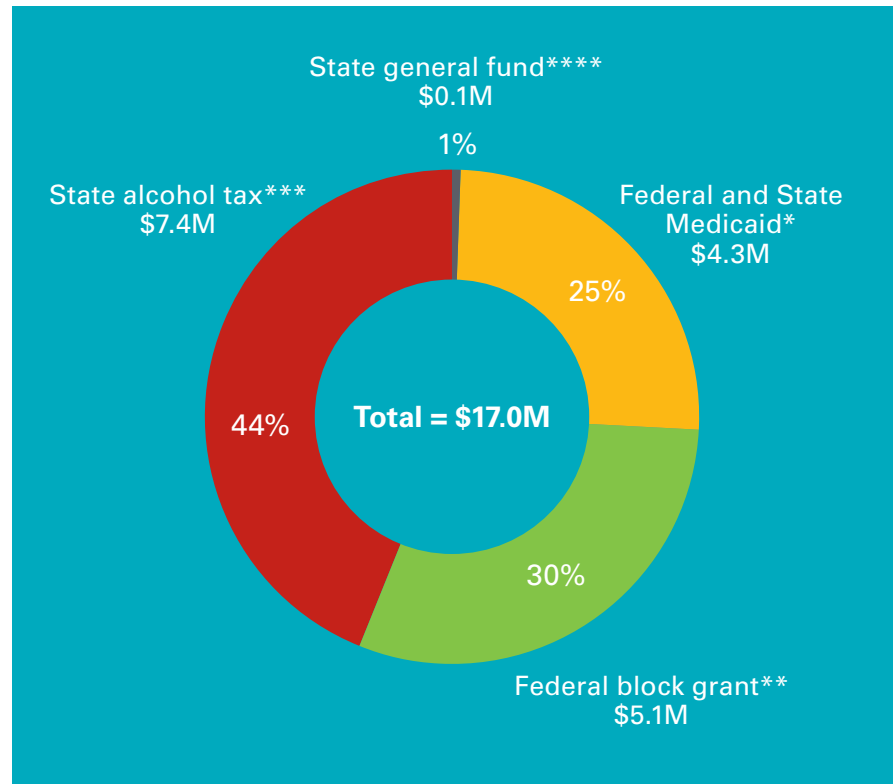
In terms of financing, this means that many of the SUD services required by the 67,000 newly eligible adults can now be funded with federal Medicaid dollars rather than block grant, alcohol tax, or State general fund dollars. Notably, the State receives an enhanced federal match (100 percent in 2016, 95 percent in 2017, and phasing down to 90 percent in 2020 and beyond) for its Medicaid spending on expansion adults. (Montana's standard federal match for Medicaid is 65 percent.⁴⁸)

As Medicaid covers a larger share of SUD treatment costs, the State saves block grant, alcohol tax and general fund dollars previously used to fund services

for uninsured Montanans with SUD. These funds may be used for a variety of purposes, including investments in Medicaid SUD services and the SUD prevention and treatment system more broadly. While it is not yet possible to assess the full amount of expansion-related savings, there are some early indications of the magnitude. Exhibit 2 breaks down Montana's spending on SUD treatment by funding source in SFY 2016, which included six months of Medicaid expansion. During this period, Medicaid expansion resulted in a number of people receiving services through Medicaid who previously would have been funded under the federal SAPT block grant. This allowed approximately \$1.5 million in block grant funding to be shifted to cover treatment services that otherwise would have been financed with general fund dollars, resulting in savings to the State.

The availability of more federal Medicaid dollars for SUD services creates savings for Montana by freeing up alcohol tax and general fund dollars that may be reinvested in other populations or services that are not covered by Medicaid, or used for other State priorities. Medicaid expansion funds also free up federal block grant dollars previously used to support SUD treatment for uninsured individuals, which may

Exhibit 2. Montana's Spending on SUD Treatment by Funding Source, SFY 2016



Notes: Sum of dollar amounts does not equal total due to rounding. Reflects only six months of Medicaid expansion, which began January 1, 2016. Excludes funding specific to the Department of Corrections and drug courts, as well as public funding for SUD treatment that does not flow through the State budget (e.g., excludes spending by the Indian Health Service and by tribes for individuals and services not covered by Medicaid, as well as spending for care financed by the Veterans Administration and Medicare).

*State share includes alcohol tax and general fund dollars. Total Medicaid amount was \$1.7 million higher than SFY 2015 (see Exhibit 3), primarily reflecting federal funding for new adults under expansion.

**Total SAPT block grant funding was \$6.8 million; amount shown here excludes \$1.4 million for prevention and \$0.3 million for administrative costs. Medicaid expansion resulted in a number of people receiving services through Medicaid who previously would have been funded with block grant dollars. Of the \$5.1 million in block grant funds for treatment shown here, approximately \$1.5 million was shifted to cover treatment services that otherwise would have been financed with general fund dollars.

***Total alcohol tax funding for SUD was \$8.3 million in SFY 2016; amount shown here excludes approximately \$0.6 million used to fund part of the State share of Medicaid SUD treatment costs and approximately \$0.3 million for administrative costs.

****Excludes amount used to fund part of the State share of Medicaid SUD treatment costs. Total is lower than the \$1.6 million originally budgeted because approximately \$1.5 million was replaced with federal block grant funds.

Source: Analysis of unpublished data from DPHHS.

Exhibit 3. Montana Medicaid Spending for SUD Treatment in SFYs 2015-2016

	SFY 2015	SFY 2016
Non-expansion enrollees	\$2,580,243	\$2,617,909
Expansion enrollees (new adult group)	\$0	\$1,698,449
Total	\$2,580,243	\$4,316,358

Note: SFY 2016 reflects only six months of Medicaid expansion, which began January 1, 2016.

Source: Analysis of unpublished data from DPHHS.

now be redeployed to fund other critical SUD services. In addition, for adults with SUD who became eligible for Medicaid for the first time (including childless adults and parents with incomes above 47 percent of the FPL), expansion has allowed access to the full range of physical and behavioral health benefits they need, rather than coverage limited to SUD treatment services financed from non-Medicaid sources.

In each of SFYs 2018 and 2019, Governor Bullock’s budget proposes to capture nearly \$3 million in State savings from an increase in Medicaid funding for SUD inpatient treatment at the state-run MCDC, which has historically been funded with alcohol tax dollars. (While there may also be MCDC-related savings in SFY 2017, the amount has yet to be determined, as MCDC did not begin billing for Medicaid expansion enrollees until late in 2016.) Specifically, the Governor proposed to replace nearly \$3 million in alcohol tax dollars supporting services at

MCDC with an equivalent amount of Medicaid funding. In turn, the alcohol tax dollars would replace general fund dollars used for non-Medicaid covered residential SUD treatment and for SUD treatment at the Montana State Hospital.⁴⁹ The bottom line is nearly \$3 million in State savings. While the State may face competing budget priorities, reinvestment of freed-up alcohol tax and general fund dollars into expanded Medicaid services is particularly advantageous because it provides a return of at least \$9 in federal matching funds for each State dollar spent on services for expansion adults and a return of about \$2 for each State dollar spent on previously eligible groups.⁵⁰

Montana Medicaid Provides Comprehensive SUD Benefits

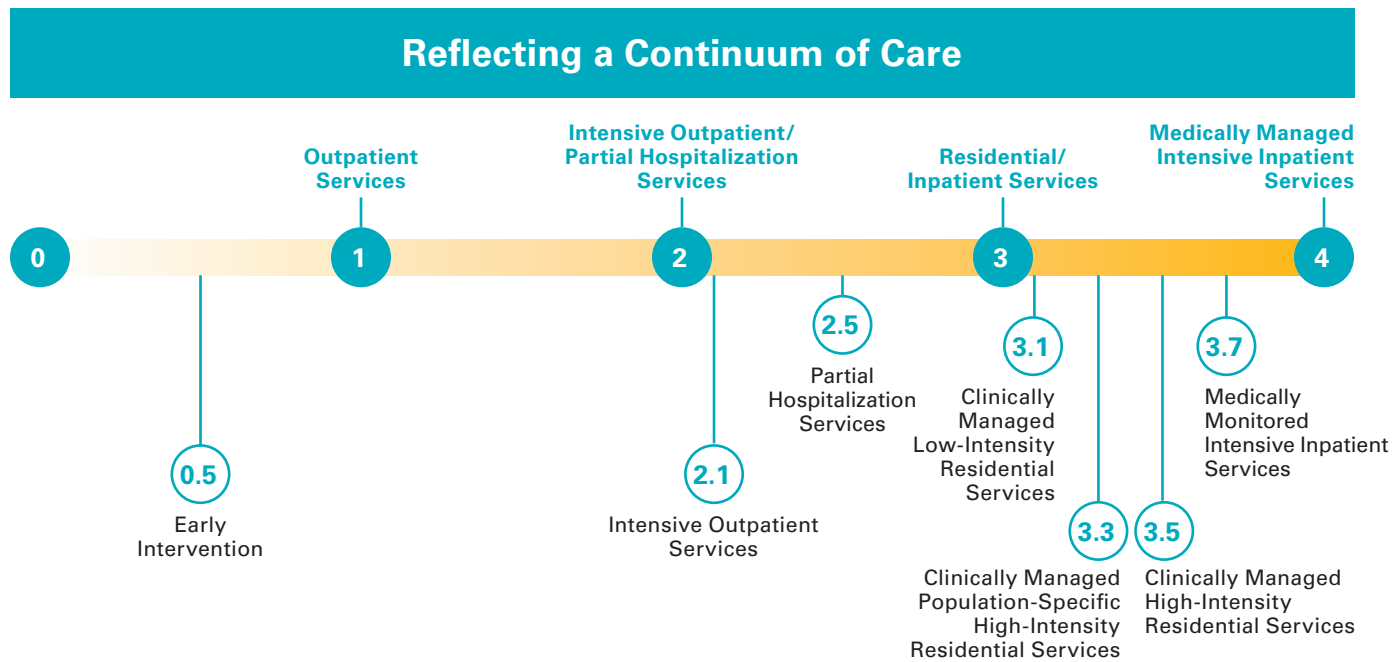
Under the ACA, states provide Medicaid expansion adults with a benefit package that includes both mental health and SUD services. This package is referred to as an “Alternative

Benefit Plan” (ABP), and federal rules require parity between the mental health/SUD and medical/surgical benefits covered under an ABP.⁵¹

When Montana expanded Medicaid coverage, the State also made a policy decision to expand SUD coverage for previously eligible adults. In addition to outpatient treatment services and hospital inpatient detoxification services, all Medicaid adults now have access to non-hospital inpatient and day treatment for SUD, which the State previously did not cover under Medicaid for adults age 21 or older.⁵²

While the terminology used to describe the SUD care continuum varies, activities are often grouped into four major categories: prevention, intervention, treatment and recovery. Additionally, American Society of Addiction Medicine (ASAM) levels of care are often referenced when referring to the intensity of services provided to an individual with SUD (Exhibit 4).

Exhibit 4. American Society of Addiction Medicine Levels of Care



Notes: Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

In Montana, ASAM level 2.5 is referred to as day treatment; level 3.1 is recovery home; level 3.3 is women's and children's residential home; and level 4 is acute care hospital.

Source: <http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

Montana Medicaid currently covers SUD services that span the full ASAM spectrum (see Section VI for additional details):⁵³

- **Intervention.** Screening, Brief Intervention and Referral to Treatment (SBIRT) is an approach that helps primary care and other providers identify and begin addressing risky alcohol and drug use behaviors early on with their patients in a variety of medical and community-based settings, with referral

to specialty treatment as needed.⁵⁴ Comprehensive SUD assessments that include a diagnosis, treatment determination and any needed referrals are also covered under the State's Medicaid program.

- **Treatment.** Services covered include hospital emergency and inpatient care for overdoses or other medical crises, inpatient detoxification, 24-hour care with medical staff or trained counselors in certain non-hospital inpatient and

residential settings, and varying levels of outpatient individual and group therapy for people who live in the community or in low-intensity residential settings. Medication-assisted treatment drugs that are used to treat opioid addiction, and in some cases alcoholism, are also covered. These include methadone, buprenorphine and naltrexone, which may be paired with counseling and other behavioral health supports.

Box 1. Medicaid Enrollees Determined To Be Medically Frail

Under Montana’s Medicaid expansion, medically frail enrollees receive their care through the Standard Medicaid program. That is, they are excluded from the TPA. Under federal rules, medically frail enrollees include those with: disabling mental disorders; chronic substance abuse disorders; serious and complex medical conditions; or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.⁵⁵ Montana’s approach to identifying these individuals is through a screening question on the Medicaid application: “Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?”. This question does not necessarily capture those with chronic SUD. Although individuals with SUD and other conditions can self-identify as medically frail at any time during their eligibility period,⁵⁶ some of these individuals may be enrolled in the TPA instead of Standard Medicaid. As of late 2016, very few TPA enrollees—less than 200 out of about 15,000—have had SUD services paid by BCBS. This may be due in part to the fact that many Montanans receiving treatment in SUD facilities have incomes below 51 percent FPL, which would exclude them from the TPA based on income.⁵⁷ Currently, each TPA enrollee is asked to complete a health assessment to help determine the level of care coordination support he or she may need.⁵⁸ This assessment includes a question on alcohol consumption. DPHHS is considering how a similar format could be used under Standard Medicaid to assess care coordination needs, as well as identify those who are medically frail and have a chronic SUD.

