



October 2019

MEDICAID

Opioid Use Disorder Services for Pregnant and Postpartum Women, and Children

Why GAO Did This Study

The misuse of prescription opioid pain relievers and illicit opioids, such as heroin, has contributed to increases in OUD and overdose deaths. Pregnant women with OUD have an increased risk of overdose during the postpartum period. Opioids also caused over half of drug overdose deaths among youth in 2017. Medicaid plays a key role in covering services to treat OUD for low-income women and children.

The SUPPORT Act includes a provision for GAO to study Medicaid coverage for pregnant and postpartum women with a substance use disorder, including OUD. The act also includes a provision for GAO to examine children's access to these services, such as through telehealth. This report describes Medicaid coverage of OUD services for (1) pregnant and postpartum women in selected states; (2) children in selected states; and (3) children delivered via telehealth in schools across all states, and utilization of these services.

GAO reviewed documentation and interviewed officials from federal agencies within HHS to understand Medicaid coverage of OUD services for pregnant and postpartum women, as well as children. GAO also interviewed officials and reviewed documentation from six states selected for variation in opioid use rates, status of Medicaid expansion, and geographic variation, among other things. GAO also conducted outreach and received responses from 49 of 50 states and the District of Columbia about Medicaid coverage and use of OUD services delivered via telehealth in schools.

HHS provided technical comments, which were incorporated as appropriate.

View [GAO-20-40](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

MEDICAID

Opioid Use Disorder Services for Pregnant and Postpartum Women, and Children

What GAO Found

All state Medicaid programs are required to provide coverage of health care services to pregnant women with incomes at or below 138 percent of the federal poverty level through 60 days postpartum. With regard to opioid use disorder (OUD), GAO found that six selected state Medicaid programs provide coverage of a range of services for eligible pregnant women with OUD. Specifically, the six states—Alabama, Arkansas, Colorado, Massachusetts, South Dakota, and Texas—covered OUD services, such as screening for opioid use, counseling, and medication-assisted treatment, which combines the use of medications with counseling. In the six selected states, women who are eligible for Medicaid coverage after 60 days postpartum can receive most of the same OUD services that were covered during pregnancy. Furthermore, GAO found that the six selected states also use other sources of funding, such as federal grants, to provide coverage of OUD services for postpartum women who are not eligible for Medicaid. GAO did not review how frequently the OUD services were actually provided to pregnant and postpartum women.

GAO found that the state Medicaid programs in all six selected states cover annual screenings for substance use, which includes opioid use, for eligible children. This coverage is provided as part of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, under which all states are required to cover certain screenings for eligible children under age 21.

GAO also found that Medicaid programs in 31 states and the District of Columbia covered OUD services, including screenings, delivered through telehealth in schools. However, state Medicaid officials said they were not aware of any instances of these services being utilized through telehealth in schools. Telehealth can be used to provide clinical care remotely, such as for screening, counseling, and therapy. Such services could be provided, for example, via a video conference on a desktop computer or laptop that connects a student in school with a provider in another location. State officials and experts cited both benefits and challenges with providing OUD services through telehealth in schools. For example, benefits included addressing provider shortages, particularly in rural areas, as well as reducing the amount of time students spend outside of the classroom accessing services. Challenges included lack of needed infrastructure and provider discomfort with using telehealth. Agencies within the Department of Health and Human Services (HHS) have recently issued guidance emphasizing the use of telehealth for OUD services, particularly in schools.

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Abbreviations

| | |
|-------------|--|
| AAP | American Academy of Pediatrics |
| CMS | Centers for Medicare & Medicaid Services |
| CRAFFT | Car, Relax, Alone, Forget, Friends, Trouble screening tool |
| ECHO | extension for community healthcare outcomes |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment |
| FPL | federal poverty level |
| HHS | Department of Health and Human Services |
| HRSA | Health Resources and Services Administration |
| MAT | medication-assisted treatment |
| OD | opioid use disorder |
| PPACA | Patient Protection and Affordable Care Act |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | screening, brief intervention and referral to treatment |
| SUPPORT Act | Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act |

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October 24, 2019

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone
Chairman
The Honorable Greg Walden
Republican Leader
Committee on Energy and Commerce
House of Representatives

The misuse of and addiction to prescription opioid pain relievers and illicit opioids, such as heroin, have contributed to increases in opioid use disorder (OUD), as well as overdose deaths, in the United States. Over 70,000 people died from drug overdoses in 2017, according to the Centers for Disease Control and Prevention, and opioids are a main driver of overdose deaths. Low-income pregnant and postpartum women, as well as children, are particularly vulnerable to the adverse effects of OUD. Pregnant women with OUD face a high risk of poor neonatal outcomes, such as having preterm labor or having a newborn with neonatal abstinence syndrome, and have an increased risk of overdose during the postpartum period.¹

Medicaid, the federal-state program that finances health care coverage for low-income and medically needy populations (including eligible pregnant women and children), plays a key role in covering services for the treatment of OUD. The Centers for Medicare & Medicaid Services (CMS)—a federal agency within the Department of Health and Human Services (HHS)—oversees Medicaid, while each state administers its own Medicaid program. State Medicaid programs must provide health

¹Neonatal abstinence syndrome is a withdrawal condition within infants that can result from the prenatal use of opioids by pregnant women. Symptoms range from excessive crying and irritability to difficulties with breathing and feeding. For more information, see GAO, *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome*, [GAO-18-32](#) (Washington, D.C.: Oct. 4, 2017).

care coverage to certain pregnant women, including those with incomes at or below 138 percent of the federal poverty level (FPL) through 60 days postpartum.² However, states have flexibility in determining which specific services are covered. Congress and stakeholders have raised questions about the extent to which OUD services are covered under states' Medicaid programs during pregnancy, as well as whether women who qualify for Medicaid during pregnancy can continue receiving OUD services beyond 60 days postpartum.

Congress has also raised questions about whether children have adequate access to OUD screening and treatment services under Medicaid. Among adolescent children, the rate of opioid use remains relatively low compared to other substances; according to the National Institute on Drug Abuse, in 2018, approximately 6 percent of 12th graders reported using an opioid in their lifetime.³ Nevertheless, opioids caused over half of drug overdoses among youth in 2017. According to the Office of National Drug Control Policy, the most effective way to mitigate the costs associated with illicit drug use is through prevention, which includes having primary care providers screen and intervene with patients at risk for opioid use. CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA)—a federal agency within HHS that leads public health efforts to reduce the impact of substance abuse and mental illness—jointly issued guidance in July 2019 stating that early intervention and treatment are critical to improving outcomes and that schools can fill a critical role in identifying children with OUD and referring them to treatment.⁴ This guidance also states that telehealth—the use of technology, including interactive telecommunication, to deliver health care services, such as counseling, to patients—can be an effective way to increase children's access to mental health services. However, little has

²42 U.S.C. § 1396a(a)(10)(A)(i)(IV). Medicaid coverage for pregnant women continues until the last day of the month in which the woman reaches 60 days postpartum at a minimum, and states have discretion to extend coverage further. Federal law provides a 5 percent disregard when calculating Medicaid eligibility, such that the minimum threshold is effectively 138 percent of the federal poverty level. The FPL is based on household income and family size, using the U.S. Census Bureau's poverty thresholds. In 2019, 138 percent of FPL for an individual was \$17,236, and for a family of four was \$35,535.

³National Institute on Drug Abuse at the National Institutes of Health, *Monitoring the Future National Survey Results on Drug Use 1975-2018: Overview, Key Findings on Adolescent Drug Use* (Ann Arbor, Mich.: January 2019).

