

Remarks to the National Association of Medicaid Directors

Alex M. Azar II

National Association of Medicaid Directors

November 13, 2018 Washington, D.C.

“ Today, CMS will be sending a letter to state Medicaid directors laying out how to apply for waivers for flexibility ... to treat serious mental illness. ... [W]e will strongly emphasize that inpatient treatment is just one part of what needs to be a complete continuum of care, and participating states will be expected to take action to improve community-based mental health care. There are effective methods for treating the seriously mentally ill in the outpatient setting, which have a strong track record of success and which this administration supports. ... Both tools are necessary and both are too hard to access today. ”

As Prepared for Delivery

Thank you for that introduction, Judy [Mohr Peterson]. Good morning, and thank you to the National Association of Medicaid Directors for having me here today.

It's great to be here. At this important meeting, the level of enthusiasm for making Medicaid work for the most vulnerable Americans is encouraging and infectious.

I should say, I haven't been around this much excitement about issues like managed care design and Medicaid IT infrastructure since I last sat at my conference room table one-on-one with Administrator [Seema] Verma.

Successful partnership between our leadership at HHS and the leaders of every state Medicaid program is vital to delivering on the mission of HHS and the mission of the Medicaid program: improving the health and well-being of the Americans we serve.

Starting in April of last year, the Trump administration called for a new era of state-federal partnership in Medicaid. I believe a great deal of progress has been made on that front already. But I am optimistic that much more progress is still ahead of us, and I want to talk about what that looks like today.

I'll highlight a few particular areas where a spirit of partnership has helped Medicaid programs lead on some of the most serious health issues we face—and where we hope that spirit of partnership can take us in the future.

I also want to flesh out what I mean by a spirit of partnership: We each have something to contribute here. I mean that literally, in the sense that both the federal government and state governments invest significant chunks of our budgets in the Medicaid program.

But successful Medicaid innovation requires more than money from both sides. At the federal level, this administration is willing to offer historic flexibility for programs to innovate. In return, we expect state commitments to invest in innovations and produce results.

There is tremendous potential for this approach to confront the serious health challenges our country faces. Thanks to the work of many of you on this room, progress has already been made on these challenges, and I believe more such progress is around the corner.

The three particular areas I want to address today are: first, efforts to improve the well-being of Americans through promoting community engagement; second, combating addiction and the opioid crisis; and third, improving the availability of treatment for Americans with serious mental illness.

I'll also note a few more areas where a successful Medicaid partnership can help advance important health priorities.

First, I want to discuss our support for community engagement requirements in Medicaid, which have been a historic step forward for our health and human services programs.

In four states now, we have brought to the largest program for low-income Americans the well-known lessons about benefits that community engagement can have for people's well-being.

I understand this has been a complicated and contentious process, but I want to emphasize that it has been a cooperative and deliberative one as well.

All Medicaid demonstration waivers carry substantial requirements around monitoring and evaluation, but we know these are even more important when we are taking the bold and innovative steps we are taking here.

As part of the waivers we've granted, we have set careful guardrails that require states to protect their most vulnerable beneficiaries, and only required community engagement from beneficiaries whose circumstances allow them to participate. We are also attentive to the paperwork burdens imposed on both beneficiaries and states, although we believe the benefits of setting the right incentives can far outweigh these costs. All of these costs and benefits will be carefully evaluated for each waiver we approve.

Beyond this demonstration opportunity, I want to encourage all Medicaid directors and stakeholders to think about how they can promote community engagement. In setting up the demonstrations, we are building on a robust academic literature that shows community engagement, such as employment, can

have substantial benefits for well-being. Finding work is associated with significant improvements in mental and physical health—and programs set up to improve Americans' health should, where feasible, reflect that.

We know this has been an area of interest from managed care organizations, which have strong incentives to recognize how community engagement can promote well-being. We are eager to work with all of you, bringing HHS's health and human services expertise to the table, to think about how community engagement can improve the health and well-being of your beneficiaries.