- **Recovery.** In Montana, Medicaid covers targeted case management (TCM) for individuals with SUD, which includes the development of a care plan and assistance with obtaining medical, social, educational and other programs and services as needed. The State does not currently cover

peer supports and other paraprofessional services for SUD under Medicaid.

While the services and benefit design under Standard Medicaid and the TPA are virtually identical, there are a small number of differences that are relevant for SUD (see

Exhibit 5). As noted earlier, expansion adults with incomes above 50 percent FPL generally receive services through the TPA, with the exception of individuals who are determined to qualify as medically frail, who are instead enrolled in Standard Medicaid (Box 1).

Exhibit 5. Comparison of TPA/BCBS and Standard Medicaid in Montana Highlighting SUD Differences

	TPA/BCBS	Standard Medicaid
New adult group enrollees	Those with incomes from 51%-138% FPL who are not otherwise excluded	Incomes <51% FPL; medically frail (including those with chronic SUD); continuity of care exemption; American Indians/Alaska Natives
Non-expansion enrollees	None	All non-expansion enrollees
Covered benefits	Same SUD services, with the exception of targeted case management that is only available in Standard Medicaid	
Prior authorization	Required for all inpatient, partial hospitalization, and intensive outpatient SUD services	No prior authorization for SUD services, except out-of-state inpatient care and certain drugs
	Prior authorization of certain drugs required for all enrollees	
Provider network	TPA must accept providers enrolled in Standard Medicaid, and may enroll others (e.g., State-licensed addiction counselors)	
Payment rates	Same for most services*	
Enrollee premiums**	2% of income	None
Enrollee copayments**	Same	

*BCBS follows the Standard Medicaid fee schedule for SUD services in nearly all cases. Two exceptions are partial hospitalization and intensive outpatient services, which are covered for all enrollees but may use different procedure codes under BCBS that are priced using a methodology agreed upon with DPHHS.

**A family’s premiums and copayments combined may not exceed 5 percent of income on a quarterly basis, and premium payments are credited toward copayments.

V. The SUD Delivery System

In this section, we describe the delivery system through which Montana Medicaid provides SUD services to Medicaid enrollees, focusing primarily on services provided through rehabilitation centers and other facilities that specialize in SUD treatment. In particular, the majority of information provided here

reflects data from the National Survey of Substance Abuse Treatment Services (N-SSATS), which is an annual census of facilities providing substance abuse treatment. In Montana, N-SSATS respondents include private, State, federal and tribal facilities and are not limited to those with State approval.⁵⁹

The focus on these specialty facilities is driven by two factors: first, most individuals in SUD treatment obtain at least some care through these facilities (about 70 percent nationwide);⁶⁰ and second, there is limited data available on the care provided in other settings in the State (e.g., self-help

groups such as Alcoholics or Narcotics Anonymous, or private offices staffed by independent practitioners).

In Montana, 32 facilities providing inpatient, residential and outpatient SUD treatment have “State approval” and may therefore bill Medicaid for covered services (see Box 2 and Appendix 2). In addition to those with State approval, other providers may bill Medicaid for SUD services under certain circumstances (see Exhibit 8). These include, for example, federally qualified health centers (FQHCs), rural health clinics (RHCs), facilities with Indian Health Service (IHS) or 638 status, and Urban Indian Health Program facilities.⁶¹

For the American Indian population that is disproportionately affected by SUD, tribal providers are a particularly important source of care. In Montana, these include seven SUD facilities with State approval (White Sky Hope on the Rocky Boy Reservation, Crystal Creek on the Blackfeet Reservation, and Fort Belknap Chemical Dependency Center on the Fort Belknap Reservation, which have IHS/638 status; Helena Indian Alliance, Missoula Urban Indian Center, Indian Family Health Clinic in Great Falls, and Indian Health Board of Billings, which are Urban Indian

facilities with FQHC status) and four SUD facilities that do not have State approval (Spotted Bull on the Fort Peck Reservation, Northern Cheyenne Recovery Center, Crow Nation Wellness, and CSKT Tribal Health on the Confederated Salish-Kootenai Reservation, all of which have IHS/638 status).⁶² As noted in recent comments submitted to the State Legislature by the Montana and Wyoming Tribal Leaders Council, SUD treatment can be more effective when it is culturally meaningful to the individual.⁶³ However, the demand for services exceeds capacity on the reservations, making it necessary to also access care from outside agencies.⁶⁴

Among SUD facilities in Montana responding to the N-SSATS, many report having programs or groups tailored for specific populations; for example, 50 percent indicate that they have programs for adolescents, 43 percent report programs for individuals with co-occurring disorders, and 6 percent report programs for pregnant or postpartum women.⁶⁵ In addition, 62 percent of SUD facility clients in Montana are served by facilities reporting that their primary focus is on a mix of mental health and SUD services, while 37 percent are served by facilities focusing on SUD services.⁶⁶ However, it is

important to note that much lower rates of co-occurring or dual diagnosis capability may be found when objective assessments are conducted by external raters. For example, one study that examined 180 addiction treatment programs across 11 states using standardized measures found that only 19 percent were at a dual diagnosis “capable” or “enhanced” level, while 81 percent were at an “addiction only services” level. Among 76 mental health treatment programs across eight states, only 9 percent were at a dual diagnosis “capable” level, while 91 percent were at a “mental health services only” level.⁶⁷

With regard to service settings for SUD treatment, a primary concern of stakeholders consulted for this report is a possible over-emphasis on inpatient and residential care in Montana. This concern is consistent with data, discussed below, indicating that Montanans in SUD treatment are more likely than the national average to receive treatment in these settings—and less likely to receive outpatient care, particularly MAT. An increase in outpatient capacity could reduce Montana’s disproportionate use of inpatient and residential beds among individuals receiving SUD treatment. However, it is unclear whether this would affect the underlying demand for SUD beds

in the State, which are below average in number and highly utilized.

Due to the fact that there are no standardized benchmarks on the appropriate level of SUD services for a given population, particularly with regard to outpatient treatment,⁶⁸ we primarily focus here on Montana's distribution of service use and its supply of inpatient and residential beds relative to the national average and to other

states. The key data points are described below and in Exhibit 6 that follows.

- Among individuals receiving treatment at a SUD facility, Montana has a higher than average percentage of individuals who receive inpatient or residential services (14.0 percent in Montana versus 9.8 percent nationally), but shorter than average stays (with only about one-quarter of the residential SUD population in

Montana having a stay of 30 days or more versus nearly two-thirds nationally).

- Most or all inpatient and residential SUD beds in Montana are occupied at any given time. Montana reports the second-highest utilization rate in the nation for its SUD beds, at well over 100 percent; in comparison, the lowest-ranking states report utilization of less than 70 percent, and the national average is 97 percent.⁶⁹

Exhibit 6. Type of Care Received by Individuals at SUD Facilities, Montana and United States

Type of Care	Montana		United States
	Number of clients	Percentage of clients	Percentage of clients
Outpatient	3,809	86.0	90.2
Regular (ASAM Level 1)	2,621	59.2	48.3
Intensive (ASAM 2.1)	731	16.5	11.8
Day treatment/partial hospitalization (ASAM 2.5)	31	0.7	1.8
Detoxification (ASAM 1-D or 2-D)	64	1.4	1.1
Medication-assisted treatment*	362	8.2	27.2
Residential	488	11.0	8.6
Less than 30 days (ASAM 3.5)	344	7.8	2.2
30 days or more (ASAM 3.1 or 3.3)	137	3.1	5.6
Detoxification (ASAM 3.2-D)	7	0.2	0.8
Inpatient**	132	3.0	1.2
Treatment (ASAM 3.7 or 4)	125	2.8	0.7
Detoxification (ASAM 3.7-D or 4-D)	7	0.2	0.5
Total	4,429	100.0	100.0

Note: Reflects clients in treatment on March 29, 2013. Sum of components may not equal totals due to rounding.

*Excludes those receiving the medications from private providers not affiliated with a SUD treatment facility. Nationally, methadone accounts for nearly 90 percent of MAT clients, but a Montana-specific figure was not reported in the source data.

**Described as "hospital inpatient" in the source data.

Source: Substance Abuse and Mental Health Services Administration.⁷⁶

- Montana ranks below the national average and in the bottom third of all states with regard to SUD inpatient and residential beds per 1,000 residents (0.28 in Montana versus 0.35 nationally).⁷⁰ The fact that Montana has a relatively small number of beds driving a high percentage of utilization among individuals in SUD treatment suggests that Montana’s overall supply of SUD services—inpatient, residential and outpatient—may be low relative to other states.
- DPHHS estimates that about 4,000 adults in Montana may be seeking but unable to access outpatient SUD treatment at current capacity levels for State-approved SUD facilities, based on an analysis of survey data, historical admission patterns and the number of SUD counselors providing services in the State.⁷¹
- Montanans in SUD treatment receive outpatient MAT at a much lower rate than the national average (8.2 percent of Montanans in SUD treatment versus 27.2 percent nationally). However, it should be noted that these figures exclude individuals receiving MAT from providers in private practice who are not affiliated with a SUD facility, and that the national average largely reflects methadone treatment, which has only been available in Montana since 2009.
- Montana currently has only 16 physicians certified to prescribe buprenorphine for opioid dependence,⁷² one of the lowest rates of buprenorphine treatment capacity in the nation,⁷³ and one of the lowest buprenorphine prescription rates.⁷⁴ There are four opioid treatment program locations in different counties throughout the State authorized to dispense methadone.⁷⁵

Box 2. State Approval of SUD Facilities in Montana

For most providers of SUD services in Montana, State approval is a prerequisite for billing Medicaid and accessing other State-administered funds (alcohol tax, general fund or block grant dollars). The State approval process for SUD facilities is separate and apart from licensure and requires, for example, demonstration of minimum service and staffing criteria. In addition, State law requires facilities to demonstrate non-duplication of existing services in a given geographic area.⁷⁷ The State may approve more than one facility in an area, but the burden is on the applicant to demonstrate a local need and non-duplication of existing services, which in practice has limited SUD treatment capacity. DPHHS has proposed removing the non-duplication requirement,⁷⁸ and the Legislature is considering this issue in the 2017 Session.

Although opioid treatment programs (OTPs) that dispense methadone are highly regulated and subject to federal certification and accreditation requirements,⁷⁹ they must meet the same State requirements as other SUD facilities in order to obtain State approval. These providers are currently exploring the State approval process. Until they gain State approval, their ability to access Medicaid or other State-administered funds for certain SUD services is limited (see Section VI of this report for more information).

VI. Medicaid Billing and Payment Policies

In Montana, the majority of Medicaid SUD services are paid on a fee-for-service basis, using a fee schedule that was developed primarily for the payment of SUD treatment services funded from non-Medicaid sources (block grant, alcohol tax and general fund dollars). While the State

has modernized and rationalized Medicaid payment methodologies for most physical health and many mental health services,⁸⁰ payment policies for SUD services continue to reflect historical practices that originated outside of the Medicaid program and bear little relation to the modern payment methods

employed in the rest of the Medicaid program.

As noted earlier, State-approved SUD facilities may bill Medicaid and other non-Medicaid public funding sources for a range of services. Exhibit 7 below notes the services paid under

Exhibit 7. SUD Fee Schedule Services for State-Approved SUD Facilities in Montana

Service (ASAM Level)	Medicaid	Non-Medicaid	Code and rate
Non-hospital inpatient detox and treatment (3.7 and 3.5)*	Yes	Yes	H0010 and H0018, \$237.07/day
Residential treatment (3.3 and 3.1)*	Yes	Yes	Medicaid pays treatment; non-Medicaid funds pay for room/board (W&C, \$135.30/day; RH, \$37.07/day)
Day treatment / partial hospitalization (2.5)	Yes	Yes	H0012, \$118.53/day**
Intensive outpatient (2.1)	Yes	Yes	Multiple units of individual/group therapy**
Individual and group therapy	Yes	Yes	H0004, \$17.51/15 min; H2035, \$25.02/patient hour
Targeted case management	Standard only	Yes	T1016, \$12.08/15 min
Assessment and placement	Yes	Yes	H0001, \$291.21/visit
Screening, Brief Intervention, Referral, and Treatment	Yes	Yes	99408, \$23.63–\$37.85/15–30 min; 99409, \$47.26–\$73.81/30+ min (varies by provider/setting)
Saliva drug test***	Yes	Yes	H0048, \$8.16/test
Dip strip drug test	No	Yes	A4250, \$9.10/test
Urinalysis drug screen	No	Yes	G0434, \$23.10/test (for laboratories only)
School-based services	No	Yes	SBS, \$17.05/15 min
Rehab aide****	No	Yes	RA, \$12.08/15 min

Notes: Non-Medicaid funding sources are block grant, alcohol tax and general fund dollars.

*ASAM 3.5 is typically referred to as residential but appears as inpatient on Montana fee schedules. ASAM 3.3 is typically a similar level of intensity as 3.5 but is categorized differently in Montana.