⁴CMS and SAMHSA, *Joint Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools* (July 1, 2019).

been known about the extent to which OUD services are delivered through telehealth, particularly in schools.

The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) includes a provision for GAO to conduct a study on Medicaid coverage for pregnant and postpartum women with a substance use disorder, including OUD. The SUPPORT Act also includes a provision for GAO to study options to improve access to these services for children, including through telehealth in schools.⁵ This report describes

1. Medicaid coverage of OUD services for pregnant and postpartum women in selected states;
2. Medicaid coverage of OUD services for children in selected states; and
3. Medicaid coverage of OUD services delivered to children via telehealth in schools across all states, and what is known about utilization of these services.

To describe Medicaid coverage of OUD services for pregnant and postpartum women in selected states, we reviewed federal and state documentation, and interviewed federal and state Medicaid officials. Specifically, we reviewed CMS policies and guidance, and interviewed CMS officials to understand the federal parameters for Medicaid coverage of services for pregnant and postpartum women with OUD. We also reviewed documentation and conducted interviews with officials from six selected states—Alabama, Arkansas, Colorado, Massachusetts, South Dakota, and Texas. We selected these states to provide variation in OUD rates, Medicaid expansion status, and geographic location.⁶ We also included states with different levels of Medicaid coverage for pregnant women as of 2019, such as states that offer pregnancy-related coverage;

⁵Both provisions appear in a section of the SUPPORT Act entitled “Medicaid provisions to address the opioid crisis.” Pub. L. No. 115-271, §§ 1005(b), 1009(c), 132 Stat. 3894, 3913, 3917 (2018).

⁶We selected states using OUD rates based on SAMHSA’s 2016 National Survey on Drug Use and Health, which was the latest data available at the time we selected states. We also selected states based on states’ Medicaid expansion status as of November 2018 and confirmed the status remained the same for our six selected states in 2019. Medicaid expansion refers to whether a state expanded Medicaid eligibility to certain adults with incomes up to 138 percent of the FPL, as authorized under the Patient Protection and Affordable Care Act (PPACA).

states that offer coverage beyond 60 days postpartum; and states with specific programs for pregnant and postpartum women with OUD.⁷ We reviewed documentation—including state plans, health care provider manuals, and waivers—of the six selected states’ Medicaid coverage of OUD services for pregnant and postpartum women.⁸

In discussing OUD services covered for pregnant and postpartum women with state Medicaid and behavioral health officials, we refer to a set of services to treat OUD. Based on background research and interviews with CMS and other expert stakeholders, we were unable to identify an existing list of a standard set of services used to treat OUD. We therefore developed our own list of OUD services to discuss with states.⁹ We did this using documentation from CMS; the American Society of Addiction Medicine; and states, including information on state substance use disorder treatment programs.¹⁰ We interviewed state Medicaid and behavioral health officials about whether these services were covered for pregnant and postpartum women. However, we did not review state information to determine how frequently these services are actually provided to pregnant and postpartum women. We also requested the six selected states provide estimates of the number of women who

⁷Women covered under certain statutory eligibility pathways are not entitled to full Medicaid coverage and instead receive a limited package of benefits that CMS calls “pregnancy-related coverage.” See 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), (IX). Although most states provide full benefits for all pregnant beneficiaries, CMS has found that three states (Arkansas, Idaho, and South Dakota) do not.

⁸Under sections 1915(b) and 1915(c) of the Social Security Act, states may obtain waivers to provide services through managed care delivery systems or otherwise limit beneficiaries’ choice of providers, and provide long-term care services in home and community based settings, rather than in institutional settings. 42 U.S.C. §§ 1396n(b), (c). States may also implement certain changes to their Medicaid programs by obtaining approval for demonstration projects authorized under section 1115 of the Social Security Act. 42 U.S.C. § 1315.

⁹The list we developed represents service categories, such as counseling and inpatient residential services, not the specific service billing codes within these categories.

¹⁰The American Society of Addiction Medicine is a professional medical society representing over 6,000 physicians, clinicians, and associated professionals in the field of addiction medicine. The society published criteria that evaluate the appropriate venue for an individual to be treated for addiction based on a multidimensional assessment, and that are designed to define one national set of criteria for providing outcome-oriented and results-based care. See American Society of Addiction Medicine, *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed. (Chevy Chase, Md.: 2013). We also received state input on our list of OUD services to determine whether we were missing any specific services.

maintained Medicaid coverage after 60 days postpartum.¹¹ We asked state officials to describe the steps they took to compile and ensure the accuracy of these estimates, and determined that the estimates were sufficiently reliable for the purpose of our report. We also reviewed federal and selected states' documentation on SAMHSA grants that can be used to fund services for target populations—such as pregnant and postpartum women—and interviewed SAMHSA and state officials about these grants. The information we obtained from the selected states is not generalizable to other states or nationally.

To describe Medicaid coverage of OUD services for children, we focused our review on non-infant children and reviewed federal and state documentation, and interviewed federal and state Medicaid officials.¹² Specifically, we reviewed CMS policies and guidance, and interviewed CMS officials to understand the federal parameters for Medicaid coverage of children with OUD. We also reviewed documentation—including state plans and health care provider manuals—and interviewed officials from the six selected states about coverage of OUD services for children as of 2019.¹³ We also interviewed officials from the six selected states about any challenges in providing OUD services to children and any state initiatives to address children's access to OUD services. The information obtained from the selected states is not generalizable to other states or nationally.

To describe Medicaid coverage of OUD services delivered to children via telehealth in schools across all states, and what is known about utilization of these services, we conducted outreach via email and phone calls to all 50 states and the District of Columbia between February and July 2019. We obtained information about whether state Medicaid programs cover

¹¹Our analysis of Medicaid eligibility focused on income requirements. We did not consider other Medicaid eligibility criteria, such as disability.

¹²Non-infant children include children between the ages of 1 and 18. For the purpose of this report, "schools" refers to school-based settings, including school clinics and school-based health centers. School clinics are on-site and operated by the school. School-based health centers can also be on-site and typically operate as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department. The specific services provided by school-based health centers vary based on community needs and resources as determined through collaborations between the community, the school district, and the health care providers.

¹³We communicated with state Medicaid officials between July and September 2019 to verify their coverage of opioid use disorder services for children.

OUO services delivered via telehealth in schools and, if they do, to what extent such services have been provided.¹⁴ We also reviewed documentation and conducted interviews with officials from CMS and SAMHSA about guidance related to telehealth and delivery of OUO services in schools. We also reviewed documentation and spoke with officials from the Health Resources and Services Administration (HRSA), the federal agency within HHS that works on improving health care for vulnerable populations, about federal grants used to provide states with funding for telehealth programs. Lastly, we conducted interviews with officials from the six selected states, officials from four telehealth programs, and four subject matter experts to learn about any programs delivering OUO services via telehealth in schools, and any potential benefits and challenges of delivering OUO services via telehealth in schools.¹⁵

We conducted this performance audit from November 2018 to October 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁴In total, 49 states and the District of Columbia responded to our outreach. Illinois did not provide information in response to our outreach. For background purposes, we also reviewed a website maintained by the Center for Connected Health Policy, which summarizes each state's current laws and policies regarding telehealth. The Center for Connected Health Policy's website indicates that the organization was designated as a center of excellence in telehealth policy and provides technical assistance to state and federal policy makers, national organizations, health systems, providers, and the public.

