



INSTITUTE FOR
MEDICAID INNOVATION

OPIOID EPIDEMIC

CRISIS TO CARE IN MEDICAID

JUNE 22, 2017

Russell Senate Office Building
Room 485
Washington, DC
10:00am - 12:30pm

#OPIOIDSUMMIT

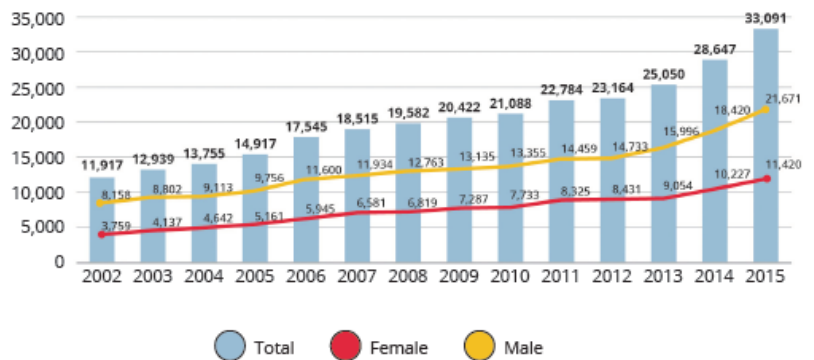
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Opioid misuse has increased over time, contributing to hospitalizations and overdose deaths. This is especially true for the Medicaid population.

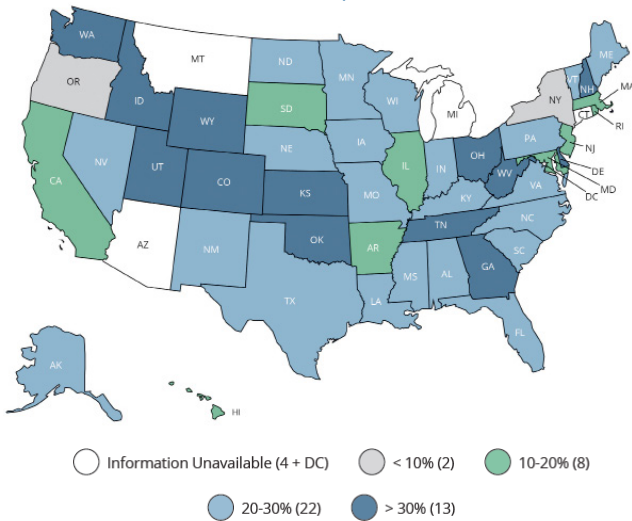
From 2000 to 2012, the rate of adult inpatient stays related to opioid misuse and dependence has nearly doubled.¹

Since 2000, drug overdose deaths from opioids have increased by 200 percent (right).² In fact, drug overdose has become the leading cause of injury death.³

National Overdose Deaths from Opioid Drugs, 2002–2015



Rates of Prescription Opioid Dispensing During Pregnancy for Women Enrolled in Medicaid by State, 2000–2007



From 2000 to 2009, rates of opioid misuse have increased from 1.19 to 5.63 for every 1,000 hospital births per year.⁴

Additionally, use of prescription opioids during the postpartum period may be a trigger for persistent opioid use.⁵

Women enrolled in Medicaid are more likely to use prescription opioids during pregnancy. They are also more likely to be prescribed opioids for pain during the postpartum period (left).⁶

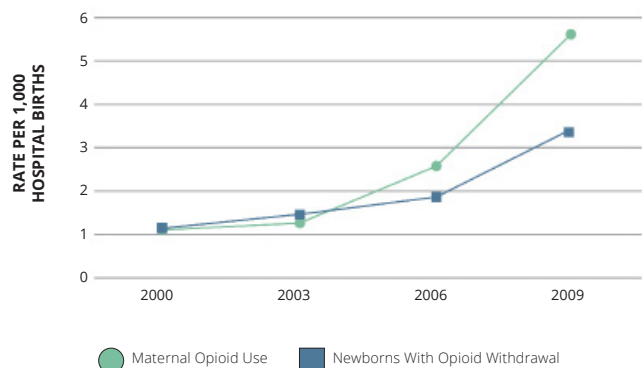
Medicaid is the largest payer of opioid-related hospital stays.

From 1993 to 2012, the Medicaid program covered the majority of opioid-related hospital inpatient stays (left).⁷

Infants born with neonatal abstinence syndrome (NAS) or presenting with withdrawal symptoms are commonly admitted into the neonatal intensive care unit (NICU).

Coinciding with the rise of opioid misuse, the national incidence of opioid-related NAS among newborns has increased from 1.2 - 3.39 for every 1,000 hospital births between 2000 to 2009, and from 3.4 - 5.8 for every 1,000 hospital births between 2009 to 2012 (right).^{4,8}

Weighted National Estimates of Rates of NAS and Maternal Opioid Use per 1,000 Hospital Births by Year



Substance use counseling and medication assistance treatment (MAT) are evidence-based approaches to treat opioid misuse amongst pregnant women.

