State Financing For Medication-Assisted Treatment: 
Results And Observation From A 
50-State NCSL/AVISA Survey (March 2008)

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Background
Medication-assisted treatment for opiate addiction and other substance dependence is not as widespread in the public sector as might be expected, given the evidence base and scientific support behind it. It is necessary to understand public reimbursement and coverage issues and managed care processes that apply to these treatments in order to assess public coverage acceptance, indifference to or rejection of these treatments at the state level, which often sets the stage for wider acceptance. For this reason, The National Conference of State Legislatures (NCSL) and Avisa collaborated in March 2008 on a 50-state survey of the states as to whether and to what extent they supported medication-assisted opiate dependence treatment with public reimbursement and/or direct state funding. Questions were asked about naltrexone, methadone and buprenorphine funding and initiatives.

The results of this survey are of even greater interest since the Wellstone/Domenici Mental Health and Addictions Parity bill was signed. Medicaid managed care plans and self-insured employer plans for more than 50 people, once exempted from the federal parity bill, now are part of the federal mental health and addictions parity amendment to the Employee Retirement Income Security Act (ERISA). Any stronger applicable state parity laws were left intact. In that context, the survey’s findings were revealing. The survey showed that coverage of medication-assisted treatment for opiate dependence under any public funding at the state level currently is limited. It also is inconsistent among the states.

The survey showed that many of the state agencies involved are not working in concert with one another and that their positions on and understanding of facts on the subject may vary considerably. The results make it clear that, although coverage or funding is necessary to begin the process, acceptance of public funding for medication-assisted treatment still is not widespread among the states. Even when acceptance occurs, access to medications may not be easily available. Coverage is necessary, but it is not sufficient for access. A comparison of access to and sales of these medications in the public and private sectors makes clear the substantial differences in access to opiate medications and treatments. This may create or
contribute to disparities in the care afforded to the privately insured and paying patient and the low-income, sometimes higher-risk, patients served by the public system.

**Survey Methodology**
The NCSL/Avisa sent the survey via email from NCSL to state Medicaid directors, State directors of substance abuse, and state methadone authorities. The survey was deliberately sent to multiple respondents in each state in case multiple agencies are involved in funding medication-assisted treatment. In some cases, telephone interviews and faxes supplemented the e-mails when conflicting answers were received from the agencies. State responses sometimes varied or even conflicted among the responding agencies. Responses that varied within the same state were returned to those involved to resolve the discrepancies among themselves. States saw only their own results for purposes of verification. Aggregate results were affirmed before any analyses or tables were prepared. The survey contained questions regarding coverage and special use, pre-authorization or formulary requirements for public sector funding and use of methadone, buprenorphine and naltrexone and associated counseling, with respect to public sector treatment of opiate addiction. We received responses from 47 states after up to four follow-up calls. Complete results are available on the NCSL Medication-Assisted Treatment for Opiate Addiction project website at [http://www.ncsl.org/programs/health/forum/mat.htm](http://www.ncsl.org/programs/health/forum/mat.htm).

**NCSL/Avisa MAT Survey Topics**
NCSL/Avisa asked states about Medicaid, the Substance Abuse Prevention and Treatment (SAPT) block grant or other state financing (or lack thereof) for MAT for opiate addiction, by medication (methadone, buprenorphine and naltrexone). Questions were included about funding for the coordinated counseling that is recommended clinically for maximum treatment effectiveness. We examined SAPT block grant “coverage” of medication-assisted treatment for opiate addiction, by medication. We asked about other existing or planned state/Medicaid funding that would be offered by the state for medication-assisted treatment for opiate addiction, by medication. Finally, we asked that the states provide information about any additional state medication-assisted treatment funding initiatives and anticipated policy changes in opiate addiction treatment or prevention. Many states had different rules for funding and access under fee-for-service Medicaid than for Medicaid managed care plans contracted with the states.

**Some Important Limitations**
To lessen the burden on respondents and to permit quicker analysis, survey responses were collected at only one point in time and were not subjected to external verification or audit via, for example, claims data. In many states, however, multiple respondents validated the responses, which improved accuracy. Still, changes in coverage and access requirements could have occurred since March in some states. The new parity requirements that now affect Medicaid managed care plans also could alter or improve coverage in states that permit Medicaid to cover substance abuse treatment. It is not yet clear that the parity act will change access to pharmaceutical medications, nor how long it will take for it to be implemented by the states and their health plans.