¹⁵The four telehealth programs were operated by the following organizations: Anne Arundel County Public Schools in Maryland; the Ohio Department of Medicaid; the Pine Ridge Reservation in South Dakota; and Children's Health in Texas. The four expert stakeholders included the School-Based Health Alliance; the National Alliance for Medicaid in Education; the Weitzman Institute; and the Medicaid and CHIP Payment and Access Commission. The School-Based Health Alliance is a national non-profit organization that works to improve the health of children through school-based health care. The National Alliance for Medicaid in Education is a non-profit organization comprised primarily of school districts and state Medicaid and education agencies who are involved in administration of Medicaid claiming for school-based services. The Weitzman Institute is a community-based research center dedicated to quality improvement and research in primary care for underserved populations. The Medicaid and CHIP Payment and Access Commission is a legislative agency that provides policy and data analysis and makes recommendations to the Congress.

Background

Opioid Use Disorder

Opioids—such as hydrocodone, oxycodone, morphine, and methadone—can be prescribed to treat both acute and chronic pain. Many opioids have a high potential for abuse and may lead to severe psychological or physical dependence. OUD, which is a type of substance use disorder, is generally characterized by a loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal.¹⁶

According to SAMHSA and the National Institute on Drug Abuse, OUD is a chronic, treatable illness. SAMHSA states that treatment for OUD should be individualized and can include a range of treatment options that include medication and behavioral health services. Specifically, services related to the treatment of OUD include the following:

- **Screening** can identify individuals who have OUD, are at risk for developing OUD, or have medical problems related to opioid use. Screening, brief intervention, and referral to treatment (SBIRT) is a specific type of screening that involves a health care provider educating individuals with a positive screen for opioid use and referring them to specialized treatment, as needed.
- **Outpatient counseling and therapy** includes counseling and treatment services individually or in a group.
- **Inpatient hospital services** include those that occur in a hospital, such as services for detoxification.
- **Inpatient residential services** include care in a 24-hour residential setting. Inpatient residential providers offer medical care in combination with housing, typically lasting from a week to several weeks or more.
- **Medication-assisted treatment (MAT)** combines the use of certain prescription medications (such as methadone, buprenorphine, and naltrexone) and behavioral therapy. Methadone and buprenorphine suppress withdrawal symptoms and control the craving for opioids, while naltrexone suppresses the euphoric effects of opioids. Research

¹⁶According to SAMHSA, the American Psychiatric Association does not count tolerance and withdrawal toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision.

has shown that MAT for OUD reduces opioid use and increases the chance that patients will continue OUD treatment compared to abstinence-based treatment (where patients are treated without medication).¹⁷

- **Case management services** include providing coordination and management of care across multiple health care providers.
- **Crisis intervention** includes immediate care intended to prevent harm.
- **Peer recovery coaching** includes recovery support through a certified peer specialist with experience of recovery from addiction.

Medicaid Program Overview

States administer their Medicaid programs within broad federal requirements and according to a state plan approved by CMS. The Medicaid program allows states to design and implement their programs within certain federal parameters, resulting in more than 50 distinct programs. A state's approved Medicaid plan outlines the services provided and the groups of individuals covered. States also have the option of using waivers to expand services under the Medicaid program. As such, the types of services covered by Medicaid can vary across states.

Historically, Medicaid eligibility has been limited to certain categories of low-income individuals, such as children, parents, pregnant women, persons with disabilities, and individuals aged 65 and older. The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, allowed states to expand Medicaid coverage to nearly all individuals with incomes up to 138 percent of the FPL, regardless of eligibility category.¹⁸ As of October 2019, 33 states and the District of Columbia expanded Medicaid eligibility, and 17 states had not.

¹⁷GAO, *Opioid Use Disorders: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment*, [GAO-18-44](#) (Washington, D.C.: Oct. 31, 2017).

¹⁸Under federal law, states may opt to expand their Medicaid programs to cover non-elderly, non-pregnant adults who are not eligible for Medicare, and whose incomes do not exceed 138 percent of the FPL.

Medicaid Services for Pregnant and Postpartum Women

Under federal law, state Medicaid programs must provide coverage for health care services for certain pregnant women, including low-income pregnant women with incomes at or below 138 percent FPL.¹⁹ Most states opt to extend coverage to pregnant women with incomes above this threshold. By statute, states are permitted to limit the services covered for certain pregnant women, including low-income pregnant women, to services related to the pregnancy. Such coverage is referred to as “pregnancy-related coverage.” CMS defines pregnancy-related services as those services necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant, which includes prenatal, delivery, postpartum, and family planning services, as well as services for other conditions that may complicate the pregnancy.²⁰ In contrast, states are required by statute to provide pregnant women who qualify for Medicaid on another basis, such as a disability, full Medicaid benefits.²¹ At a minimum, states must provide Medicaid coverage for pregnant enrollees through 60 days postpartum, though states may extend coverage further.²² Some women may qualify for continued Medicaid coverage after the 60-day postpartum period if they meet the requirements for another eligibility pathway, such as for parents, while others may transition to other programs or become uninsured.

¹⁹42 U.S.C. § 1396a(a)(10)(A)(i)(IV). Specifically, states must provide coverage to low-income pregnant women with income at or below a threshold set at the greater of either (1) 138 percent FPL, or (2) the income threshold established in that state as of December 19, 1989 or in authorizing legislation as of July 1, 1989, up to 185 percent FPL. 42 C.F.R. § 435.116 (2019). For purposes of this report, we call these beneficiaries “low-income pregnant women.”

²⁰42 C.F.R. § 440.210(a)(2)(i) (2019). In 2012, CMS amended its regulation to clarify that, because the health of a pregnant woman and the expected child are intertwined, pregnancy-related services are necessarily comprehensive. 42 C.F.R. § 435.116(d)(3) (2019). However, as of February 2016, CMS found that three states (Arkansas, Idaho, and South Dakota) do not provide full benefits for all pregnant Medicaid beneficiaries.

²¹Full Medicaid coverage generally consists of all mandatory and optional benefits covered under a state’s plan. 42 C.F.R. § 435.116(d)(2) (2019).

²²Specifically, coverage must extend through the last day of the month in which the woman reaches 60 days postpartum, a period that begins on the last day of pregnancy. 42 U.S.C. § 1396a(e)(5).

Medicaid Services for Children

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is the primary mechanism to help ensure the provision of appropriate health care services to children under Medicaid. Under the EPSDT benefit, states are required to cover comprehensive health screenings and preventive health services, such as those related to vision and oral health, and all other Medicaid coverable services that are necessary to correct or ameliorate any conditions discovered through screenings.²³ States are required to follow a schedule of screenings, known as a periodicity schedule, that are recommended for children at specific ages and frequencies. States can develop their own schedule within federal parameters or follow an established schedule, such as from the American Academy of Pediatrics (AAP).²⁴

States are required to report annually on the provision of certain EPSDT services to CMS. States must report information on the number of children provided health screening services, the total number of health screenings services provided, the number of children referred for corrective treatment, the number of children receiving dental services, and the state's results in attaining EPSDT participation goals.²⁵ States may also voluntarily report annually on the quality of health care services provided under EPSDT using a set of quality measures known as the Child Core Set.²⁶ CMS plans to increasingly use the Child Core Set in the future and state reporting will be mandatory beginning with the state reports for fiscal year 2024.

²³The EPSDT benefit is a mandatory benefit covered under the state plan for all categorically eligible children until age 21 and may be provided at state option to children under age 21 who are eligible as medically needy individuals under Medicaid. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B). We refer to those services listed in section 1905(a) of the Social Security Act as Medicaid coverable services.