**May be billed to BCBS for TPA enrollees using S0201 and H0035.

***Misabeled in fee schedule; code typically refers to drug test collection/handling.

****Only in certain residential homes.

Source: July 2016 fee schedules.⁸¹

the SUD fee schedule and also indicates whether the service is reimbursed under Medicaid, by non-Medicaid sources, or both. In addition to State-approved facilities that bill under the

SUD fee schedule, acute care hospitals, FQHCs, RHCs, facilities with IHS or 638 status, Urban Indian Health Programs (all of which are FQHCs in Montana) and certain other

practitioners may bill Medicaid for SUD services under circumstances described in Exhibit 8 below.

Exhibit 8. Medicaid Payment of SUD Services for Providers Other Than State-Approved SUD Facilities

Provider	Medicaid payment of SUD services
Acute care hospitals	Acute care hospitals may bill for inpatient stays that include detoxification, but these services are typically provided by non-hospital SUD facilities in Montana. Payment is based on an All Patient Refined Diagnoses Related Group (APR-DRG) method, where the payment amount depends on a patient's specific diagnosis and severity.
FQHCs and RHCs	Medicaid covers any service during an FQHC or RHC visit that is within the facility's scope, including SUD services provided by State-licensed addiction counselors. SUD services are billed using SUD-specific revenue codes and must include an allowable procedure code (assessment, individual therapy, or group therapy) from the SUD fee schedule. Payment is a per visit rate, based on a facility-specific prospective payment system (PPS).
IHS and tribally-operated 638 facilities	Medicaid coverage of SUD services is similar to FQHCs. IHS/638 providers bill Medicaid for SUD services using a SUD-specific revenue code and an allowable procedure code (assessment, individual therapy, or group therapy) from the SUD fee schedule. Payment is a per visit rate, using an IHS all-inclusive rate that does not vary by facility.
Urban Indian Health Program facilities	Urban Indian facilities in Montana are FQHCs, and may receive FQHC payment for SUD services.
Pharmacies and other providers of MAT drugs	MAT drugs may be billed by outpatient pharmacies or physicians and other practitioners, depending on how they are prescribed and dispensed (see Appendix 1). Other services associated with the provision of MAT drugs are billed separately (e.g., SUD counseling, office visits to monitor physical health) and are subject to applicable restrictions (e.g., for most providers, State approval is required to bill for SUD fee schedule services).
State-licensed addiction counselors	SUD services provided to TPA enrollees may be billed by State-licensed addiction counselors who participate in the TPA network. In contrast, Standard Medicaid only pays for their services when billed by a State-approved SUD facility or an FQHC, RHC, or IHS/638 facility as indicated above.
Other practitioners	In addition to State-approved facilities, SBIRT may be billed by physicians and mid-level practitioners (physician assistants and advanced practice registered nurses).

Note: Medicaid payment for SUD services provided by FQHCs and RHCs that are not State-approved SUD facilities was implemented through a State regulatory change in 2016.

Sources: Communication with DPHHS, and DPHHS provider manuals and related guidance.⁸²

Aggregate Spending by Type of Service

In SFY 2016, Montana Medicaid spent \$4.3 million (including federal and State dollars) for SUD treatment services provided to

Medicaid enrollees, with group therapy representing one-third of the total and non-hospital inpatient detoxification and treatment about one-quarter. At 13 percent each, individual

therapy and MAT drugs accounted for the next largest shares. A full breakdown is shown below in Exhibit 9.

Exhibit 9. Montana Medicaid Spending for SUD Services by Type, SFY 2016

	Non-hospital inpatient detox and treatment	Individual therapy	Group therapy	Targeted case management	Assessment and placement	SBIRT	Medication-assisted treatment drugs	Total
Total spending	\$1,170,047	\$574,768	\$1,441,686	\$266,780	\$289,378	\$2,262	\$571,438	\$4,316,358
Distribution of total	27.1%	13.3%	33.4%	6.2%	6.7%	0.1%	13.2%	100%

Note: For categories other than MAT drugs, reflects amounts paid by Medicaid for SUD fee schedule codes in Exhibit 7. Includes State-approved SUD facilities, as well as providers who may bill for SUD fee schedule codes under circumstances noted in Exhibit 8. For MAT drugs, reflects amounts paid to pharmacies and excludes manufacturer rebates that reduce overall Medicaid drug costs in Montana by more than 60 percent.⁸³

Source: Analysis of unpublished data from DPHHS.

Payment Methodologies and Levels

Historically, Montana Medicaid’s SUD coverage and payment policies have been developed apart from those for physical and mental health, and outside the insurance context. In this respect, Montana is like the majority of states where different agencies or separate branches within an agency have primary responsibility for physical versus mental health and SUD. Within Montana’s DPHHS, physical, mental health and SUD services are handled across several divisions and bureaus:⁸⁴

- The Medicaid and Health Services Branch serves as the umbrella for all Medicaid services in the State.

- For SUD, the Chemical Dependency Bureau within the Addictive and Mental Disorders Division (AMDD) of the Medicaid Branch has primary responsibility for coverage and payment policies.
- For mental health, services are managed by the Mental Health Services Bureau within AMDD, as well as the Children’s Mental Health Bureau within the Developmental Services Division.
- Physical health services are primarily managed by the Health Resources Division.

Prior to the State’s coverage expansion in 2016, decisions regarding SUD payment methodologies and levels had relatively little impact on

Medicaid because the majority of SUD services were financed from non-Medicaid sources (block grant, alcohol tax and general fund dollars), and SUD comprised a very small share of the state’s overall Medicaid spending.

As a result, the State has not extended the modernized payment methodologies it uses to pay for physical and most mental health services to SUD services. For example, for most physician and practitioner services (including mental health), Montana Medicaid pays using Resource-Based Relative Value Scale (RBRVS) methods that are used by Medicare and many private insurers;⁸⁵ most services in the outpatient hospital setting are paid using the Ambulatory

Exhibit 10. Montana Medicaid Payment Rates for Selected SUD and Mental Health Services

Service	SUD	Mental health
Individual therapy	\$35.02 per 30 min (H0004, 2 x \$17.51 per 15 min)	\$48.84 per 30 min (90832)
Group therapy	\$25.02 per patient hour (H2035)	\$18.05 per session (90853)
Targeted case management	\$12.08 per 15 min (T1016, modifier HF)	\$17.86 per 15 min (T1016, modifier HB)
Variation in service types and payment methods makes other SUD and mental health comparisons difficult:		
Assessment	<ul style="list-style-type: none"> • \$286.50 for alcohol and drug assessment (H0001) 	<ul style="list-style-type: none"> • \$92.75 for psychiatric diagnostic evaluation (90791)
Inpatient	<ul style="list-style-type: none"> • Medicaid base payments for an acute hospital inpatient stay is \$5,425; actual payment can be substantially higher/lower based on specific diagnosis and severity • For ASAM 3.7 and 3.5 non-hospital inpatient detoxification and treatment, Medicaid pays \$237.07/day 	<ul style="list-style-type: none"> • Medicaid base payments for an acute hospital inpatient stay is \$5,425; actual payment can be substantially higher/lower based on specific diagnosis and severity • For youth with serious emotional disturbance in a psychiatric residential treatment facility, Medicaid pays \$327.48/day
Residential	<ul style="list-style-type: none"> • For ASAM 3.3 and 3.1 residential treatment, Medicaid pays case management and treatment services at fee schedule rates and DPHHS pays for room and board at \$135.30/day and \$37.07/day 	<ul style="list-style-type: none"> • For adult mental health group home and children's therapeutic group home services, Medicaid pays therapeutic component at \$108.00/day and \$194.46/day

Source: July 2016 fee schedules and a crosswalk provided by DPHHS.⁹²

Payment Classification (APC) system developed by Medicare;⁸⁶ and hospital inpatient services are paid using an All Patient Refined Diagnosis Related Group (APR-DRG) method that bases payment on a patient's specific diagnosis and severity.⁸⁷ By contrast, Montana's SUD fee schedule is built on a payment system designed in the context of block grant funding. Montana is not alone in this regard. New York serves as a rare example of a state that has moved to an Ambulatory Patient Group (APG) methodology for outpatient SUD

facilities, which takes the level of resources required to provide a given combination of services into account (e.g., discounting some payments by 10 percent when multiple services are provided to a client on a single day in recognition that there are preparation time, record-keeping and other efficiencies that may be gained).⁸⁸

With respect to payment levels, providers interviewed for this report emphasized that the amounts they receive from Medicaid and other sources drive staffing decisions and

overall profitability. Among those in the SUD treatment field, a high turnover rate is commonly attributed to inadequate compensation (due in large measure to inadequate reimbursement rates, according to interviewees), which is significantly lower than for other health and non-health professions requiring similar levels of training.⁸⁹ In Montana, substance abuse and behavioral disorder counselors have an average hourly wage of \$18.10, which ranks in the bottom quarter of all states. In

comparison, neighboring North Dakota and Wyoming (\$24.76 and \$22.60) rank in the top 10; Idaho and South Dakota (\$20.39 and \$18.45) are higher than, but closer to, Montana's level.⁹⁰

For non-hospital inpatient SUD services in particular, the rate paid by Medicaid is a point of concern for stakeholders, with some indicating that the amount is not sufficient to meet

the needs of pregnant women and other complex patients. Another issue raised was a lack of clarity on whether and which services may be billable to Medicaid outside of the rate for non-hospital inpatient SUD services (e.g., physician care, lab work, medications), as the current DPHHS provider manual for SUD facilities is not explicit in this regard.⁹¹ Stakeholders also highlighted differences between

payment levels for comparable outpatient SUD and mental health services. However, the direction of the disparity is mixed, with higher payments for SUD group therapy and assessments and lower payments for SUD individual therapy and targeted case management (Exhibit 10). For other SUD and mental health services, variation in service types and payment methods make comparisons difficult.

VII. Leveraging Medicaid's Role in SUD Treatment Coverage, Access and Improvement: Options for Montana to Consider

Recognizing the increasing demand for SUD treatment in Montana, that Medicaid is fast becoming the primary payer for SUD treatment services, and the savings generated by the Medicaid expansion, the State seeks to determine how to leverage its role to cover and pay for the right care in the right setting for the right price: that is, cost-effective, quality treatment services that improve the health of the individual and the community. In the earlier sections of this report, we reviewed the existing Medicaid SUD landscape, noting among other things the impact of the Medicaid expansion. In this final

section, we put forward options the State may want to consider to maximally leverage Medicaid's role in the SUD delivery system.

Optimizing SUD Funding

With the Medicaid expansion, Montana is able to tap into a new funding stream for SUD services that is largely composed of federal dollars from the enhanced match provided for expansion adults. Given that many of the services for this newly covered Medicaid population were previously financed with State alcohol tax or general fund dollars, or by federal block grant funds, non-Medicaid savings are generated. These savings can

be used in any number of ways, including reinvestment in the Medicaid system through options detailed in the remainder of this report, which would improve access to quality, effective SUD services in Montana. For instance, some state Medicaid agencies are using expansion-related savings to invest in expansion of SUD treatment provider capacity by increasing Medicaid payment rates. During his 2016 State of the State and Budget Addresses, Governor Chris Christie announced that \$127 million would be invested in enhanced behavioral health services rates for New Jersey providers, including \$74 million

for SUD treatment services, and funded through expansion savings.⁹³

In addition, to the extent Medicaid now pays for services previously underwritten by federal block grant funds, those dollars can be reinvested in SUD services and patients that are not Medicaid eligible. The State of Arizona, for instance, is using block grant and other non-Medicaid funds to provide permanent supportive housing to Medicaid enrollees with complex behavioral needs and has a dedicated Medicaid agency effort with respect to the delivery of and payment for housing services to high-need enrollees.⁹⁴

Montana should also consider what steps it might take to ensure that Medicaid-eligible individuals in need of SUD treatment are enrolled and that the program is paying for Medicaid-covered services. In Texas, for example, providers that receive SAPT block grant funding are required to have a process in place to verify Medicaid eligibility so that block grant funding is used as the payer of last resort.⁹⁵ Montana may wish to consider implementing a similar policy for its State-approved SUD facilities to ensure that clients are consistently assessed for Medicaid eligibility when seeking services.

Finally, as Montana examines its opportunities for investment in SUD treatment and prevention

moving forward, it should focus on evidence-based practices.⁹⁶ Oregon provides one example of a state that has assembled information and tools to guide its own work in this area, motivated in part by a legislative mandate to increase its use of evidence-based practices for behavioral health.⁹⁷ One noteworthy element of Oregon's work has been to establish a system for consulting with Native American researchers and providers on effective practices in the context of Native American culture and values,⁹⁸ which Montana may look to as it considers how to expand access to SUD services for this population.

Improving Coverage of SUD Treatment Services

Medically frail enrollees. Under Montana's Medicaid expansion, medically frail enrollees receive their care through the Standard Medicaid program (Box 1). Enrolling medically frail individuals into standard Medicaid is important for several reasons, including ensuring access to a targeted case management benefit. To ensure that medically frail individuals are appropriately directed to Standard Medicaid, the State may consider implementing additional post-enrollment processes. For example, Iowa developed a strategy for identifying medically frail individuals that includes retrospective claims review on

a quarterly basis using a state-specified algorithm. In Arkansas, eligible adults complete an online health questionnaire to determine their status as medically frail. While the Arkansas tool does not currently include a specific question about SUD, Montana could choose to do so.⁹⁹ As noted earlier (see Box 1), the State is already considering whether to implement a health assessment for Standard Medicaid enrollees that could help to evaluate care coordination needs as well as identify individuals who may qualify as medically frail.