One place where we know we need a comprehensive approach to well-being is the treatment of addiction. In our country's fight against opioid addiction in particular, Medicaid programs have played an important role, both by covering treatment and by offering connections to the social services necessary to support recovery.

A key piece of this has been rethinking the boundaries of how Medicaid pays for mental health treatment. Different forms of treatment work for different patients, but the decades-old restriction on Medicaid reimbursement for inpatient treatment at institutions for mental diseases, or IMDs, has been a significant barrier. That is why the Obama administration began, in 2015, granting demonstration waivers that provided flexibility around this restriction.

In November of last year, the Trump administration unveiled a new approach to these waivers, simplifying and expediting the process. Under President Trump, we have approved 13 waivers, and we have a number of others in the pipeline.

Where we have been able to assess results, they have already been impressive. Virginia's waiver was granted in 2016, under the previous administration, and an independent assessment of its early effects has found substantial improvements. The state saw a 39 percent decrease in opioid-related emergency-room visits, and a 31 percent decrease in substance-use-related ER visits overall. The number of residential treatment centers expanded dramatically, as did the number of opioid-specific treatment programs. Other changes Virginia implemented as part of the SUD waiver demonstration also helped increase, by almost half, the number of intensive outpatient treatment providers.

Inpatient treatment exists toward one end of a spectrum of options—from hospitalization and closely monitored residential treatment to monitored outpatient treatment and independent living. It's crucial that the inpatient option be available, but it's just as important that Medicaid programs are supporting medication-assisted treatment and recovery across that whole spectrum.

That is why we encourage states to use Medicaid to support outpatient care coordination as well. In Vermont, for instance, we approved a waiver that builds on the successful hub-and-spoke model, established under their health home benefit, where a provider of medication-assisted treatment acts as

the center of an array of service providers. Vermont's program has resulted in reductions in drug use, overdoses, hospital visits and arrests.

Within the last two months, we have also announced two new models at the Center for Medicare and Medicaid Innovation that are focused on mothers, children and substance use. These two models, the Integrated Care for Kids model and the Maternal Opioid Misuse, or MOM, model, aim to integrate the services needed during pregnancy and then in a child's early years.

Further, thanks to legislation signed last month by President Trump, Medicaid will also now be able to reimburse for services at what are called pediatric recovery centers, which have sprung up to help support new mothers struggling with opioid addiction. I've been able to see firsthand the good these centers can do.

Earlier this year, I visited a clinic in Dayton, Ohio—one of the hardest hit communities in the country—that treats new mothers who are struggling with addiction and their infants, who are sometimes born physically dependent on opioids, with neonatal abstinence syndrome.

We met a young mother who was just a few months into recovery from opioid addiction. One day, late in her pregnancy, she got in a car crash on her way to buy drugs from a dealer. The crash sent her to the hospital, where her baby was born—alive, but physically dependent on opioids. If she had not gone to the hospital that day, doctors said, her baby probably would not have lived.

Today, she is able to care for her child and share her story of recovery in part thanks to the support she received at the pediatric recovery center—the kind of care we will now be able to support through the Medicaid program.

I want to emphasize one final point about SUD waivers and substance abuse.

It is local efforts to connect Americans to treatment and prevention services that have helped produce encouraging signs in national drug overdose trends, but each state faces different, local challenges.

While we typically speak about SUD waivers in the context of opioid addiction, and that remains our most significant addiction challenge, the waivers are not singularly focused on opioid addiction. Some states face almost as great a challenge from, say, cocaine or methamphetamine as they do opioids, and our data suggests these other challenges are rapidly growing. Our approach to these waivers is flexible and not focused on treating one addiction to the exclusion of others.

In fact, inpatient treatment is sometimes most important for substance use disorders besides opioid addiction. But maybe the single most pressing need for inpatient treatment is where someone is experiencing a co-occurring substance use disorder and a serious mental illness.