²⁴The AAP is a national organization that has published a recommended periodicity schedule, known as Bright Futures, since 1994.

²⁵42 U.S.C. § 1396a(a)(43)(D).

²⁶The Children's Health Insurance Program Reauthorization Act of 2009 required the Department of Health and Human Services to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and children's health insurance programs. See Pub. L. No. 111-3, § 401, 123 Stat. 8, 72 (codified as amended at 42 U.S.C. § 1320b-9a). For additional information, see GAO, *Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings*, [GAO-19-481](#) (Washington, D.C.: Aug. 16, 2019).

States also have flexibility in determining where EPSDT services can be delivered. As a means of improving access—particularly in underserved communities, such as rural areas—Medicaid programs may cover certain services delivered by health care providers in schools. There were approximately 130,000 schools across the United States as of 2016, according to data from the Department of Education. Some of these schools have health clinics. Additionally, there were approximately 2,600 school-based health centers as of 2017, some of which served children in underserved communities, according to the School-Based Health Alliance.²⁷

Telehealth as a Modality to Provide Services

Some state Medicaid programs allow for services to be delivered via telehealth, including in schools. Telehealth can be used to provide clinical care remotely, such as for screening, counseling, and therapy. Health care providers offer care to patients through remote technology, such as a live, two-way video call. Such services could be provided, for example, via a video conference on a desktop computer or laptop that connects a student in school with a provider in another location. States have flexibility to choose whether to cover services delivered via telehealth. Because the federal Medicaid statute does not recognize telehealth as a distinct service, CMS views telehealth as a service delivery mechanism. According to CMS, services delivered via telehealth are subject to the same Medicaid requirements as those services provided in person.²⁸

²⁷H. Love, et al., “Twenty Years of School-Based Health Care Growth and Expansion,” *Health Affairs*, vol. 38, no. 5 (2019): p.755-764.

²⁸CMS guidance notes that states do not need to obtain CMS approval to provide Medicaid services through telehealth unless they plan to pay for such services differently than they pay for face-to-face services. CMS, *State Medicaid Directors Letter: Leveraging Medicaid Technology to Address the Opioid Crisis*, State Medicaid Directors Letter #18-006 (Baltimore, Md.: June 11, 2018); and CMS and SAMHSA, *Joint Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools* (July 1, 2019).

Selected States Provide Medicaid and Other Coverage for a Range of Opioid Use Disorder Services for Eligible Pregnant and Postpartum Women

Selected States Provide Medicaid Coverage of Most Opioid Use Disorder Services for Eligible Pregnant Women and Women through 60 Days Postpartum

The Medicaid programs in our six selected states provided coverage of most OUD services during pregnancy and the first 60 days postpartum, as of January 1, 2019. Specifically, the selected states' Medicaid manuals indicate these states provide coverage for at least seven of the eight OUD services we identified in our review, such as screenings, inpatient and outpatient services, and MAT.²⁹ (See fig. 1.)

²⁹The terms "covered" or "coverage" refer to services that states covered under their state plans and any waivers. While the six selected states provide Medicaid coverage of OUD services, we did not review the extent to which OUD services were actually delivered to pregnant or postpartum women in the selected states. We also did not compare the number of services provided or duration of benefits allowed by the state.

Figure 1: Medicaid Coverage of Opioid Use Disorder Services for Eligible Pregnant Women in Selected States, as of January 1, 2019

| ODU Services | Alabama | Arkansas | Colorado | Massachusetts | South Dakota | Texas |
|--|---------|----------|----------|---------------|--------------|-------|
| Screening services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) | ● | ● | ● | ● | ● | ● |
| Outpatient counseling and therapy | ● | ● | ● | ● | ● | ● |
| Inpatient hospital services | ● | ● | ● | ● | ● | ● |
| Inpatient residential services | ● | ● | ● | ● | ● | ● |
| Medication-assisted treatment (medication component) | ● | ● | ● | ● | ● | ● |
| Case management | ● | ● | ● | ● | ● | ● |
| Crisis intervention | ● | ● | ● | ● | ● | ○ |
| Peer recovery coaching ^a | ● | ○ | ● | ● | ○ | ● |

- Service covered by Medicaid for pregnant women
- Service not covered by Medicaid for pregnant women

Source: GAO review of documentation and interviews with officials from six selected states. | GAO-20-40

Notes: We developed the list of opioid use disorder (OUD) services using documentation from the Centers for Medicare & Medicaid Services, the American Society of Addiction Medicine, and states, including information on state substance use disorder treatment programs. We also received state input on our list of OUD services.

Eligibility for pregnant women continues through 60 days postpartum. We asked states about Medicaid coverage of OUD services for low-income pregnant women. Arkansas and South Dakota officials told us they limit coverage for pregnant women to pregnancy-related services. Alabama, Colorado, and Texas officials told us they cover certain OUD services for pregnant women under Medicaid that they do not cover for other Medicaid beneficiaries. Massachusetts officials said they generally cover the same OUD services for pregnant women and other Medicaid beneficiaries.

^aPeer recovery coaching is generally not a covered service for pregnant women or other Medicaid-eligible beneficiaries in South Dakota. According to Arkansas officials, pregnant women covered under the state's Medicaid pregnancy-related coverage are not eligible for peer recovery coaching.

In the six states we reviewed, we did not identify differences between the types of covered OUD services for pregnant women in expansion and non-expansion states. For example, the three expansion states—Arkansas, Colorado, and Massachusetts—and the three non-expansion states—Alabama, South Dakota, and Texas—each covered at least seven of the eight OUD services for pregnant women.

Similarly, we did not identify differences in Medicaid coverage for OUD services between the selected states that limited coverage to pregnancy-related services and those that provided full benefits. Arkansas and South Dakota—the two states providing only pregnancy-related coverage—

covered seven of the eight OUD services for pregnant women. According to Medicaid officials in these two states, the programs cover these OUD services because they are considered medically necessary. In contrast, neither state generally provides Medicaid coverage for peer recovery coaching for beneficiaries, including pregnant women.³⁰

Three of the selected states—Alabama, Colorado, and Texas—covered certain OUD services for pregnant women that they do not cover for other beneficiaries under Medicaid.³¹ For example, in Alabama, screening services and inpatient residential services were covered only for pregnant women, but not other eligible, low-income women. In Colorado, pregnant women were the only group in the state for whom residential OUD services were covered under Medicaid.³² In Texas, pregnant women were the only group in the state for whom case management is a covered service under Medicaid.

Selected States Provide Medicaid Coverage for Most Opioid Use Disorder Services If Women Are Able to Maintain Medicaid Eligibility beyond 60 Days Postpartum

In all six selected states, once Medicaid coverage furnished on the basis of pregnancy ends after 60 days postpartum, women can continue to receive most OUD services under Medicaid if they qualify for Medicaid on another basis. For example, these women could qualify if their income is equal to or lower than the maximum allowable income for parents. However, in the six selected states, the maximum allowable income for eligible parents was generally lower than that for pregnant women, as of January 2019. (See fig. 2.)