Recovery supports. Although Montana Medicaid covers at least some services across the full continuum of care delineated for SUD by the American Society of Addiction Medicine, recovery supports—and in particular the use of peer supports—are key areas where Montana has opportunities to learn from best practices in other states.¹⁰⁰ In the case of peer supports for those with SUD, there is evidence of reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.¹⁰¹ As of 2016, 29 states had Medicaid reimbursement for mental health peer support programs, and 14 states had Medicaid reimbursement for SUD peer support programs.¹⁰² In Montana,

Medicaid coverage of peer supports is currently limited to a small number of individuals in specialized programs, including adults with severe and disabling mental illness who receive home and community-based services under a waiver,¹⁰³ and youth with serious emotional disturbance who meet specified criteria.¹⁰⁴

The State may consider expanding its coverage of peer supports to a broader group of Medicaid enrollees that includes those with SUD in various treatment settings. In conjunction with any decision to more broadly cover peer supports, the State will need to consider issues related to supervision by a competent professional (as defined by the State), coordination of the service within an individualized plan of care, and training and credentialing for peer providers.¹⁰⁵ In Montana, standards for certification of peer support providers are currently addressed through a non-credentialing Peer Support Task Force that was formed as a collaborative effort between DPHHS and Montana's Peer Network in 2012.¹⁰⁶ Notably, a bill that would provide for certification of behavioral health peer support specialists has been introduced in the State Legislature.¹⁰⁷

Kansas is piloting another recovery support service that Montana may want to examine.

The Addiction Comprehensive Health Enhancement Support System (ACHESS) is a recovery-support smartphone application that helps individuals with SUD achieve and maintain sobriety. ACHESS provides support, monitoring, communications and information to individuals in a simple, user-friendly format that can be accessed at any time, with initial studies indicating a significant drop in risky drinking days.¹⁰⁸ At the conclusion of the Kansas pilot of ACHESS, it is expected that members will show increased engagement in outpatient services and a reduction in the use of costly emergency department and inpatient services, leading to reduced health-related spending.¹⁰⁹

Montana may also wish to consider its existing TCM benefit for SUD in the context of a broader review of care coordination and management policies for this population. As discussed earlier, TCM is intended to aid recovery by providing linkages to medical, educational, and social supports for individuals with SUD, but in Montana this benefit is limited to those who are enrolled in Standard Medicaid. While the State could consider extending TCM to TPA enrollees, some stakeholders consulted for this report suggested that aspects of the current system may be

inefficient or duplicative and that there is a need to think more holistically about care coordination and management for individuals with SUD. In a 2012 review of the literature on this topic, care coordination concepts were typically inclusive of SUD as a component of primary care but rarely considered SUD a central target, suggesting that SUD facilities may continue to be key players in care integration for individuals with alcohol and drug addiction while primary care sites continue to build their capacity to serve individuals with SUD.¹¹⁰

Integrated care. As noted in a recent MHC report, the concept of integrated behavioral and physical health has emerged as a prominent issue over the past decade. Innovative models are being implemented nationwide to better serve clients with complex healthcare needs, including those with mental health and SUD.¹¹¹ Given the chronic nature of addiction and its relationship to physical health problems, a focus on managing SUD in primary care settings—similar to diabetes or other chronic illnesses—is gaining traction.¹¹² Various approaches to integration are being tested around the country, including:¹¹³

- **SUD services delivered in primary care settings.** Sites using this model typically have specialty providers, such as counselors and social workers, in the primary care setting to screen and intervene for mental health and SUD conditions. In some cases, the orientation of staff is geared more toward mental health than SUD treatment, and additional training or protocols may be required to help identify and manage substance use behaviors in addition to psychological health. Other models tackle this issue by employing SUD specialists to screen for SUD and provide intervention and psychosocial services on-site.¹¹⁴

- **Primary care services in SUD settings.** In many instances, sites that are implementing the “reverse co-location” model are licensed methadone clinics, which are already required to have physical health providers on-site. Services offered include physicals, chronic disease screenings and referrals to medical specialists when necessary.

In Arizona, the State recently determined to increase Medicaid reimbursement by 10 percent for certain physical health services—including routine office visits—delivered at integrated care sites. Eligible providers are those registered with the State

as integrated clinics and licensed as outpatient treatment centers that provide both behavioral and physical health services.¹¹⁵ Were Montana to consider this approach, clear definitions of the types of integration meriting enhanced payment rates would need to be developed. In New Jersey, for example, specific payment rates have been developed for services delivered to individuals with co-occurring SUD and mental health conditions, with recent rate increases intended to enhance providers’ ability to hire staff with the credentials necessary to provide co-occurring capable services.¹¹⁶ As noted later in this report, while there are direct costs associated with increased coverage or payment of SUD services, findings from modeling conducted by Washington State indicate that these investments can be more than offset by savings in other areas (e.g., reductions SUD-related medical care and criminal justice involvement).

Even where on-site integration is not feasible, the State could adopt the Medicaid “health home” option that provides states with two years of 90 percent federal match for coverage of coordinated care provided to enrollees with chronic conditions (including SUD) or serious mental illness. The payment for health home services is separate from what

is provided for underlying Medicaid services, and the health home services may include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, patient and family support, and referral to community and social supports.¹¹⁷ Health homes bring together a team of professionals to provide coordinated and person-centered care to Medicaid enrollees with complex conditions, with the goal of improving outcomes and lowering costs.¹¹⁸ Maryland, Rhode Island and Vermont in particular have Medicaid health home state plan amendments targeting individuals with opioid dependence,¹¹⁹ while other states have a more broadly targeted benefit that includes individuals with SUD who have or are at risk for another chronic condition.¹²⁰

In Vermont, a “Hub and Spoke” system was created to build on the existing medication-assisted treatment infrastructure of opioid treatment programs initially established to provide highly regulated methadone treatment, along with office-based opiate treatment (OBOT) settings where authorized physicians prescribe buprenorphine. Hubs are regional OTPs for clinically complex patients. Spokes are medical homes that coordinate care and support services for people with SUD, providing MAT and other

services to less clinically complex patients. Findings from Vermont's analysis of Medicaid data indicate that individuals with an opioid dependence diagnosis receiving MAT have lower medical care costs than those receiving non-MAT SUD treatment or no treatment at all, and that longer MAT engagement corresponds to lower non-treatment related medical care costs.¹²¹

While not focused on opioid dependence, Montana is currently using federal grant funds to pilot a behavioral health home model for youth ages 16 to 25 with SUD who may also have co-occurring mental health conditions.¹²² The pilot is intended to build capacity and address infrastructure issues prior to seeking approval of the health home services under Medicaid so that sites are fully operational when the two-year clock for receipt of 90 percent federal funding begins. Four participating entities have both licensed mental health and SUD providers operating and billing on-site, using evidence-based assessments and treatment. By the end of the project, the State expects to submit a Medicaid state plan amendment to the federal government to create sustainable systems for reimbursement of comprehensive SUD and mental health treatment at a single facility.¹²³

In addition to its current plans for a Medicaid health home benefit targeting youth with SUD, Montana may wish to consider targeting individuals with opioid dependence. By providing an explicit Medicaid health home payment for care coordination activities, the State could help to incentivize the provision of MAT services in a variety of settings. In Vermont, for example, the health home benefit supports nursing and case manager staff for both "hub" providers that specialize in MAT and "spoke" providers where MAT is positioned in a primary care setting.¹²⁴ However, increasing the limited supply of MAT prescribers in Montana may require efforts that extend beyond Medicaid. Missouri, for example, has used private foundation and federal grants along with State funds to successfully expand the use of MAT by state-contracted SUD providers, some of which have developed relationships with community providers to facilitate prescribing.¹²⁵ For pregnant women, the need to develop collaborative relationships between MAT prescribers and obstetric providers may be particularly acute in light of the specialized care needs of this population.¹²⁶

In a recent review of 12 MAT models of care for opioid use disorder (OUD) in primary care settings, half were found to have a specific non-physician

staff person who is designated to coordinate OUD treatment, primary medical care and mental health needs. This care coordinator may serve as the main point of contact for patients, offloading the burden of care from physicians and allowing them to manage more patients with OUD. While the review indicated that care coordination is often a key component of successful MAT models of care, it also noted that methods varied among the models examined and no study evaluated the effectiveness of different coordination and integration methods.¹²⁷

Prior authorization. The use of prior authorization and other utilization management techniques is common among managed care plans and private insurers, although the specifics vary (e.g., with regard to timing as prospective, concurrent or retrospective) and some states have imposed limits to ensure access to SUD services under certain circumstances (e.g., for acute treatment and clinical stabilization, or for a pre-approved period of time).¹²⁸ In evaluating the appropriate level of care for TPA enrollees seeking inpatient or intensive outpatient services for SUD, BCBS follows ASAM criteria.¹²⁹ Although Standard Medicaid does not require prior authorization for these SUD services, DPHHS references the

ASAM criteria in its provider manual, and there is an expectation that services on the SUD fee schedule are provided in accordance with them.¹³⁰

To ensure that Medicaid enrollees receive the care that best meets their needs and that public funds are used efficiently, Montana could consider whether utilization management policies might be warranted for certain high-intensity inpatient, residential, and outpatient SUD services provided under both Standard Medicaid and non-Medicaid DPHHS contracts. However, benchmark data are not readily available on the appropriate length of inpatient and residential stays or the duration and mix of outpatient treatment services. As a result, utilization management policies might begin with an analysis to better understand the current distribution of services within Montana's SUD system and to identify providers or patterns of care that appear to be outliers. While not driven by a formal utilization review policy, recent changes at MCDC demonstrate how shorter lengths of stay may result in more individuals receiving SUD treatment. Prior to SFY 2016, MCDC had about 600 admissions annually and an average stay of 35 to 45 days; as of SFY 2016, it had more than 700 admissions with an average stay of 24 days.¹³¹ It is unclear how these shorter lengths of stay relate to

individuals' underlying needs, the availability of services at other levels of care in the State, and the outcomes ultimately realized for those who receive treatment.

In the case of MAT drugs, Montana may wish to consider removing the prior authorization that is required for pharmacies to fill buprenorphine prescriptions under Medicaid's outpatient drug benefit. Physician-administered MAT drugs (including methadone and buprenorphine prescribed and dispensed by OTPs) are not currently subject to this restriction (see Appendix 1). Many states currently require prior authorization, but removal of this barrier is one of several practices that can encourage the use of MAT.¹³² Washington State's Medicaid program has eliminated prior authorization for buprenorphine at dosages less than or equal to 24 mg per day;¹³³ in the private sector, Cigna, Anthem and Aetna have ended the practice for their commercially insured patients.¹³⁴ Although making this change would not address underlying issues that limit access to MAT in Montana—including the small number of prescribers, as well as biases against MAT that linger despite scientific evidence backing its effectiveness—it would ease some of the burden associated with providing MAT to Medicaid enrollees with opioid addiction.

Enhancing Delivery System Capacity

As noted earlier, demand for the below-average number of inpatient and residential SUD treatment beds is quite high in Montana, exceeding capacity. Anecdotal information from interviewees confirms the difficulty in accessing these beds, with reports that wait times may be weeks long and, in some cases, dependent on established relationships between the referring and receiving providers. Only five facilities offer high-intensity inpatient and residential care in Montana, and two are ineligible for most Medicaid payments because they have more than 16 beds and are subject to a prohibition on federal funding of care provided to individuals age 21 through 64 in an IMD.¹³⁵ As noted earlier, a relatively small number of beds driving a high percentage of utilization among individuals in SUD treatment suggests that Montana's overall supply of SUD services may be low relative to other states, and low MAT rates along with a DPHHS estimate that about 4,000 adults may be seeking but unable to access outpatient treatment indicate a need for additional capacity (see data cited in Section V).

To address capacity issues, Montana is considering removal of a statutory requirement that limits State approval of SUD

facilities (and therefore Medicaid billing and other public funding) to those that can demonstrate a local need with no duplication of existing services in a geographic area. DPHHS has proposed eliminating the non-duplication requirement¹³⁶ in an effort to remove a barrier to entry for providers, which could have the impact of increasing both inpatient and outpatient capacity. If there is a desire to emphasize outpatient services, the State could first remove the restriction for facilities providing such treatment and later address the issue of inpatient and residential beds.