**General Findings**
Medicaid coverage of the three substance abuse medications was not common among the states, but it was far more common than coverage of the associated substance abuse
counseling or recovery support services. Under Medicaid rules, substance abuse services are an option for states, not a requirement. In a small follow-up study by Avisa, states were asked whether they funded methadone treatment under the rehabilitation, the clinic or the outpatient services options. Of seven states contacted, all but one large state reported they use either the clinic or the rehabilitation options or both. A variety of special rules and pre-authorization requirements or full-fledged managed care approval processes were described by many states as applying to the opiate addiction medications and to the recommended counseling, treatment and recovery supports that typically accompany them. Some states covered none of the medications, some covered one, and some covered all three, often under different rules, especially for methadone. Unlike buprenorphine or naltrexone, methadone is offered in a separate patient service system and, when used for treatment of opiate addiction, is dispensed, not prescribed like the other two medications.

**Findings of Substantial Differences Between State-Reported Coverage and Sales of the One Medication**

Several large states reported covering buprenorphine via Medicaid or funding it through state-only revenues or from the block grant funds. Sales data for these states subsequently obtained by Avisa from the manufacturer for that same time period, however, showed little or no relationship to the state-reported coverage. In other words, even when formal coverage is available, more sales in the public sector or increased in public access to this evidence-based treatment may not occur. This finding is, perhaps, surprising given the fact that buprenorphine was the opiate addiction medication most often reported to be covered by state Medicaid programs. Private-sector sales of Buprenorphine nationally increased rapidly after the medication was launched, increasing from 48,000 prescriptions for the two buprenorphine formulations in 2003 to 1.9 million prescriptions in 2007 (IMS data reported in Tami Mark et al, *Alcohol and Opioid Dependence Medications, Drug and Alcohol Dependence* 2008, in press, available online at sciencedirect.com). The authors note, however, that overall substance dependence medications, including those for opiate dependence, are experiencing relatively small sales in comparison to the size of the opiate-addicted population who could benefit from them.

**More NCSL/Avisa Survey Findings**

States also reported that Substance Abuse Prevention and Treatment block grant funds were rarely or never used to cover medication-assisted treatment for opiate addiction. The few exceptions occurred in states cases where states supplemented medication-assisted treatment funding in methadone clinics to permit them to offer these medications.

**Distribution of Coverage Among States**

Out of 18 possible coverage policies states could report they provide, the median number of actual coverage options implemented among the 47 respondent states was six. One-quarter of the states have implemented fewer than four of the possible coverage policies listed in the survey, and one-quarter have implemented nine or more. The statistical correlation between actual public sector sales of buprenorphine and the number of coverage policies states have implemented is quite low: \( r^2 = .08 \), confirming that coverage only opens the door to implementation, which continues to lag in both the public and private sectors.

**Anticipated Changes**
Only a few states reported that they anticipate any funding increases for opiate addiction prevention and treatment programs or changes in policy regarding medication-assisted treatments or medications for opiate addiction.

**Policy Results and Possible Issues**
States and state Medicaid plans varied from no coverage to substantial coverage of medication-assisted treatments (medication and counseling) for opiate addiction. More precisely, the number of coverage strategies employed among the 47 respondent states varied from 0 to 17, with a median of six. Interstate variations in coverage are the norm. They predominantly affect the lower-income and potentially higher-risk people who use public sector-funded opiate dependence treatments. Fewer than one-quarter of respondent states reported that they plan any medication-assisted treatment for opiate addiction affirmative coverage or policy changes or other medication-assisted treatment enhancements in the near future. States did not report any special incentives to increase coverage initiatives for opiate-dependent people. Access to and implementation of medication-assisted treatment for opiate addiction (or other drug dependence that can be thus treated) also is reported to be subject to a variety of specific rules and authorization requirements focused on state-level medication-assisted treatment.

**Implications**
MAT coverage alone or partial coverage of medications only is not sufficient to ensure actual and equitable access to evidence-based medication-assisted treatments for opiate and other substance dependence. A focus on the quantitative results of policy, as measured by actual use of medication-assisted treatment in target populations would be required to measure true access and serve as a baseline for monitoring any policy changes.