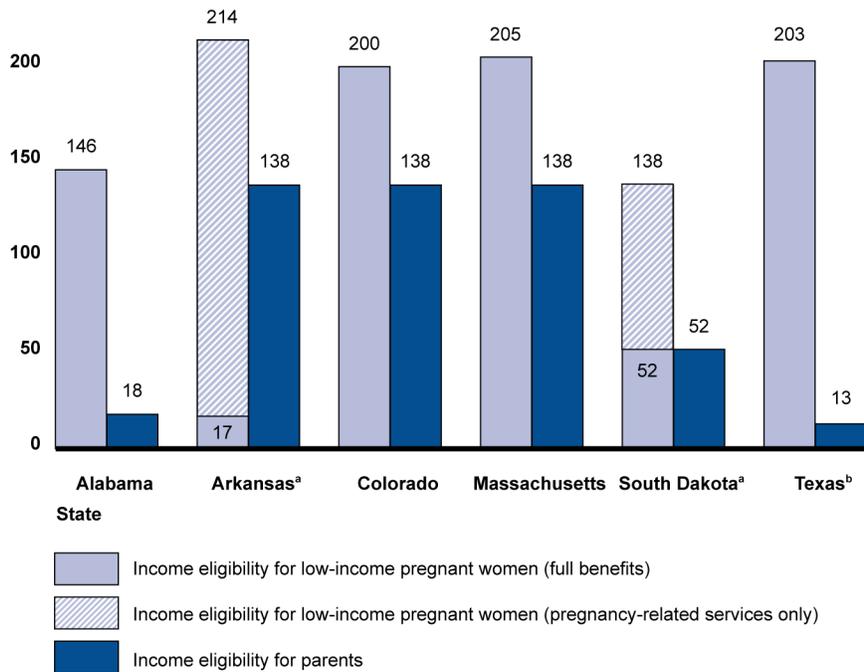
³⁰According to Arkansas officials, pregnant women covered under the state's Medicaid pregnancy-related coverage are not eligible for peer recovery coaching. Officials said that under Arkansas' Medicaid expansion program, women who become pregnant and who are assessed to be medically frail would be eligible for peer recovery coaching.

³¹Officials noted they also cover these services for beneficiaries younger than 21 who are eligible for the EPSDT benefit.

³²Officials told us that they are planning to submit an application for a section 1115 demonstration project to CMS in the fall of 2019 to expand this benefit to all Medicaid beneficiaries.

Figure 2: Maximum Allowable Income for Medicaid Coverage for Eligible Low-Income Pregnant Women Compared with Eligible Parents, as of January 1, 2019

Percent of the federal poverty level required for Medicaid eligibility
250



Source: GAO summary of documentation and interview responses from six selected states. | GAO-20-40

Note: Under federal law, state Medicaid programs must provide coverage for pregnancy-related health care services for certain pregnant women, including low-income pregnant women with incomes at or below 138 percent of the federal poverty level (FPL). 42 U.S.C. § 1396a(a)(10)(A)(i)(IV). Coverage continues through at least 60 days postpartum. For purposes of this report, we call these beneficiaries “low-income pregnant women.”

^aArkansas provides full Medicaid benefits for pregnant women under 17 percent of the FPL and limits coverage to pregnancy-related services for pregnant women between 17 percent and 214 percent of the FPL. South Dakota provides full Medicaid benefits for pregnant women under 52 percent of the FPL and limits coverage to pregnancy-related services for pregnant women between 52 percent and 138 percent of the FPL.

^bTexas calculates Medicaid eligibility for parents based on monthly income limits. In January 2019, the monthly income limit to qualify for Medicaid was \$230 for a family of three, which translates to approximately 13 percent of the FPL.

Women in the six selected states who are eligible to maintain Medicaid coverage after 60 days postpartum can continue most of the same OUD services that were covered during pregnancy. However, officials in two states said that the OUD services covered specifically for pregnant women under Medicaid would generally not be covered after the postpartum period ends. Four of the selected states provided estimates of

the number of women who maintain Medicaid eligibility after the postpartum period ends.³³ For example, officials in Massachusetts, an expansion state, estimated that in 2017 and 2018, approximately 99 percent of women with Medicaid coverage while pregnant maintained Medicaid coverage after the postpartum period ended. State officials in Colorado, also an expansion state, estimated that in 2015, 75 percent of women maintained coverage after the postpartum period ended.³⁴ Additionally, in Arkansas, another expansion state, officials estimated that about 60 percent of women in 2017 and 2018 maintained Medicaid coverage after the postpartum period ended.³⁵ Officials in Alabama, a non-expansion state, estimated that in 2017, about 43 percent of women maintained Medicaid coverage after the postpartum period ended.

States may also obtain approval from CMS, such as under a waiver, to extend Medicaid coverage for women with OUD beyond 60 days postpartum, according to CMS officials. However, CMS officials were not aware of the number of states that have done so. In our review, we found that one of the six selected states, Colorado, used a section 1915(b) waiver to extend Medicaid eligibility for substance use services, including OUD services, for women beyond 60 days postpartum. Under the state's "Special Connections" program, which was approved under the waiver, women who are eligible for Medicaid during their pregnancy can continue Medicaid coverage for OUD services for up to 12 months postpartum, including inpatient residential services, which would not otherwise be covered under Medicaid. A state official told us that the program began in 1991 to provide substance use disorder services to pregnant women and up to 60 days postpartum. In 2006, the state extended coverage under the program to provide substance use disorder services up to 12 months

³³States used their own data systems to provide these estimates. We did not obtain estimates for the number of women who maintain Medicaid eligibility beyond 60 days postpartum for South Dakota and Texas, both non-expansion states. According to officials in South Dakota, the state does not track this type of data. Officials in Texas were unable to provide unduplicated counts of women that maintained Medicaid coverage postpartum. However, according to officials in Texas, the population of women who remain eligible for Medicaid benefits after the 60-day postpartum period is expected to be very small.

³⁴According to Colorado officials, 2015 was the most recent data available.

³⁵Arkansas officials told us their estimates do not include women that obtain coverage after pregnancy under Medicaid expansion; as a result, the figures for 2017 and 2018 may be underestimates.

postpartum.³⁶ The program aids in early identification and intervention for pregnant women with substance use disorders who are at risk of delivering low birth weight babies with health complications. Officials said the goal of the program is to improve the likelihood that the mother remains free from substance abuse. According to Colorado officials, 227 women participated in the program in 2018.³⁷

Selected States Use Other Funding Sources to Provide Coverage of Opioid Use Disorder Services for Postpartum Women Not Eligible for Medicaid

We also found that the six selected states use other funding sources to provide coverage of OUD services for women with incomes that exceed the state's Medicaid eligibility thresholds. Officials from the six selected states reported that they received SAMHSA grants so each state could provide OUD services for pregnant and postpartum women that extend beyond 60 days. According to the SAMHSA officials we interviewed, grants have been used to increase access to MAT, expand recovery support for pregnant women, and provide enhanced services for women to access OUD treatment. Furthermore, SAMHSA officials said that pregnant and postpartum women are specifically identified as target populations for grants, such as the agency's State Targeted Response to the Opioid Crisis grant and its State Opioid Response grant.³⁸ For

³⁶Officials told us they are planning to submit an application for a section 1115 demonstration project to CMS in the fall of 2019 to expand substance use disorder services to all Medicaid beneficiaries, as well as amend the section 1915(b) waiver, under which the state provides services under Special Connections to align with other program changes.

³⁷We also found that some states not in our review have extended or considered extending eligibility beyond 60 days postpartum more generally. For example, Missouri, a non-expansion state, enacted legislation in June 2018 extending Medicaid coverage for substance abuse treatment for up to 1 year after childbirth for women who are adherent to treatment. In June 2019, legislation was introduced in Illinois that would extend Medicaid coverage for up to 12 months postpartum.