Another option for consideration is to allow State-licensed addiction counselors (LACs) to enroll in and bill Medicaid directly for services provided to enrollees in Standard Medicaid, as is permitted by BCBS for TPA enrollees. Such a change could increase access to care for individuals in need of SUD outpatient treatment. This would increase costs to the Medicaid program for LAC services, but some of these costs would be offset by benefits (e.g., savings from lower public and private spending for health conditions associated with substance abuse or dependence, higher tax revenues and personal income from employment) that accrue to taxpayers and others (e.g., individuals in treatment and those who otherwise would

have been victims of crimes). Washington State, for example, has developed a standardized cost-benefit model with findings indicating that taxpayer savings exceed the cost of most SUD services examined, and that returns on investment are even higher when non-taxpayer benefits are included.¹³⁷ BCBS currently has 90 single-licensed LACs contracted for the TPA, and an estimated 120 LACs who are dual-licensed as clinical professional counselors or social workers.¹³⁸

Allowing LACs to bill can facilitate integrated, team-based approaches by allowing primary care clinics, prenatal care providers, and others to use LACs within an integrated care framework. Similar to Montana, Minnesota restricts licensed alcohol and drug counselors from billing for certain publicly funded services provided outside of SUD facilities that are licensed by the State. In response to a legislatively mandated study, a steering committee noted that lifting this restriction would allow for greater integration of and access to care, with individuals permitted to receive SUD services at a variety of sites such as a primary care clinic, medical or behavioral health home, pain clinic or mental health facility.¹³⁹ Vermont is another example where licensed alcohol and drug abuse counselors were limited in their ability to

participate in Medicaid until 2015, when legislation was enacted to allow these providers to bill the program for covered services within their scope of practice without restrictions.¹⁴⁰

Modernizing Payment Methodologies and Levels

Medicaid payment policies are a powerful tool to support and incentivize State priorities and ensure that Medicaid is purchasing quality, cost-effective care. As Medicaid's coverage and financing of SUD services grows, consideration of how best to rationalize payment policies for SUD and align with mental and physical health is warranted. There are two interrelated issues that the State will want to consider in any review of its payment policies: payment methodologies and payment levels.

As noted earlier, Medicaid's current payment methodology for SUD services is fee-for-service, based on a historical rate-setting methodology that is distinct from the State's approach to payment for physical and most mental health services. Many of the State's physical and mental health services are paid using methods in widespread use by other states and other payers (including RBRVS, APCs, and APR-DRGs). All of these methodologies incorporate some consideration of relative value, something that is missing in the

current fee schedule approach. Montana was a leader among state Medicaid programs in crafting inpatient and outpatient payment methodologies for its physical health services, and could similarly consider how to extend these methodologies to SUD services. For example, Montana did not simply adopt Medicare's system for inpatient hospital stays; instead, it developed an APR-DRG approach that is customized for the Medicaid population and better accounts for patients' clinical complexity. As in New York, for example, Montana could adopt an APG approach to payment for outpatient SUD treatment that accounts for the resources required for each service provided during a patient visit and disaggregates large categories of assessment, individual and group services into more discrete, clinically related service delivery and billing categories.¹⁴¹

Payment levels are another important tool in ensuring adequate capacity. As noted earlier, New Jersey intends to implement a \$74 million increase in Medicaid rates for SUD services with the stated purpose of increasing access to substance use treatment. In particular, payment levels can be targeted to high-priority populations or services; for example, to the extent that treatment capacity is lacking for

pregnant women or individuals with co-occurring mental health and SUD conditions, the state could provide incentives through higher rates. Relative to mental health, some SUD services in Montana are currently reimbursed by Medicaid at lower rates, but group therapy is one area where the SUD payment is more generous (Exhibit 10). As it considers changes to payment methods and levels, the State could undertake a cost study of the providers offering Medicaid-covered services. Indeed, with technical assistance provided by the federal Substance Abuse and Mental Health Administration, the State has already begun to consider what a cost study might entail.¹⁴²

A review of payment methodologies and levels will take some time. In the shorter term, Montana may consider introducing a bundled payment for MAT provided by OTPs. For those with opioid addiction, studies show that ongoing "maintenance" treatment approaches may be more effective than short-term managed withdrawal methods that seek to discontinue all opioid use.¹⁴³ Opioid treatment programs, of which there are currently four in Montana, are required under federal rules to provide a variety of medical, counseling and other services. However, OTPs currently must

bill for these recurring services on a piecemeal basis, which is cumbersome and inefficient. Payers have taken a variety of approaches to developing bundled payments for the MAT provided by OTPs, including a rate of \$125 per patient per week proposed for the military's Tricare program.¹⁴⁴ Montana's existing OTPs serve a largely private-pay population and have only just begun to bill Medicaid for some of their services, excluding those on the SUD fee schedule that may only be billed by State-approved facilities. If the State wishes to incentivize enrollee access to these providers, a bundled rate could help to do so.

Optimizing the Role of Medicaid for Populations Disproportionately Affected by SUD

In this section we focus on American Indian people and justice-involved individuals, two populations for whom SUD affects a disproportionate share of Montanans. Although high-level options are presented here for the State to consider as it contemplates how Medicaid can best facilitate access to SUD treatment and recovery services, we acknowledge that the issues faced by these populations are complex and warrant additional attention beyond the discussion provided in this report.

American Indians. As noted earlier, Montana's American Indian population experiences significant disparities across a wide range of health conditions and outcomes, including but not limited to those that are SUD-related. Geographic and financial disparities are also problematic, with American Indian residents much more likely to live in medically underserved areas or face the challenges of unemployment and poverty. However, Montana's Medicaid expansion creates a historic opportunity to address the underfunding of Indian healthcare—including SUD treatment and recovery services—in both reservation and urban communities.

As of February 2017, American Indians accounted for more than 9,000 out of the 71,000 new adults who have gained Medicaid coverage.¹⁴⁵ While great strides have been made with tribal benefit coordinators on the ground facilitating enrollment in Montana's American Indian communities, a sustained effort is required to reach additional individuals who are eligible but not enrolled.¹⁴⁶ To this end, the State could examine the extent to which it is maximizing the use of strategies for enrolling American Indians that were recently outlined in federal guidance.¹⁴⁷ Montana is already one of the few states partnering with tribes to administer the Medicaid program,

allowing them to receive federal Medicaid administrative match for these activities. With regard to eligibility determinations in particular, the State currently has agreements in place with two tribes to perform this function and is pursuing similar opportunities with the two other tribes eligible to enter into such agreements.¹⁴⁸

Another area for Montana to consider is how additional guidance and support can be provided to SUD providers—both tribal and non-tribal—that are not currently billing Medicaid for their services or have had difficulty doing so. In a consultation with tribal government leaders and tribal health directors held prior to implementation of the State's Medicaid expansion, tribal capacity to administer and bill Medicaid emerged as a major challenge and opportunity for improvement.¹⁴⁹ In response to questions that had been raised about billing, DPHHS assembled detailed documentation outlining key aspects of reimbursement for Medicaid and non-Medicaid SUD services by provider type (IHS/638, Urban Indian FQHC and non-FQHC, and all other providers on or off reservations).¹⁵⁰ To date, only two of the seven SUD providers with IHS/638 status in Montana are billing Medicaid for their SUD services, with a third planning to begin soon; among the four Urban Indian SUD providers

(which are FQHCs), three are billing Medicaid for SUD services.¹⁵¹ For IHS/638 facilities, developing the capacity to bill Medicaid for SUD services could provide a vital revenue source, as the all-inclusive rate paid for an outpatient visit is substantial (\$368 in 2016). In addition, since Medicaid services received through an IHS/638 facility are financed with 100 percent federal funds, the State would not bear any of the costs of expanded billing.¹⁵²

Justice-involved individuals. Justice-involved individuals are a population for whom there is a tremendous need for SUD treatment. However, as noted earlier, Medicaid is prohibited from financing the care of anyone committed to a prison, jail, detention center or other penal facility. The one exception is that Medicaid can pay for services provided during an inpatient stay of at least 24 hours in a medical institution outside the prison or jail. In addition, because all inmates reside in the community prior to incarceration and nearly all are released back, Medicaid can play a key role in facilitating access to SUD treatment and other services that help to reduce the risk of initial incarceration as well as recidivism.¹⁵³

Since the vast majority of incarcerated individuals released into the community are low-income and therefore eligible

for Medicaid, Montana could consider a number of strategies to ensure that individuals are enrolled in the program at re-entry and are connected with necessary physical and behavioral health services, including SUD treatment. These include leveraging DPHHS capacity to support Medicaid enrollment with a dedicated call line for the justice-involved population; expanding on existing application assistance resources (e.g., by providing timely discharge rosters to Corrections and DPHHS staff who facilitate enrollment); identifying high-need inmates and targeting them for enrollment; and ensuring care transition and coordination processes (which should begin prior to release and could potentially be funded with Medicaid dollars under a waiver, as discussed in the final section of this report).¹⁵⁴

As noted earlier, Montana's drug courts provide an alternative to incarceration for some individuals. In the case of drug court participants who are low-income and meet the other eligibility criteria for Medicaid, the program can pay for the full range of SUD inpatient, residential and outpatient services. However, these covered services currently exclude certain types of drug screening tests that are commonly used by the courts to monitor compliance, and Montana may wish to consider

whether the Medicaid benefit package should be expanded to include them. This would allow federal matching funds to substitute for other State, local, and federal sources used to pay for these tests, which may accrue as savings to the State or be redeployed for other purposes.

Pursuing State Innovation Through a Section 1115 Waiver for SUD

States are permitted under Section 1115 of the Social Security Act to pursue demonstrations to waive certain Medicaid statutory requirements to advance state policy priorities and test innovations in their Medicaid programs, provided that their demonstrations are budget neutral to the federal government (meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver) and "further the goals of the Medicaid program." States are always free to apply for Section 1115 waivers of their own design, but targeted opportunities are sometimes outlined by the Centers for Medicare & Medicaid Services (CMS), including a call for SUD-related proposals announced in 2015.¹⁵⁵

The SUD waiver opportunity is available to states that are developing a comprehensive strategy to ensure a full continuum of SUD services,

focusing greater attention on integration efforts with primary care and mental health treatment, and working to deliver services that are considered promising or evidence-based. CMS is also seeking to support states that are interested in developing new payment mechanisms and performance quality initiatives. A full list of CMS expectations specific to SUD waivers is provided in Appendix 3. However, given the open-ended nature of Section 1115 waiver authority and the fact that approval is subject to the discretion of the Administration, states seeking Section 1115 waivers typically must engage in a lengthy negotiation process with CMS to develop Medicaid demonstrations. It is unclear at this time how the future direction and priorities for Section 1115 waivers may shift under the new Administration.

All of the Medicaid SUD options discussed in this report for Montana's consideration could be included in a Section 1115 waiver request, and there are at least two key areas where changes could *only* occur under a waiver. The first is coverage of services in SUD facilities with more than 16 beds that are subject to a prohibition on federal funding of care provided to individuals age 21 through 64 in an IMD, with two states (California and Virginia) noted below as having received approval of waivers that

include IMD services. The other is coverage of SUD services for individuals prior to their release from jail or prison.

Several states, including both expansion and non-expansion states, have submitted or are developing Section 1115 waiver proposals with a substantial SUD component. Examples of the provisions included in these proposals, many of which reflect options described in this report, are highlighted below:

- California's approved 1115 waiver builds on the State's previous Drug Medi-Cal program by expanding covered benefits on a continuum of SUD services modeled after the ASAM Criteria; these include residential services for up to 90 days in facilities of any size (i.e., including IMDs that would otherwise be ineligible for Medicaid reimbursement), recovery residence services, partial hospitalization services, and reimbursement for additional MAT activities.¹⁵⁶
- Virginia's approved 1115 waiver seeks to expand the State's residential treatment capacity. Previously, the State had developed a comprehensive Medicaid Addiction and Recovery Treatment benefit that carved community-based services into managed care, expanded short-term inpatient detox and residential treatment to all Medicaid

members, increased rates for SUD services, and added peer supports to the Medicaid benefit package. The 1115 waiver requested an expansion of residential treatment capacity to support the new benefit, including the ability to cover services provided in facilities with more than 16 beds that are IMDs. Care coordination focused on SUD as well as physical and mental health will be expanded under the waiver amendment.¹⁵⁷

- Massachusetts' approved 1115 waiver extension adds enhanced services for individuals with SUD to its list of covered Medicaid benefits. These include ASAM Level 3.1 treatment services currently funded by the state, with funds generated via federal matching dollars used to increase the number of placements by 18 percent, purchase care coordination and recovery coach services that address addiction as a chronic condition, and pilot a new ASAM-based assessment tool. The state also plans on adding ASAM Level 3.3 services that are not currently available in the state and re-launching an improved prescription monitoring program that can be integrated into electronic health records and connected with nearby states.¹⁵⁸
- New Hampshire's approved 1115 waiver makes use of regional,

provider-based Integrated Delivery Networks to promote the integration of physical and behavioral health. The networks must implement projects from a menu of care transition, capacity building, and primary and behavioral healthcare collaboration options. A focus on screening, SBIRT and MAT is required, and other projects may include expansion of peer supports, partial hospitalization and residential care services, SUD treatment focused on adolescents and young adults, and treatment for co-occurring disorders.¹⁵⁹

- Illinois' 1115 waiver proposal would redesign its SUD service continuum with benefits that include short-term residential SUD treatment in an IMD; substance use disorder case management for those not receiving it otherwise; withdrawal management services; and recovery coaching. For justice-involved populations, the state proposes Medicaid coverage of specified behavioral health services 30 days prior to release, including injectable naltrexone (Vivitrol); it has also requested federal match for "Designated State Health Programs" that include non-Medicaid SUD treatment currently provided in Department of Corrections and Department Juvenile Justice facilities.¹⁶⁰