However, criminalization policies, program capacity limitations, and provider shortages may prevent women from receiving treatment.

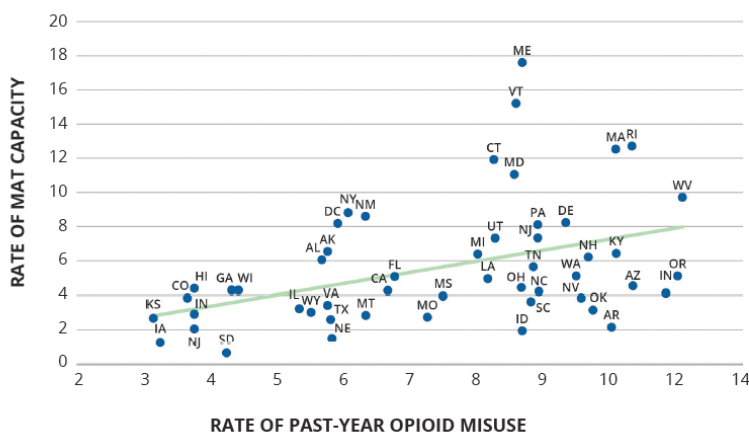
Medication assistance treatment (MAT) is defined as “the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.”⁹

The standard of care to treat opioid use disorder in pregnant women is a referral for MAT with a prescription for methadone. However, growing evidence suggests that single entity buprenorphine may be used as an alternative under certain circumstances.^{4,10-12}

An analysis of the 2012 National Survey of Substance Abuse Treatment Services (N-SSATS) found that only 13 percent of outpatient-only substance use treatment programs and 13 percent of residential treatment facilities offered programs tailored for pregnant and postpartum women.¹³

As of March 2017, 27 states have developed drug treatment programs that are specific for the needs of pregnant women.¹⁴

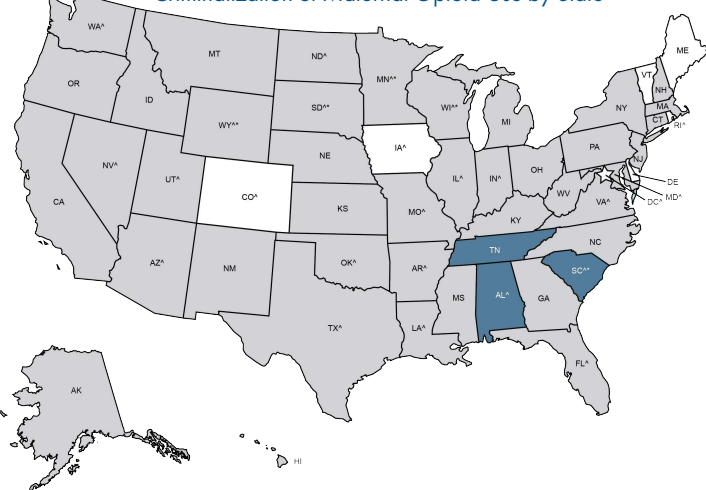
Comparison of State Rates of Past-Year Opioid Users and Capacity to Provide Medication-Assisted Treatment, 2012



From 2003 to 2012, the number of Drug Addiction Treatment Act (DATA)-waived physicians with 30- and 100-patient limits grew.¹⁵

Despite this growth, the number of individuals with opioid misuse disorder requiring treatment exceeded the number of available clinicians.¹⁵

Criminalization of Maternal Opioid Use by State



In 44 states, there are legal consequences for pregnant women who seek treatment for opioid misuse (left).^{14,16} The criminalization of pregnant women may disincentivize them from accessing needed treatment for themselves and their neonates, further contributing to the stigma of opioid misuse.

Substance Use during Pregnancy:

- Is a crime and results in Prosecution (3)
- Results in Prosecution (41)
- ▲ Is considered Child Abuse (24 + DC)
- ★ Is grounds for civil commitment (4)

Additional efforts are needed to slow the rate of opioid misuse and deaths from overdose in pregnant and postpartum women enrolled in the Medicaid program.



Clinical Priorities

- Treat opioid use disorder and substance use disorders as a chronic medical condition.
- Create opportunities for clinician education of clinical guidelines and evidence-based treatments across clinical specialties.
- Develop standardized, national clinical guidelines.



Research Priorities

- Conduct medical research to evaluate causes for opioid misuse targeted to pregnant and postpartum women.
- Identify evidence-based interventions that are designed to address opioid misuse among pregnant and postpartum women.
- Expand evidence base for non-opioid treatment options for pain management.



Policy and Advocacy Priorities

- Replace criminal penalties, prosecution, and incarceration of pregnant and postpartum women with increased access and coverage for opioid treatment programs.
- Develop streamlined and efficient enrollment processes for pregnant women.
- Engage multiple stakeholders to address opioid misuse in a concerted effort.
- Develop a national prescription drug monitoring program (PDMP).
- Expand workforce development to increase the number of clinicians trained to prescribe and/or provide MAT.

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