³⁸SAMHSA's State Targeted Response to the Opioid Crisis and State Opioid Response grants are awarded to states and territories to address the opioid crisis by increasing access to treatment, reducing unmet treatment needs, and reducing opioid overdose related deaths. All 50 states and the District of Columbia received funding from at least one of the two grants. SAMHSA awarded the six selected states with funding from these grants, ranging from \$2 million to \$27 million in fiscal year 2017, and ranging from \$4 million to \$46 million in fiscal year 2018. Additionally, SAMHSA's Pregnant and Postpartum Women grant program includes two types of grants for pregnant and postpartum women with a primary diagnosis of substance use disorder: one for residential services, and one for outpatient services. SAMHSA officials reported that in fiscal year 2019, they awarded 41 grants to provide residential treatment services and funded six states to provide outpatient treatment services for pregnant women and women through 12 months postpartum.

example, officials in Arkansas told us that by using SAMHSA grants, they are able to allow uninsured or underinsured women who are seeking treatment for OUD to continue MAT treatment after 60 days postpartum. In addition, officials in the six selected states told us that women beyond 60 days postpartum generally would not experience gaps in treatment for OUD when transitioning from Medicaid to SAMHSA grant-funded programs, as women can generally continue receiving the same services and seeing the same providers. For example, state officials in Alabama, South Dakota, and Texas told us the state Medicaid agency contracts with providers that agree to participate in both the state's Medicaid program and SAMHSA's grant programs to allow for continuity of eligible services.

Officials in Texas also told us they used state funds to implement a program to provide OUD services for up to 18 months postpartum. State officials told us that in this program—called the Neonatal Abstinence Syndrome-Opioid Treatment Services program—when a woman's Medicaid coverage ends, she transitions to state-funded treatment to continue the same OUD services with the same provider. According to state officials, this program, funded since 2015, expands treatment services to postpartum women who would typically lose Medicaid coverage and become unable to pay for MAT services, which officials say help reduce relapse, overdose, and maternal mortality risk. State officials added that there is flexibility to extend services for postpartum women participating in the program for up to 2 years, if needed. State officials told us that since 2016, 296 women have participated in the program.

In addition to the efforts in the selected states, the federal government has planned efforts to help states combat the opioid crisis, specifically for pregnant and postpartum women with OUD. For example, CMS plans to offer up to 12 cooperative agreements to states under the Maternal Opioid Misuse model as a way to improve access to services under Medicaid to pregnant and postpartum women with OUD.³⁹ The model will have a 5-year performance period, 2020 through 2024, to allow states to implement strategies to improve the quality of care for pregnant and

³⁹The CMS Innovation Center was established by section 1115A of the Social Security Act, as added by section 3021 of PPACA. See Pub. L. No. 111-148, §§ 3021, 10306. 124 Stat. 119, 389, 939 (Mar. 23, 2010) (codified at 42 U.S.C. § 1315a). The Innovation Center also tests and evaluates payment and service delivery models to reduce spending and improve quality of care for Medicaid and State Children's Health Insurance Program beneficiaries.

postpartum women with OUD. According to CMS officials, the model does not require that states extend coverage beyond 60 days postpartum, but states could choose to do so. CMS published the funding opportunity for the model in February 2019, and plans to select states to participate by the fall of 2019.⁴⁰ In July 2019, CMS issued guidance to states regarding Medicaid coverage of services such as counseling for postpartum women while their infant is receiving treatment for Neonatal Abstinence Syndrome.⁴¹ The Centers for Disease Control and Prevention also issued a publication in September 2019 summarizing an initiative on state strategies to address OUD among pregnant and postpartum women and infants prenatally exposed to substances. The initiative identified five focus areas, including access to and coordination of quality services, provider awareness and training, and financing and coverage.⁴² In addition, the SUPPORT Act includes a provision for HHS to issue guidance to improve care for postpartum women with substance use disorder by the fall of 2019.⁴³

⁴⁰The President's 2020 budget request also proposes spending \$245 million over a 10-year period to give states flexibility to provide Medicaid coverage for 1 year postpartum for women with substance use disorders, including OUD. As of October 2019, legislation providing for such an extension of coverage had not been enacted.

⁴¹Centers for Medicare & Medicaid Services, "*State Guidance for Implementation of the Treatment for Infants with Neonatal Abstinence Syndrome in Residential Pediatric Recovery Centers provisions of Section 1007 of Pub. L. 115-271, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act*" (Baltimore, Md.: July 26, 2019). In July 2019, CMS also issued guidance to states on Medicaid coverage for pregnant and postpartum women in Institutions for Mental Diseases. Institutions for Mental Diseases are generally hospitals or facilities larger than 16 beds that primarily provide diagnosis, treatment, or care to individuals with behavioral health conditions. Centers for Medicare & Medicaid Services, "*State Guidance for the New Limited Exception to the IMD Exclusion for Certain Pregnant and Postpartum Women included in Section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Help for Moms and Babies*" (Baltimore, Md.: July 26, 2019).

⁴²C. D. Kroelinger, et al., *State Strategies to Address Opioid Use Disorder Among Pregnant and Postpartum Women and Infants Prenatally Exposed to Substances, Including Infants with Neonatal Abstinence Syndrome*, Morbidity and Mortality Weekly Report 2019, vol. 68, no.36 (Centers for Disease Control and Prevention, Sept. 13, 2019).

⁴³Pub. L. No. 115-271, § 1005(a), 132 Stat. 3894 (2018).

Selected States Provide Medicaid Coverage for Annual Screenings and Any Medically Necessary Services for Substance Use, Including Opioids, for Eligible Children

The six selected states provide Medicaid coverage for annual screenings of eligible children for substance use, including opioids, as well as any medically necessary treatment for conditions identified through these screenings, as of 2019.⁴⁴ This coverage is provided through the Medicaid EPSDT benefit.⁴⁵ Based on our review of Medicaid state plans and EPSDT policies and periodicity schedules, we found that the six selected states established the following screening schedules at the time of our review:

- Arkansas' Medicaid state plan and Colorado's and South Dakota's EPSDT policies specify that these states follow AAP's screening schedule. AAP recommends annual substance use screening for all children beginning at age 11 until they reach the age of 21.⁴⁶
- Alabama's EPSDT policy requires annual screening for all children ages 6 to 13.⁴⁷
- Massachusetts' EPSDT policy requires providers to conduct an annual assessment of every child's risk for substance use as part of a health history assessment during a child's annual visit. This assessment can be conducted at any age.
- Texas' EPSDT periodicity schedule recommends annual screening for all children ages 12 to 18.

⁴⁴We communicated with state Medicaid officials between July and September 2019 to verify their coverage for opioid use disorder services for children.

⁴⁵Under EPSDT, substance use screenings are not universally required. However, states are required to follow a periodicity schedule that describes the circumstances under which screenings, which can include substance use screenings, should occur. States are also required to cover any medically necessary screening or service.

⁴⁶The AAP's recommended periodicity schedule includes a screening for substance use called the Tobacco, Alcohol, or Drug Use Assessment. This screening may include opioid use. In 2017, AAP began recommending screening all children for substance use beginning at age 11 (referred to as a universal screen). Prior to 2017, AAP recommended screening children at risk for substance use beginning at age 11 (referred to as a selective screen). Officials from Arkansas said providers may determine whether to conduct a substance use screening based on their assessment of the child's risk for substance use.