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- As part of Utah’s current request to extend its existing Primary Care Network Demonstration 1115 waiver, the state is requesting a waiver to cover ASAM Level 3 residential treatment in non-institutional, non-medical, short-term residential programs for Medicaid members without a bed capacity limit (i.e., including facilities that would otherwise be subject to the IMD exclusion).¹⁶¹
 - West Virginia’s 1115 waiver proposal outlines efforts that would increase the availability of community-based and outpatient SUD treatment services; make residential treatment opportunities available, as appropriate; add access to methadone as a treatment strategy; widely distribute naloxone; provide recovery supports; and improve the SUD treatment coordination with other behavioral and physical health services, as well as transitions to outpatient care.¹⁶²
 - As part of Indiana’s current request to extend its existing Healthy Indiana Plan 1115 waiver, the state is seeking to add new SUD coverage that will include an expansion of inpatient detoxification, additional residential services (including stays in IMDs for up to 30 days), and the addition of addiction recovery management services that include recovery education, peer recovery supports, housing support services, recovery-focused case management and relapse prevention services.¹⁶³

VIII. Conclusion

As in most states, substance use disorder prevalence, morbidity and mortality in Montana is a serious and growing public health problem. With implementation of expansion, Medicaid is becoming the State’s primary payer for SUD treatment services and Montana’s most potent tool in combatting alcoholism, methamphetamine use, opioid abuse and overdose, and the myriad social consequences of addiction. In stepping into its role

as a primary source of funding for SUD treatment in the State, Montana Medicaid is confronted with challenges that include provider capacity limitations and an obsolete payment methodology. This paper offers options for the State to address these challenges, rooted in the experience and best practices of other state Medicaid programs and those of other payers. By investing in and adopting of some of these practices, Montana

Medicaid can leverage its critical role as a primary purchaser of SUD treatment services to shape a delivery system that provides the right care, in the right setting, at the right time for Montana Medicaid enrollees. By doing so, the State can fulfill its goal of effective stewardship of state and federal dollars while improving the health, wellbeing and lives of its residents.

Appendix 1.

Medicaid Policies for MAT Drugs in Montana

For medication-assisted treatment drugs covered under Montana's Medicaid program, prior authorization and payment policies vary based on whether they are billed by an outpatient pharmacy or by a physician or other provider who administers the drug:

- For buprenorphine-containing products that can only be prescribed to a limited number of patients by a physician with a federal waiver,¹⁶⁴ coverage is typically under the outpatient pharmacy benefit, and prior authorization and a number of other criteria must be met (e.g., compliance with counseling, drug screens, and office visits).¹⁶⁵ Once a prescription is authorized, it may be filled and billed to Medicaid by an outpatient pharmacy.
- In the case of methadone prescribed for opioid use disorders, the drug is always physician-administered because only opioid treatment program facilities that are subject to federal certification and accreditation requirements may dispense it.¹⁶⁶ Physician-administered drugs are typically billed directly to Medicaid by a provider that serves as both the prescriber and dispenser. There is no prior authorization requirement for methadone, or for buprenorphine, when billed as

a physician-administered drug.

- For naltrexone, the oral form is covered under the outpatient pharmacy benefit with no prior authorization. The injectable form (Vivitrol) must be administered by a physician regardless of how it is billed. In the case of physician-administered billing, prior authorization is not required. In the case of outpatient pharmacy billing, which allows certain providers to avoid the high cost of stocking the drug, prior authorization is required.¹⁶⁷

Other services associated with the provision of MAT drugs (e.g., SUD counseling and medical office visits to monitor physical health) are billed separately. As with other SUD providers, MAT providers typically must be State-approved to bill Medicaid for SUD fee schedule services (e.g., individual or group therapy for SUD) and are subject to the rules that apply to other fee schedules as well (e.g., those governing medical office visits under the physician fee schedule).¹⁶⁸ See Exhibits 7 and 8 earlier in this report for information on the circumstances under which various SUD services may be billed to Medicaid.

Appendix 2.

Supplemental Data on Services Provided by Montana's State-Approved SUD Facilities

In 2015, State-approved SUD facilities in Montana reported data to DPHHS indicating that there were more than 5,000 admissions for treatment (See Exhibit 11 on the following page). Outpatient care accounted for the majority of admissions. Higher-intensity inpatient admissions (ASAM levels 3.5 and 3.7), which provide 24-hour care with medical staff

or trained counselors to stabilize individuals who are at imminent risk of relapse, exceeded the number of lower-intensity residential admissions that provide 24-hour living support with at least five hours of clinical service each week (ASAM 3.1). (See Exhibit 4 for information on the ASAM levels of care.)

Exhibit 11. Number of Admissions at State-Approved SUD Facilities in Montana by ASAM Level of Care, 2015

Facility	Total admissions	ASAM 3.7	ASAM 3.5	ASAM 3.1	ASAM 2.5	ASAM 2.1	ASAM 1	ASAM 0.5	ASAM level not provided
Alcohol & Drug Services of Gallatin County	297	–	–	12	–	39	231	–	15
Benefis Health Center	138	–	–	–	–	–	–	–	138
Blackfeet Tribe – Crystal Creek Lodge	162	–	141	–	–	13	1	–	7
Boyd Andrew Community Services	138	–	–	13	–	43	73	–	9
Bullhook Community Health Center	88	–	2	–	–	1	34	3	48
CCCS, SMART	181	–	–	–	–	5	25	–	151
Center for Mental Health	32	–	–	–	–	–	32	–	–
Choices for Change Counseling	60	–	–	–	–	1	59	–	–
District 2 – Glendive	193	–	–	–	–	–	187	–	6
Eastern Montana Community Mental Health Center	190	–	–	13	–	1	127	1	48
Flathead Valley Chemical Dependency	313	–	–	3	–	90	163	–	57
Fort Belknap Chemical Dependency Treatment Center	145	5	21	–	–	9	26	43	41
Gateway Recovery	245	–	–	20	–	98	62	–	65
Helena Indian Alliance	59	–	–	–	–	–	14	2	43
Indian Family Health Clinic	35	–	1	–	–	–	26	6	2
Indian Health Board Billings	77	–	–	–	–	25	34	–	18
Intermountain Childrens Home	16	–	–	–	–	–	1	–	15
MCDC	646	377	237	–	–	–	–	–	32
Missoula Urban Indian Health Center	25	–	–	–	–	14	7	–	4
New Day Intermediate Care	53	–	–	–	–	52	1	–	–
New Horizons Recovery Center	26	–	–	–	–	–	–	–	26
Pathways Treatment Center	10	–	–	–	–	–	–	–	10
Recovery Center	42	6	35	–	1	–	–	–	–
Rimrock Foundation	374	1	272	4	–	69	19	2	7
Rocky Boy Health Board – White Sky Hope	105	–	–	22	–	–	83	–	–
SCMHADP	392	3	–	–	–	118	250	1	20
SWCD – Park County Alcohol Drug Referral	230	–	–	24	–	26	116	–	64
Western MT Addiction Services	674	–	20	22	–	283	285	–	64
Western MT Tri-County Addiction Services	41	–	–	–	–	–	27	2	12
Wilderness Treatment Center	120	–	–	–	–	–	–	–	120
Youth Dynamics Inc.	63	–	–	–	–	20	4	–	39
Number of Admissions	5,170	392	729	133	1	907	1,887	60	1,061

Source: Analysis of Substance Abuse Management System (SAMS) from DPHHS.

Note: Excludes Department of Corrections admissions, which are not consistently reported in SAMS. Totals may undercount the total number of admissions, as DPHHS indicates that some facilities do not consistently report admissions that are not billed to DPHHS contracts financed with block grant funds. The number of admissions exceeds the unique number of people served, as some individuals have more than one admission during the year.

Appendix 3.

Requirements for a Transformed SUD System Under Medicaid Section 1115 Waiver Authority

CMS expectations for a transformed SUD system under Section 1115 waiver authority include the following:¹⁶⁹

- Comprehensive evidence-based design (including SBIRT, withdrawal management, MAT, care coordination, long-term recovery; may include short-term inpatient/residential care in an IMD)
- Appropriate standards of care (at a minimum, ASAM for inpatient and residential)
- Entity other than rendering provider to perform an assessment of care needs
- Provider network development plan
- Care coordination (between levels/settings and different types of healthcare)
- Integration of physical health and SUD (e.g., health homes, patient-centered medical homes)
- Program integrity (provider screenings, agreements, and billing/compliance processes)
- Benefit management (e.g., prior authorization, targeted post-payment review, billing edits)
- Community integration (requirements related to person-centered planning and care settings)
- Strategies to address prescription drug abuse (e.g., prescribing guidelines)
- Strategies to address opioid use disorder (e.g., opioid-specific prescribing practices, expanded use and distribution of naloxone, expansion of MAT)
- Services for adolescents and youth with SUD
- Reporting of quality measures
- Collaboration between a state's Medicaid and SUD agencies

Appendix 4.

Interviewees and Stakeholder Meeting Participants

Name	Title and Organization
Bill Gallea	President, Montana Medical Association Board; Emergency Medicine Physician
Dorothy Dupree	Director, Billings Area Indian Health Services
Jean Branscum	CEO, Montana Medical Association
Jessica Cotton	CEO, Southwest Community Health Center
Michael Cummins	President, Montana Addiction Services Providers; Executive Director, Flathead Valley Chemical Dependency Clinic
Peg Shea	Independent Counselor
Robert Sherrick	Medical Director, Community Medical Services
Tressie White	Executive Director, Helena Indian Alliance
Amy Tenney	CEO, Boyd Andrew Community Services
Becky Buska	Financial Services Director, Montana Department of Justice
Bill Reiter	President, Reiter Foundation, Inc.
Bob Wigdorski	Executive Director, Gateway Community Services
Cindy Smith	CEO, Bullhook Community Health Center
Courtney Rudbach	Clinical Supervisor, Pathways Treatment Center, Kalispell Regional Medical Center
Dan Krause	COO, Boyd Andrew Community Services
David Mark	CEO, Bighorn Valley Health Center
Derek Gibbs	President, Together Our Recovery Center Heals
Jeff Kushner	Statewide Drug Court Coordinator, Montana Department of Justice
Lenore Myers	Director, White Sky Hope Rocky Boy Clinic
Leslie Nyman	Administrator, Pathways Treatment Center, Kalispell Regional Medical Center
Natalie McGillen	COO, Western Montana Mental Health Center
Teri Jackson	Clinical Director for Community Services, Youth Dynamics

¹ <http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/HELP%20Enrollment%20by%20County%20%209%2017.pdf>

² Throughout this report, Montana statistics are reported as similar to the national average when there is overlap between confidence intervals provided in a data source (e.g., National Survey on Drug Use and Health tables).

³ Among 31 counties surveyed between 2012-2014, 24 identified alcohol or substance abuse as their top concern, and the remainder identified this issue in their top three concerns. See Brandn Green, *Data Review for 2017 Behavioral Health Access Act*, DPHHS, January 2017.

⁴ http://www.samhsa.gov/data/sites/default/files/2015_Montana_BHBarometer.pdf; https://www.dasis.samhsa.gov/webt/state_data/MT13.pdf; Table 3.3, http://www.samhsa.gov/data/sites/default/files/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf

⁵ <https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf>

⁶ https://www.cdc.gov/pcd/issues/2014/13_0293.htm

⁷ Behavioral Risk Factor Surveillance System (BRFSS) 2014, <https://www.cdc.gov/brfss/brfssprevalence/index.html>; High School Youth Risk Behavior Surveillance System (YRBSS) 2015, <https://nccd.cdc.gov/Youthonline/App/Default.aspx>

⁸ Tables 1, 3, and 6, <https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf>

⁹ http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSAUDrugDeaths_2003-2014%20FIXED%20T43.pdf?ver=2016-05-20-134905-287

¹⁰ <http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/MTHDDS/Special%20Reports/Drugdeathshosps.pdf>

¹¹ <https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm650501e1.pdf>; http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSAUDrugDeaths_2003-2014%20FIXED%20T43.pdf?ver=2016-05-20-134905-287

¹² Table 2.3, https://www.dasis.samhsa.gov/dasis2/teds_pubs/2013_teds_rpt_st.pdf

¹³ Table 2.2 and Figure 34, https://www.dasis.samhsa.gov/dasis2/teds_pubs/2013_teds_rpt_st.pdf; Table 6b, https://www.dasis.samhsa.gov/dasis2/teds_pubs/2005_teds_highlights_rpt.pdf; Table 2.2, https://www.dasis.samhsa.gov/dasis2/teds_pubs/2009_teds_rpt_st.pdf

¹⁴ http://mthcf.org/wp-content/uploads/2016/06/IBH-Report-FINAL_4.26.16.pdf

¹⁵ <http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>

¹⁶ DPHHS, *SFY 2014 Montana Final Financial Map: Mental Health, Chemical Dependency & Co-Occurring*, April 4, 2016.

