Medicaid is the largest source of public insurance in the US and plays a major role in financing substance use disorder (SUD) treatment. Nearly 4 in 10 outpatient SUD treatment episodes are financed by Medicaid.\(^1\) In 2018, only 12 states paid for the full continuum of services to treat SUD in their Medicaid programs.\(^2\) In response to opioid and other drug epidemics, state Medicaid agencies have recently undertaken several reforms. Many states have adopted section 1115 demonstration waivers\(^3\) to expand access to residential treatment in Medicaid. Several states have expanded access to medications for opioid use disorder. Others have added payment for peer recovery support.

A critical mechanism through which states can improve SUD treatment is through their contracts with managed care organizations (MCOs). States enroll fully 69.5% of Medicaid beneficiaries in mandatory managed care programs. Most states (36 of 41) with Medicaid managed care programs include both inpatient and outpatient SUD services in their contracts with MCOs primarily focused on physical health. The remaining 5 states “carve out” SUD services, contracting with separate behavioral health MCOs to manage them.\(^4\) Medicaid MCOs shape access to and quality of SUD treatment through their clinician and facility networks and payment, coverage of services, performance measurement, investments in care coordination, and utilization management, among other activities. States can shape MCO behavior on these domains through the standards, financial incentives, performance measures, and enforcement mechanisms embedded in their contracts with MCOs.

In this policy context, both state-level and MCO-level variation in performance and outcomes for SUD treatment in Medicaid is likely to exist. Yet, while the Centers for Medicare & Medicaid Services (CMS) reports a handful of SUD-related performance measures at the state level,\(^5\) few estimates are available for MCOs. This information gap is striking given Medicaid’s important role in financing SUD treatment and managed care’s important role in Medicaid.

A cross-sectional study by Alegría and colleagues\(^6\) in this issue of *JAMA Health Forum* seeks to fill this gap. The authors analyze 9 years of data from New York City, where two-thirds of Medicaid beneficiaries in New York state reside. They compare performance on a variety of SUD-related access and quality indicators across 9 MCOs using data from 159,016 adults from 2009 through 2017.

The study\(^6\) has 2 key strengths. The first is the use of a comprehensive set of 19 metrics, covering domains related to screening for SUD, multiple indicators of initiation and engagement in treatment, follow-up care, identification of co-occurring mental health conditions, receipt of psychosocial interventions, outcome measures related to readmission and relapse, and per capita expenditures on SUD treatment. Some measures were obtained from measure stewards, such as the National Committee for Quality Assurance, and others were obtained from the peer-reviewed literature. This breadth of measures is an improvement on prior Medicaid studies that compared only a handful of SUD metrics. The study provides a road map for states to develop a comprehensive set of performance measures for SUD.

The second strength is the use of random MCO assignment to mitigate confounding due to differences among beneficiaries in the prevalence or severity of SUD in estimates of MCO-level performance.\(^6\) This approach takes advantage of a distinctive feature of Medicaid policy, which is the use of mandatory managed care with auto-assignment to MCOs. Nearly 25 million Medicaid enrollees are expected to be assigned to an MCO over the next decade.\(^7\) The fraction of enrollees assigned to
a MCO (because they do not make a choice or are not given a choice of plan) varies significantly from
less than 10% in New York to 100% in Hawaii and Tennessee.7 In the study by Alegria and
colleagues,6 participants were drawn from the 4% of enrollees who were randomly assigned, which
may limit generalizability, as the authors acknowledge.

The study6 reports 2 key findings. First, overall performance on the SUD metrics was poor. Only
2.6% of eligible Medicaid beneficiaries received tobacco screening, and 2.2% eligible for smoking
cessation were engaged in that care. Only 25.8% received follow-up care within 14 days of
withdrawal (detoxification) management. Similarly, only 23.1% received outpatient follow-up within
30 days of an emergency department visit for alcohol or other drug use disorder. Even the indicator
with the best performance—engagement in opioid pharmacotherapy—was delivered to only 58.1% of
eligible beneficiaries.

The second key finding was that plan-level differences in performance were modest or
nonexistent.6 For 10 of the 18 indicators on which plan-level differences were assessed, there were
no statistically significant differences across the 9 MCOs, including on most process measures of
care. Two notable exceptions were for SUD treatment initiation, where 2 plans performed 9.1 and 15.2
percentage points below the mean plan performance, and monthly SUD treatment expenditures,
which varied by roughly $100 across plans, a substantial amount considering that spending on all
enrollees was included, not just those with SUD. Statistically significant differences were noted in 3
of 4 outcome measures with small but clinically meaningful differences in readmission and relapse
across MCOs.

The study by Alegria and colleagues6 has important policy implications for the federal
government, states, MCOs, and researchers. The CMS could stimulate the development and
reporting of a comprehensive set of SUD performance measures in Medicaid. The CMS identified 20
measures to include in its 2022 Behavioral Health Core Set for voluntary reporting by state Medicaid
programs.8 Unfortunately, only 5 of the 20 measures relate to SUD treatment, and all are process
measures. There is an urgent need for CMS to work closely with quality measure stewards, states,
and researchers to develop comprehensive SUD performance measures for Medicaid. Measures
should assess quality throughout the care continuum, including screening and identification of SUD;
initiation and engagement in treatment; follow-up after acute care, detoxification, and residential
treatment; continuity of care; and receipt of psychosocial and pharmacologic care. These efforts
could prioritize outcome measures, which are lagging for SUD treatment, such as client experience
and satisfaction with SUD treatment collected via survey data.

State Medicaid agencies can build on their efforts to expand treatment options for SUD in
Medicaid by instituting comprehensive performance measurement. Performance measures could be
publicly reported for the state overall and regions or counties, by MCO, and by subgroup to identify
inequities among the Medicaid population. Once a robust system of performance measurement is in
place, states can hold MCOs accountable for performance on SUD treatment. Notably, only 17 states
have specified performance programs with financial quality incentives tied to any measures of SUD
care in their contracts with MCOs.9

Finally, expanded research is urgently needed on SUD treatment in Medicaid managed care.
Findings from studies of access, quality, and cost (in general, not specific to SUD) in Medicaid
managed care are mixed and point to substantial variation by state and population.10 The recent
availability of more complete data on Medicaid managed care encounters (from the Transformed
Medicaid Statistical Information System Analytic Files) should enable researchers to fill important
knowledge gaps. Researchers should partner with Medicaid MCOs to identify the features of
managed care that yield the best performance on SUD care and address many unanswered
questions. What are optimal rates of reimbursement for physicians prescribing pharmacotherapy for
opioid or alcohol use disorder? How can care coordination be targeted to improve SUD outcomes?
What value-based payment models achieve the best outcomes for beneficiaries with SUD?
Coordinated efforts by CMS, states, MCOs, and researchers can address the substantial gaps in SUD
performance in Medicaid managed care to improve outcomes for vulnerable populations.
Meeting the Needs of Medicaid Beneficiaries With Substance Use Disorders in Managed Care

REFERENCES