⁴⁷While Alabama's EPSDT policy requires a substance use screening for children from ages 6 to 13, Alabama Medicaid officials told us that most providers in their state follow AAP's recommended screening for substance use from ages 11 until they reach the age of 21. At the time of our review, state officials acknowledged that their EPSDT policy may need to be updated to reflect provider practices.

Additionally, Massachusetts and Texas Medicaid programs require behavioral health screening for all eligible children. The Medicaid programs in these states provide separate payment for behavioral health screening if the screening is conducted using an approved screening tool, some of which also screen for substance use, such as opioids.⁴⁸ Texas officials reported that substance use screenings are considered part of the required overall mental health screening component of annual checkups. Similarly, Arkansas officials said that as part of a new EPSDT policy they are drafting, the state Medicaid program will require behavioral health screening for all children, which can include substance use screening if determined medically necessary by the provider.⁴⁹

The six selected state Medicaid programs report data on the total number of screenings provided under EPSDT for children's health care needs. However, officials from five of the selected states said that it is difficult or impossible to separate and thus track the number of the substance use screenings as distinct from other types of EPSDT screenings or visits that are recorded in Medicaid data.⁵⁰ States are required to track and report the total number of EPSDT screenings provided, but not the number of substance use disorder screenings.

Officials from all six selected states said that they conduct outreach and education to providers and parents to ensure awareness of the EPSDT benefits, as required.⁵¹ We found that the extent of information the states provide on these services varied among the six states. For example,

⁴⁸States may vary on which screening tools are approved for Medicaid payment, but one of the tools that was reported to be approved in numerous states, as well as recommended by the AAP, is the Car, Relax, Alone, Forget, Friends, Trouble screening tool, known as the CRAFFT. With this tool, providers ask patients questions about their habits—such as if they've used drugs to relax or if they've used drugs alone—to assess their probability of substance misuse or dependence.

⁴⁹Arkansas officials explained that they were drafting the new policy to be more consistent with AAP's recommendations. However, as of July 2019, Arkansas' draft policy did not explicitly require substance use screening for all children beginning at age 11, as recommended by AAP.

⁵⁰Officials from Colorado noted that because providers bill separately for screenings and routine visits, the state has the ability to track data on the number substance use screenings. However, officials stated that they were in the process of building a dashboard to facilitate tracking this data more easily and had not yet analyzed the number of substance use screenings.

⁵¹Under EPSDT, all state Medicaid agencies are required to inform all eligible children and their families that EPSDT services are available.

outreach materials from three of the six selected states included information about the availability of substance use screening, and one of these three states, Alabama, also included information about services for opioid use.

For all six selected states, officials emphasized that Medicaid's EPSDT benefit requires states to cover any medically necessary treatment or service to address health conditions for a child, including opioid use. Officials from the six selected states also described a variety of initiatives to increase access to substance use disorder, including OUD, services for children. For example:

- Officials from Alabama said they recently began a program that offers more substance use disorder services in schools in a face-to-face capacity to help increase convenience and reduce stigma around these services for both the children and the parents. They explained that the Alabama Department of Mental Health added modifiers to ensure that their systems can capture data appropriately and analyze trends in providing school-based services, which are currently offered in over 40 individual schools. Officials added that Medicaid pays for covered services that are provided to Medicaid-eligible children in schools under this program.
- Officials from two states—Arkansas and Massachusetts—said they recently expanded the types of substance use disorder services covered for all Medicaid beneficiaries. Officials from Arkansas added that they are working to expand the number of providers who can offer substance use disorder treatment under Medicaid.⁵²
- Officials from two states—Massachusetts and Texas—said they had recently developed programs specifically aimed at serving children with substance use disorder, including OUD, using federal authority. Massachusetts received approval from CMS to conduct a Medicaid demonstration to establish OUD programs for children. Texas is using SAMHSA grant funding to support eight youth recovery centers that

⁵²In the state's draft application for a fiscal year 2018-2019 SAMHSA Block Grant, Arkansas officials described numerous initiatives to expand the number of providers who can offer substance use disorder treatment under Medicaid, such as by allowing substance abuse providers to become Medicaid providers through different avenues, allowing independently licensed clinicians to co-locate with primary care physicians, and making the primary care physician's office an allowable place of service in the state's new outpatient behavioral health system. Arkansas officials reported that the number of substance use disorder providers in the state has more than doubled since July 2018.

are intended to improve services and recovery supports for youth with substance use disorder, including OUD.

Over 30 States Reported Medicaid Coverage of Opioid Use Disorder Services Delivered through Telehealth in Schools, but No Evidence Services are Being Used

We conducted outreach to Medicaid officials from all 50 states and the District of Columbia between February and July 2019 to inquire about whether the state provided Medicaid coverage of OUD services delivered via telehealth in schools as a means of increasing access to these services for children. Officials from 31 states and the District of Columbia reported that they provide Medicaid coverage of OUD services delivered in schools via telehealth.⁵³ Medicaid officials from some states reported that their Medicaid policies explicitly allow for coverage of OUD services provided in schools via telehealth, while others reported that they allow for Medicaid coverage of these services, but their policies do not explicitly address the issue. (See app. I for the state responses regarding Medicaid coverage of OUD services provided in schools via telehealth.)

Officials from the remaining 18 states reported that their Medicaid policies do not allow for payment for OUD services delivered in schools via telehealth. Some of these state officials reported that they did not allow schools to serve as a location for patient services during a telehealth visit for Medicaid payment purposes.⁵⁴ Other state officials reported that they allowed Medicaid payment for certain services provided in schools via telehealth, but OUD services were not among them. For example, officials from Texas said the state established a school-based telehealth program for behavioral health services. However, this program does not include services for the treatment of substance use disorder, including OUD. Officials added that the state has a requirement that substance use disorder services can only be delivered in certain approved facilities.

While Medicaid officials from 31 states and the District of Columbia reported that they provide Medicaid coverage of OUD services in schools via telehealth, they also said they were not aware of any instances of these services being utilized. Medicaid officials from the 31 states and the District of Columbia reported that either these services were not being provided based on data or other information they had, or they were

⁵³In total, 49 states and the District of Columbia responded to our outreach. Illinois did not provide information in response to our outreach request.

⁵⁴Medicaid policies generally refer to the location of the patient when receiving telehealth services as the originating site. Some state Medicaid policies do not allow schools to serve as the originating site for payment purposes.

unaware if the services were being provided. Officials from seven states responded that they either reviewed Medicaid utilization data or asked school-based staff and determined that there was no utilization of these services. For example, officials from one state—Ohio—conducted a data query and found that in 2018 there had been two instances of substance use disorder services billed to Medicaid that were delivered via telehealth in a school. However, officials noted that these instances involved treatment for substances other than opioids. While not for OUD, these two instances were the only instances of Medicaid payment for substance use disorder services delivered via telehealth in schools that we identified in our review.

As part of our outreach to states and background research, we did find that some states or localities have taken steps to facilitate the use of telehealth for delivery of substance use disorder services, including OUD, in schools. For example:

- Officials from one county in Maryland said they recently began using a telehealth smart device application to screen students in schools for substance use disorder, including OUD, and refer them to treatment. However, county officials said that the program was locally funded, and they had not considered seeking Medicaid payment.
- A South Dakota tribal reservation recently implemented a new school-based telehealth program for behavioral health. According to officials, this program could include OUD services delivered via telehealth in schools, and these services could be billed to Medicaid if the provider was already licensed to bill Medicaid; however, officials said that none of these services had been provided to date.
- Massachusetts recently expanded its Medicaid telehealth policy to allow for the payment of mental health and substance use disorder services provided in many locations, including schools. However, officials said the state was still building the telehealth infrastructure, and services had not yet been provided at the time of our review. Officials were unsure whether OUD services would be delivered via telehealth in schools under the new policy once implementation began.