¹⁷ https://www.samhsa.gov/data/sites/default/files/report_2107/ShortReport-2107.pdf; <https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm>

¹⁸ http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1; <https://www.ncbi.nlm.nih.gov/pubmed/11802085>; <https://www.ncbi.nlm.nih.gov/pubmed/19478286>

¹⁹ <http://opi.mt.gov/pdf/IndianEd/Resources/MTIndiansHistoryLocation.pdf>; <http://www.montanabudget.org/mbpcs-montana-indian-country-index/>

²⁰ <http://www.dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/StateOfTheStatesHealth.pdf>

²¹ <http://www.dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/StateOfTheStatesHealth.pdf>

²² Table 5.4B, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf>

²³ <http://www.ehd.org/pdf/sources/828.pdf>

²⁴ DPHHS, unpublished analysis of Medicaid claims data.

²⁵ <http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/MTHDDS/Surveillance%20Reports/NeonatalAbstinenceSyndromeinMontanaNewborns20002013.pdf>

²⁶ <https://healthandjusticejournal.springeropen.com/articles/10.1186/s40352-015-0015-5>

²⁷ For a series of articles on these issues, see: <http://www.reuters.com/investigates/special-report/baby-opioids/>; for an older discussion of variation in hospital policies regarding testing at birth, see: <https://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf>

²⁸ http://billingsgazette.com/news/state-and-regional/montana/meth-use-drives-demand-for-montana-foster-homes/article_b3fdd541-82a9-5302-8fcc-b3497c70efb7.html

²⁹ <https://www.ncbi.nlm.nih.gov/pubmed/23439891>

³⁰ https://masshealthpolicyforum.brandeis.edu/forums/Documents/FINAL-SEN-IssueBrief_For-Print.pdf

³¹ https://store.samhsa.gov/shin/content/SMA13-4803/TIP58_LiteratureReview.pdf

³² <https://wwwn.cdc.gov/psr/?state=Montana>; <https://www.cdc.gov/media/releases/2015/p1015-excessive-alcohol.html>

³³ <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>

³⁴ <https://cor.mt.gov/Portals/104/Resources/Reports/2015BiennialReport.pdf>; http://www.mtacd.org/attachments/CPE/Chico_2015/5_CAmbroseDOCComProg.pdf; <https://csgjusticecenter.org/wp-content/uploads/2016/06/Behavioral-Health-Programming-and-Treatment-in-Corrections.pdf>

³⁵ <http://leg.mt.gov/content/Committees/Interim/2015-2016/Sentencing/Committee-Topics/Study-Resources/lad-treatment-sop-2007-07P-08.pdf>

³⁶ Includes service contracts with private providers and internal clinical expenditures. See: <https://cor.mt.gov/Portals/104/Resources/Reports/2015BiennialReport.pdf>

³⁷ https://courts.mt.gov/portals/113/cao/ct_services/treatment/docs/2015rpt.pdf; <http://leg.mt.gov/content/Publications/Audit/Report/13P-08.pdf>

³⁸ In 2009, the most recent year for which information is available, 69 percent of U.S. spending on SUD treatment came from public sources. See: <http://www.pewtrusts.org/~media/assets/2015/03/substanceusedisordersandtheroleofthestates.pdf>

³⁹ Analysis of Substance Abuse Management System (SAMS) data from DPHHS. Nearly 70 percent of admissions to State-approved SUD facilities in 2015 had an expected payment source of Medicaid, block grant, Medicare or other government (including admissions to the state-run Montana Chemical Dependency Center with a designation of “no charge”). Another 5 percent had an unidentified “other” source, likely public given that most of these admissions were for the Montana Chemical Dependency Center or tribal-related facilities. The remaining one-quarter had an expected payment source of private insurance or self-pay. All figures exclude admissions to acute care hospitals and other treatment provided outside of State-approved SUD facilities.

⁴⁰ <https://aspe.hhs.gov/sites/default/files/pdf/190506/BHMedicaidExpansion.pdf>

⁴¹ <http://dphhs.mt.gov/helpplan/waiversubmission>

⁴² <https://dphhs.mt.gov/Portals/85/Documents/2015MedicaidReport.pdf>

⁴³ Communication with DPHHS and draft report on SUD residential care submitted by Addictions Consulting Group to DPHHS. It is important to note that not all public funding for SUD treatment flows through the State budget; excluded amounts include spending by the Indian Health Service and by tribes for individuals and services not covered by Medicaid, as well as spending for care financed by the Veterans Administration and Medicare.

⁴⁴ http://leg.mt.gov/bills/mca/title_0160/chapter_0010/part_0040/sections_index.html; http://leg.mt.gov/bills/mca/title_0530/chapter_0240/part_0010/section_0080/0530-0240-0010-0080.html; http://leg.mt.gov/bills/mca/title_0530/chapter_0240/part_0020/section_0060/0530-0240-0020-0060.html

⁴⁵ As noted earlier, treatment costs for individuals in Montana’s drug courts are funded from multiple sources.

⁴⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

⁴⁷ Analysis of Substance Abuse Management System (SAMS) data from DPHHS. Among admissions where at least some income was reported for an individual, about 60 percent had an amount that was at or below 138 percent FPL. Admissions with zero income were excluded from the calculation because DPHHS indicates that facilities do not consistently report income for admissions that are not billed to DPHHS contracts financed with block grant funds, and it is not possible to determine whether records that indicate zero income are accurate.

⁴⁸ <https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures>

⁴⁹ http://budget.mt.gov/Portals/29/execbudgets/2019_Budget/Section%20B%20-%202019B.pdf

⁵⁰ With a federal share of at least 90 percent for newly eligible adults and \$100 in total spending, for example, the State contributes \$10 and the federal government contributes \$90 (corresponding to \$9 federal for each State dollar). With Montana's regular federal medical assistance percentage (FMAP) of 65.56 percent for federal FY 2017, the \$100 in total spending would reflect \$34.44 from the State and \$65.56 from the federal government (corresponding to \$1.90 federal for each State dollar).

⁵¹ Under the Mental Health Parity and Addiction Equity Act, parity requirements apply to ABP and managed care populations in Medicaid. Cost-sharing requirements, quantitative treatment limitations (e.g., caps on the number of visits) and non-quantitative treatment limitations (e.g., policies regarding prior authorization) must be no more restrictive for mental health/SUD than for medical/surgical benefits. States may place prescription drugs into tiers based on reasonable factors specified in federal regulations, but must do so without regard to whether they are generally prescribed for MH/SUD or medical/surgical conditions. Parity rules do not address provider payment rates, which in the case of Medicaid are generally determined by states and managed care plans within broad federal parameters. For parity background, see: <https://www.medicaid.gov/medicaid/benefits/abp/index.html>; for payment, see: <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>

⁵² <http://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2015/changestomontanamedicaid12312015.pdf>

⁵³ While a recent journal article indicates that Montana does not cover ASAM level 4, the State's Medicaid program does in fact pay for acute care hospital inpatient stays that include detoxification. In addition, while the article indicates that two or fewer opioid use disorder medications are covered, Montana Medicaid does currently cover methadone in addition to buprenorphine and naltrexone (see Appendix 1 in this report). For article, see: <http://content.healthaffairs.org/content/35/12/2289.abstract>; for acute care hospital payment policies, see sources cited for Exhibit 8 in this report.

⁵⁴ http://www.integration.samhsa.gov/sbirt_issue_brief.pdf

⁵⁵ See 42 CFR 440.315(f): <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/xml/CFR-2011-title42-vol4-sec440-315.xml>

⁵⁶ The TPA's Member Services department is trained to refer individuals seeking to self-identify as medically frail to the Medicaid agency for follow-up. See: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-15-0027.pdf>

⁵⁷ As described in an earlier note, DPHHS indicates that facilities do not consistently report income for admissions that are not billed to DPHHS contracts financed with block grant funds. As a result, the exact number of individuals in treatment with incomes below 51 percent FPL is not known.

⁵⁸ <https://dphhs.mt.gov/Portals/85/hrd/documents/1115/12-14-15%20BCBSMT%20Medicaid%20Welcome%20Brochure%20v30%20to%20DPHHS%20121415.pdf>

⁵⁹ For annual directories that list facilities in each state, see: <https://www.dasis.samhsa.gov/dasis2/nssats.htm>; for the number of facilities of each type included in the 2013 Montana data cited as the source for most statistics in this section, see: https://www.dasis.samhsa.gov/webt/state_data/MT13.pdf

⁶⁰ Tables 5.25B and 5.33B, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>

⁶¹ Although not a prerequisite for billing Medicaid, some of these providers have obtained State approval in order to qualify for non-Medicaid funds administered by the State (e.g., federal SAPT block grant dollars).

⁶² Communication with DPHHS.

⁶³ <http://leg.mt.gov/content/Committees/Interim/2013-2014/Children-Family/Meetings/August-2014/draft-final-report-appendix-e-tribal%20recs.pdf>

⁶⁴ <https://prevention.mt.gov/Portals/22/Interviews.pdf>

⁶⁵ The percentage of clients receiving these services is not provided. See: https://www.dasis.samhsa.gov/webt/state_data/MT13.pdf

⁶⁶ While most of the information in this section is for 2013, a question on facility focus was not included that year. For 2012 Montana data, see: https://www.dasis.samhsa.gov/webt/state_data/MT12.pdf; for 2012 national data and information on measures collected each year, see Tables 2.2 and A.1: https://www.dasis.samhsa.gov/dasis2/nssats/2012_nssats_rpt.pdf

⁶⁷ <https://www.ncbi.nlm.nih.gov/pubmed/23183873>; http://www.integration.samhsa.gov/pbhci-learning-community/05_20_14_Introduction_to_the_DDCMHT.pdf

⁶⁸ For example, see: <http://www.mass.gov/courts/docs/csat-access-to-substance-use-disorder-treatment-in-mass.pdf>

⁶⁹ Because SUD treatment clients may also occupy beds that are not designated for SUD treatment, utilization rates may be more than 100 percent; see Table 6.9: https://www.samhsa.gov/data/sites/default/files/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf

⁷⁰ Analysis of Table 6.9, https://www.samhsa.gov/data/sites/default/files/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services/2013_N-SSATS_National_Survey_of_Substance_Abuse_Treatment_Services.pdf; and <https://factfinder.census.gov/bkmk/table/1.0/en/PEP/2015/PEPAGESEX>

⁷¹ Brandn Green, *Data Review for 2017 Behavioral Health Access Act*, Montana DPHHS, January 2017.

⁷² Among 23 Montana physicians currently listed on the SAMHSA website as being authorized to treat opioid dependency with buprenorphine, DPHHS contacted each one and found that 7 had retired or moved to another state; of the remaining 16, 3 were not accepting new patients. See: https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=MT

⁷³ <https://www.ncbi.nlm.nih.gov/pubmed/26066931>

⁷⁴ https://www.imshealth.com/files/web/IMSH%20Institute/Reports/Healthcare%20Briefs/IIHI_Use_of_Opioid_Recovery_Medications.pdf

⁷⁵ <http://dpt2.samhsa.gov/treatment/directory.aspx>

⁷⁶ https://www.dasis.samhsa.gov/webt/state_data/MT13.pdf; https://www.dasis.samhsa.gov/dasis2/nssats/2013_nssats_rpt.pdf

⁷⁷ <http://leg.mt.gov/bills/mca/53/24/53-24-208.htm>; <http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37%2E27%2E1>

⁷⁸ <http://leg.mt.gov/css/committees/interim/2015-2016/Children-Family/Meetings/Aug-2016/aug-2016.asp>; <http://leg.mt.gov/content/Committees/Interim/2015-2016/Children-Family/Legislation/aug2016-dphhs-behavioral-health-care-act.pdf>

⁷⁹ <https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone>

⁸⁰ For a discussion of various methods and Medicaid payment issues, see: <https://www.xerox.com/downloads/services/white-paper/medicaid-care-coordination.pdf>; http://www.chcs.org/media/Medicaid_Payment_Reform_Brief.pdf

⁸¹ <http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/CDStandardMedicaidCodesandRates.pdf>; <http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/ChemicalDependencyBureauContractFeeSchedule.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2016/July2016Finalized/fsRBRVSSandAnesthesiaSFY2017.xlsx>

⁸² For acute care hospitals, see: <http://www.mtrules.org/gateway/ruleno.asp?RN=37.86.2902> (Montana Administrative Register Notice 37-737 references the 2016 removal of authorization for inpatient hospital detoxification lasting over 7 days); <http://medicaidprovider.mt.gov/Portals/68/docs/manuals/hospitalin012016.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/aprdrg/faqs06152015.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/aprdrg/2016/aprdrg06162016.pdf>. For FQHCs and RHCs, see: http://medicaidprovider.mt.gov/Portals/68/docs/manuals/RHCFQHC/2016/RFC_FQHCmanual07262016.pdf; https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2016/provnoticeprov55_56LACaddedtoFQHCRHC.pdf; <http://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2017/provnotice5556LAC02212017.pdf>. For IHS/638 providers, see: <https://medicaidprovider.mt.gov/Portals/68/docs/manuals/IHS/IHSManual08082016.pdf>; <https://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2017/fsapproved/q1approvedfs/fsprov57IHSJanuary201701202017.pdf>.