This brings me to the third major priority I want to address, which is how we can use the Medicaid program to provide Americans with serious mental illness the treatment they need to live healthier lives.

Serious mental illness is a challenge many of you know well. By one estimate, more than a quarter of adults with a serious mental illness are on Medicaid. But it is worth remembering the daunting scale of the challenge we face, which can be summed up in three numbers: 10 million, 10 years, and 10 times.

First, about 10 million American adults in a given year experience a serious mental illness, meaning one that seriously impairs one or more major life activities, like holding down a job or maintaining relationships.

Second, they live, on average, lives that are 10 or more years shorter than other Americans', which is a tragic outcome for illnesses that we know how to treat.

Third, by one estimate, 10 times more Americans with serious mental illness are in jail or prison than in inpatient psychiatric treatment. This is a disturbing, systemic failure.

Now, inpatient psychiatric treatment is far from the only solution for serious mental illness. It is not appropriate for many patients. But access to it has been unnecessarily restricted by the decades-old policy I just discussed, the IMD exclusion.

Many of you know the history of why Medicaid doesn't pay for inpatient mental health treatment. The policy was conceived to discourage states, which traditionally provided mental health care, from offloading these responsibilities onto the Medicaid program. But around the same time Medicaid was implemented, states were already pulling back on their investments in treating mental illness—often with good intentions, of course, because this support went to house patients in inhumane, intolerable conditions.

But today, we have the worst of both worlds: limited access to inpatient treatment and limited access to other options. Given the history, it is the responsibility of state and federal governments together, alongside communities and families, to right this wrong.

More treatment options are needed, and that includes more inpatient and residential options that can help stabilize Americans with serious mental illness.

That is why, today, CMS will be sending a letter to state Medicaid directors laying out how to apply for waivers for flexibility around the IMD exclusion to treat serious mental illness. As with the SUD waivers, we will strongly emphasize that inpatient treatment is just one part of what needs to be a complete continuum of care, and participating states will be expected to take action to improve community-based mental health care.

There are effective methods for treating the seriously mentally ill in the outpatient setting, which have a strong track record of success and which this administration supports. We can support both inpatient and outpatient investments at the same time. Both tools are necessary and both are too hard to access today.

There are so many stories of Americans with serious mental illness, and their families, that end in tragic outcomes because treatment options are not available or not paid for.

I urge everyone involved in state Medicaid programs here today to consider applying for the kind of waiver I've just outlined. These waivers will help complement the good work so many of you are already doing to fight substance abuse, and will help build a system where Americans with serious mental illness and their families can finally find the treatment and support they need.

In closing, I want to emphasize that we also see Medicaid programs as a valued partner in a number of other priorities we have set forth for HHS, including bringing down prescription drug prices and moving toward a healthcare system that pays for health and outcomes rather than procedures and sickness. As one example, state Medicaid efforts have often paved the way on providing care for seriously ill Americans in their homes, rather than in hospitals or skilled nursing facilities. We want to continue supporting efforts in that direction.

On these priorities, we want to work with you on developing innovative approaches—and we want to make that process as quick and painless as possible.

Last year at this gathering, Administrator Verma laid out progress that had already been made on faster processing of waiver applications.

Since then, progress has continued. From 2016 through the first quarter of 2018, we cut the median approval time for a state plan amendment by 23 percent. Approval times for waivers for long-term care- and home-and-community-based-services dropped, too. On top of that, last week, we proposed a new Medicaid managed care rule, which would help formalize more flexibilities for the ever-growing number of states that use managed care.

We'll give you the flexibility you need, and you just need to show us the results. That is the kind of partnership we envision for the Medicaid program.

We know all of you care about our country's pressing health challenges. All of you do the often thankless work you do because it's a chance to help address these challenges. Everyone who wants to engage with this administration on these challenges will find an open door and open minds.

So thank you very much for having me here today, thank you for your efforts to engage with us, and thank you for the work you do every day to support and care for the most vulnerable Americans.