State officials and subject matter experts that we spoke with also reported a range of potential benefits and challenges associated with providing substance use disorder services, including OUD services, in schools via telehealth. (See table 1.)

Table 1: Potential Benefits and Challenges Associated with Providing Substance Use Disorder Services in Schools via Telehealth, as Cited by Stakeholders

| | |
|----------------------|---|
| Potential benefits | <ul style="list-style-type: none"> Using telehealth can help address provider shortages and increase access in certain areas, particularly rural areas. There is no need to arrange and pay for transportation to and from appointments. Students who receive services spend less time outside of the classroom while accessing the services. Providing these services can help increase awareness and destigmatize perceptions of behavioral health care. |
| Potential challenges | <ul style="list-style-type: none"> Several states do not reimburse for these types of services provided via telehealth in schools. Some providers do not feel comfortable or have interest in providing these types of services via telehealth. There can be reluctance or hesitation from parents to let their children seek treatment via telehealth. Officials are not sure about the need for opioid use services as compared to other substances. Some schools, providers, or communities: <ul style="list-style-type: none"> May not have enough resources (i.e., funding) or proper infrastructure (i.e., equipment, bandwidth) to offer these services. Need to meet certain requirements or have proper licensing or credentials to offer telehealth or to provide certain services. Are not familiar with the billing policies for telehealth in states that cover these services. |

Source: GAO summary of information from interviews with stakeholders. | GAO-20-40.

Note: We cited benefits and challenges reported by at least three of 14 stakeholders. The 14 stakeholders comprised officials from the six selected states, officials from four telehealth programs, and four subject matter experts.

There have also been federal efforts to emphasize the use of telehealth to improve access to OUD services for children. For example, these efforts include the following:

- In June 2018, CMS issued guidance emphasizing the use of telehealth as a means of improving access to OUD services and noted that states need not necessarily submit a change to their state plan to begin delivering covered Medicaid services through telehealth.⁵⁵ Similar to what we heard from experts, this guidance

⁵⁵CMS, *State Medicaid Directors Letter: Leveraging Medicaid Technology to Address the Opioid Crisis*, State Medicaid Directors Letter #18-006 (Baltimore, Md.: June 11, 2018).

suggests that leveraging technology to provide such services might help with addressing provider shortages, particularly in rural areas.

- In July 2019, CMS and SAMHSA jointly issued guidance on addressing mental health and substance issues in schools.⁵⁶ The guidance states that telehealth for mental health services in schools has been found to be effective. This guidance also emphasizes that telehealth can be helpful for ensuring that Medicaid services are provided to Medicaid beneficiaries who are in rural areas or in areas where qualified practitioners are scarce.⁵⁷
- HRSA officials we spoke with also described several different HRSA programs from which funds could be used to facilitate or deliver substance use disorder services via telehealth, including in some school-based health centers; however, the officials were not able to determine whether telehealth is being utilized to deliver OUD services in school-based health centers, specifically.

The SUPPORT Act also includes a provision for HHS to issue guidance to states on Medicaid coverage of substance use disorder services delivered via telehealth, including in school-based health centers, by fall of 2019.⁵⁸

Agency Comments

We provided a draft of this report to HHS for review. HHS provided technical comments, which we incorporated as appropriate.

⁵⁶CMS and SAMHSA, *Joint Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools* (July 1, 2019).

⁵⁷We also spoke with officials from the Weitzman Institute, a community-based research center that uses the University of New Mexico's platform for Project ECHO (extension for community healthcare outcomes) to leverage telehealth technology allowing local clinicians to communicate with specialists in other locations. Officials said the Weitzman Institute operates ECHO clinics with providers in 15 different states, primarily in rural settings. Officials also said the program connects these providers, including school-based providers, with specialists for the purpose of education and consultations on particularly complex patients. The program can be used for many different medical specialties, including behavioral health. While this is not an instance of patients receiving direct care via telehealth, it is an example of how telehealth can be utilized to increase access to specialized medical knowledge and improve the quality of in-person care.

⁵⁸Pub. L. No. 115-271, § 1009(b), 132 Stat. 3894 (2018).

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, the Health Research and Services Administration, the Substance Abuse and Mental Health Services Administration, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact Jessica Farb at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix II.



Jessica Farb
Director, Health Care

Appendix I: State Reported Medicaid Coverage of Opioid Use Disorder Services Delivered through Telehealth in Schools

Table 2: State Reported Medicaid Coverage of Opioid Use Disorder Services Delivered through Telehealth in Schools

| States that reported Medicaid coverage of OUD services in schools delivered through telehealth (N=32) | States that reported no Medicaid coverage of OUD services in schools delivered through telehealth (N=18) |
|--|---|
| Alabama | Alaska |
| Arkansas | Arizona |
| California | Connecticut |
| Colorado | Idaho |
| Delaware | Iowa |
| District of Columbia | Kansas |
| Florida | Kentucky |
| Georgia | Michigan |
| Hawaii | Minnesota |
| Indiana | Montana |
| Louisiana | New Hampshire |
| Maine | Oklahoma |
| Maryland | Pennsylvania |
| Massachusetts | Rhode Island |
| Mississippi | Texas |
| Missouri | Virginia |
| Nebraska | Wisconsin |
| Nevada | Wyoming |
| New Jersey | |
| New Mexico | |
| New York | |
| North Carolina | |
| North Dakota | |
| Ohio | |
| Oregon | |
| South Carolina | |
| South Dakota | |
| Tennessee | |
| Utah | |
| Vermont | |
| Washington | |
| West Virginia | |

Source: GAO summary of information reported by state Medicaid officials. | GAO-20-40.

Note: We conducted our outreach to all 50 states and the District of Columbia between February and July 2019. Officials from Illinois did not provide information in response to our outreach request. Based on our review and assessment of Illinois' Medicaid policy, the state does cover opioid use disorder (OUD) services in schools through telehealth. However, we were not able to verify this information with state officials.

Appendix II: GAO Contact and Staff Acknowledgements

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Rashmi Agarwal (Assistant Director), Kaitlin McConnell (Analyst-in-Charge), Arushi Kumar, Kimberly Lloyd Perrault, Jennifer Rudisill, and Emily J. Weisenberger made key contributions to this report. Also contributing were Drew Long and Ethiene Salgado-Rodriguez.

Related GAO Products

Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings. [GAO-19-481](#). Washington, D.C.: August 16, 2019.

Opioid Crisis: Status of Public Health Emergency Authorities. [GAO-18-685R](#). Washington, D.C.: September 28, 2018.

Adolescent and Young Adult Substance Use: Federal Grants for Prevention, Treatment, and Recovery Services and for Research. [GAO-18-606](#). Washington, D.C.: September 4, 2018.

Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome. [GAO-18-32](#). Washington, D.C.: October 4, 2017.

Drug Control Policy: Information on Status of Federal Efforts and Key Issues for Preventing Illicit Drug Use. [GAO-17-766T](#). Washington, D.C.: July 26, 2017.

Medicaid Expansion: Behavioral Health Treatment Use in Selected States in 2014. [GAO-17-529](#). Washington, D.C.: June 22, 2017.

Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs. [GAO-17-365](#). Washington, D.C.: April 14, 2017.

School Based Health Centers: Available Information on Federal Funding. [GAO-11-18R](#). Washington, D.C.: October 8, 2010.

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