⁸³ Although providers may bill for MAT drugs that are physician-administered (see Appendix 1), no amounts were shown in the SFY 2016 data. For Medicaid drug rebates, an amount specific to MAT drugs is not available; for an overall rebate percentage in Montana, see: <https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-27.-Medicaid-Gross-Spending-and-Rebates-for-Drugs-by-Delivery-System-FY-2015-millions.pdf>

⁸⁴ <https://dphhs.mt.gov/Portals/85/Documents/bureauorgchart.pdf>; <https://dphhs.mt.gov/Portals/85/Documents/biennialreports/MedicaidandHealthServicesManagement2015.pdf>

⁸⁵ <http://medicaidprovider.mt.gov/Portals/68/docs/manuals/adultmentalhealth/AdultMentalHealth08252016.pdf>

⁸⁶ <https://medicaidprovider.mt.gov/Portals/68/docs/manuals/hospitalout06172015.pdf>

⁸⁷ <https://medicaidprovider.mt.gov/Portals/68/docs/aprdrg/aprdrgfaqs10272015.pdf>

⁸⁸ <https://oasas.ny.gov/admin/hcf/apg/index.cfm>

⁸⁹ <https://aspe.hhs.gov/sites/default/files/pdf/203761/ExamSUD.pdf>

⁹⁰ Employment statistics are available for two occupation categories that encompass a substantial proportion of the SUD treatment workforce: substance abuse and behavioral disorder counselors and mental health and substance abuse social workers. However, the share of these categories represented by SUD treatment versus mental health professionals is unknown. See: <https://www.bls.gov/oes/current/oes211011.htm>; <https://www.bls.gov/oes/current/oes211023.htm>

⁹¹ <https://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/CDProvider%20Manual/CDProviderManualSFY17.pdf>

⁹² <http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/CDStandardMedicaidCodesandRates.pdf>; <http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/ChemicalDependencyBureauContractFeeSchedule.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2016/July2016Finalized/prov60fsMCDYouthMHJuly2016.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2016/July2016Finalized/fsprov59medicaidadultmentalhealthjuly2016.pdf>; <http://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2016/July2016Finalized/fsRBRVSSandAnesthesiaSFY2017.xlsx>; <http://medicaidprovider.mt.gov/Portals/68/docs/aprdrg/2016/aprdrg06162016.pdf>

⁹³ http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf; <http://nj.gov/governor/news/news/552016/approved/20160407c.html>

⁹⁴ Communication with Arizona Health Care Cost Containment System.

⁹⁵ <https://www.dshs.texas.gov/mhsa/sud/providers/>

⁹⁶ See, for example: <https://www.samhsa.gov/ebp-web-guide/substance-abuse-treatment>

⁹⁷ <https://www.oregon.gov/oha/amh/Pages/ebp.aspx>

⁹⁸ <https://www.oregon.gov/oha/amh/ebp/Position%20Paper%20on%20Native%20American%20Treatment%20Programs%20and%20Evidence-Based%20Practices.pdf>

⁹⁹ https://www.thenationalcouncil.org/wp-content/uploads/2015/07/15_Medically-Frail-Issue-Brief-v4.pdf

¹⁰⁰ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/07282016-sud-nds2.pdf>

¹⁰¹ <https://www.ncbi.nlm.nih.gov/pubmed/24838535>

¹⁰² <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/07282016-sud-nds2.pdf>

¹⁰³ <http://dphhs.mt.gov/Portals/85/amdd/documents/HCBSWaiverApplication.pdf>

¹⁰⁴ [https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/FINAL915\(i\)HCBSProviderPolicyManualOct15.pdf](https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/FINAL915(i)HCBSProviderPolicyManualOct15.pdf)

¹⁰⁵ <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>; <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf>

¹⁰⁶ <http://mtpeernetwork.org/wp-content/uploads/2014/03/Peer-Support-Toolkit-Final-Edition.pdf>

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- ¹⁰⁷ [http://laws.leg.mt.gov/legprd/LAW0203W\\$BSRV.ActionQuery?P_SESS=20171&P_BLTP_BILL_TYP_CD=SB&P_BILL_NO=62&P_BILL_DFT_NO=&P_CHPT_NO=&Z_ACTION=Find&P_ENTY_ID_SEQ2=&P_SBJT_SBJ_CD=&P_ENTY_ID_SEQ=](http://laws.leg.mt.gov/legprd/LAW0203W$BSRV.ActionQuery?P_SESS=20171&P_BLTP_BILL_TYP_CD=SB&P_BILL_NO=62&P_BILL_DFT_NO=&P_CHPT_NO=&Z_ACTION=Find&P_ENTY_ID_SEQ2=&P_SBJT_SBJ_CD=&P_ENTY_ID_SEQ=)
- ¹⁰⁸ <http://jamanetwork.com/journals/jamapsychiatry/fullarticle/1847578>
- ¹⁰⁹ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/20150511tlo3continuaofcare.pdf>
- ¹¹⁰ <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>
- ¹¹¹ http://mthcf.org/wp-content/uploads/2016/06/IBH-Report-FINAL_4.26.16.pdf
- ¹¹² http://www.integration.samhsa.gov/clinical-practice/13_May_CIHS_Innovations.pdf; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4643942/>
- ¹¹³ See, for example, a 2012 review of California's experience with integrating SUD and primary care: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3664544/>
- ¹¹⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3664544/>
- ¹¹⁵ For the public notice, see: https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/NOPI_FFS_RateChange07182016.pdf; for the list of services eligible for adjusted rates, see: <https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/ValueBasedPaymentRateDifferentialPublicNoticeForCs04192016Attachment1.pdf>
- ¹¹⁶ http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf
- ¹¹⁷ <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Guide-to-Health-Homes-Design-and-Implementation.html>
- ¹¹⁸ <https://www.manatt.com/insights/newsletters/medicaid-update/manatt-on-medicaid-are-health-homes-here-to-stay>
- ¹¹⁹ <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-for-opiod-dependency.pdf>
- ¹²⁰ <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>
- ¹²¹ <https://www.nga.org/files/live/sites/NGA/files/pdf/2015/1510StateExpHealthCimaglio.pdf>
- ¹²² <https://dphhs.mt.gov/Portals/85/Documents/SIM/GovernorsCouncilonHealthcareInnovationPlan160630.pdf>
- ¹²³ http://www.mthcf.org/wp-content/uploads/2016/06/IBH-Report-FINAL_4.26.16.pdf
- ¹²⁴ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/20150713tlo5integratinggsud.pdf>; <http://www.chcs.org/media/HH-IRC-Health-Homes-for-Opioid-Dependency.pdf>; <https://dmh.mo.gov/ada/provider/medicationassistedtreatment.html>
- ¹²⁵ <https://dmh.mo.gov/docs/ada/bulletin2016aprilmedicationassistedtreatmentwherewearenow.pdf>; <http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf>; <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/20150713tlo5integratinggsud.pdf>
- ¹²⁶ <http://www.aatod.org/wp-content/uploads/2016/07/2nd-Whitepaper-.pdf>
- ¹²⁷ <https://effectivehealthcare.ahrq.gov/ehc/products/636/2350/opioid-use-disorder-report-161123.pdf>
- ¹²⁸ For example, see requirements for pre-approved days in Vermont Medicaid: <http://legislature.vermont.gov/assets/Legislative-Reports/SA-res-care-days12.12.14.pdf>; also see prohibition on prior authorization of certain services in Massachusetts: <http://www.mass.gov/courts/docs/csat-access-to-substance-use-disorder-treatment-in-mass.pdf>
- ¹²⁹ Health Care Service Corporation (BlueCross BlueShield of Illinois, BlueCross BlueShield of Montana, BlueCross BlueShield of Oklahoma, BlueCross BlueShield of New Mexico, and BlueCross BlueShield of Texas) Behavioral Health Care Management, *2016 Behavioral Health Medical Necessity Criteria*.
- ¹³⁰ <http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/CDProvider%20Manual/CDProviderManualSFY17.pdf>

¹³¹ Unpublished data from DPHHS.

¹³² http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final; <http://www.abhw.org/publications/pdf/ABHW%20Opiod%20Paper.pdf>

¹³³ https://chpw.org/resources/Providers/MAT_Guidelines.pdf

¹³⁴ <http://khn.org/news/facing-pressure-insurance-plans-loosen-rules-for-covering-addiction-treatment/>

¹³⁵ <https://www.macpac.gov/wp-content/uploads/2016/03/The-Medicaid-Institution-for-Mental-Diseases-IMD-Exclusion.pdf>

¹³⁶ <http://leg.mt.gov/bills/mca/53/24/53-24-208.htm>; <http://www.mtrules.org/gateway/Subchapterhome.aspx?scn=37%2E27%2E1>; <http://leg.mt.gov/css/committees/interim/2015-2016/Children-Family/Meetings/Aug-2016/aug-2016.asp>; <http://leg.mt.gov/content/Committees/Interim/2015-2016/Children-Family/Legislation/aug2016-dphhs-behavioral-health-care-act.pdf>

¹³⁷ <http://www.wsipp.wa.gov/BenefitCost?topicId=7>

¹³⁸ Based on communication with DPHHS. Dual-licensed individuals are listed in BCBS databases available to the State as LCPC or LCSW, rather than LAC. The estimate of 120 is based on a previous evaluation of dual-licensed LCPS/LCSWs and LACs contracted for the BCBS PPO network, although the number who chose to contract with the TPA network is unknown.

¹³⁹ http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_195241.pdf

¹⁴⁰ <http://digital.vpr.net/post/new-law-expands-medicaid-licensed-drug-and-alcohol-abuse-counselors>

¹⁴¹ <https://oasas.ny.gov/admin/hcf/apg/index.cfm>

¹⁴² JBS on behalf of SAMHSA, *TA 6367 Summary Report: Montana SYT-I, September 7–8, 2016*.

¹⁴³ For example, see: <http://icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf>

¹⁴⁴ <http://atforum.com/2016/04/treatment-otp-paid-costs-more-than-price-medication/>

¹⁴⁵ Communication with DPHHS.

¹⁴⁶ <http://www.montanabudget.org/wp-content/uploads/2016/09/AI-MedEx-report-FINAL.pdf>; http://billingsgazette.com/news/state-and-regional/montana/tribes-begin-to-benefit-from-health-care-reform-but-more/article_213a5707-93a9-5f29-8727-35b37513f8ca.html

¹⁴⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112816.pdf>

¹⁴⁸ <https://dphhs.mt.gov/Portals/85/Documents/biennialreports/FINAL%20PRINTED%20%201-7-17%202017%20MEDICAID%20REPORT.pdf>

¹⁴⁹ http://www.mthcf.org/wp-content/uploads/2016/01/Tribal-Consultation-Summary-Report_January-29-2016-FINAL.pdf

¹⁵⁰ DPHHS, *Medicaid: Reimbursement Types for Chemical Dependency Services FAQs*, August 11, 2015; and DPHHS, *Non-Medicaid: Reimbursement Types for Chemical Dependency Services FAQs*, August 11, 2015.

¹⁵¹ Communication with DPHHS.

¹⁵² <https://medicaidprovider.mt.gov/Portals/68/docs/manuals/IHS/IHSManual08082016.pdf>; <https://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2016/prov57ihfs012016.pdf>; <https://www.gpo.gov/fdsys/pkg/FR-2016-03-09/pdf/2016-05252.pdf>

¹⁵³ <http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf>

¹⁵⁴ Manatt Health, *Justice Involved Populations and Medicaid: Potential Strategies to Connect Justice Populations to Care*, Departments of Corrections and Public Health and Human Services Working Session, December 1, 2016.

¹⁵⁵ <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

¹⁵⁶ <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

¹⁵⁷ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf>

¹⁵⁸ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>;
<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amend-ext-app-08302016.pdf>

¹⁵⁹ <http://www.dhhs.nh.gov/section-1115-waiver/documents/approval-protocols.pdf>

¹⁶⁰ The Designated State Health Programs (DSHPs) would not be required to enroll as Medicaid providers; instead, the State would use the funds generated from receipt of federal match for the DSHPs to invest in Medicaid services proposed under the waiver. See: https://www.illinois.gov/hfs/SiteCollectionDocuments/1115%20Waiver%20for%20CMS%20Submission_final.pdf

¹⁶¹ http://health.utah.gov/MedicaidExpansion/pdfs/Utah_1115_Waiver_Amendments_Extension7-16.pdf

¹⁶² <http://www.dhhr.wv.gov/bms/News/Documents/WV%20Proposed%20Medicaid%20SUD%20Waiver%20Application.pdf>

¹⁶³ https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver.pdf

¹⁶⁴ <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management>

¹⁶⁵ <http://medicaidprovider.mt.gov/Portals/68/docs/forms/PABuprenorphinecontainingproducts.pdf>

¹⁶⁶ <https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone>

¹⁶⁷ The State has “white bagging” process where certain injectable drugs and other high-cost items may be prescribed by FQHCs and RHCs for a Medicaid enrollee, filled and billed by an outpatient pharmacy, and then delivered directly by the pharmacy for the physician to administer. For medications that require prior authorization, including Vivitrol, the pharmacy or the prescriber must call to explain that the drug is being white-bagged.

¹⁶⁸ DPHHS, letter on MAT from Mary Dalton to Community Medical Services, April 2016.

¹⁶⁹ <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

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