U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

State and Local Policy Levers for Increasing Treatment and Recovery Capacity to Address the Opioid Epidemic:

Final Report

September 2017

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This report was prepared under contract #HHSP233201600021I between HHS's ASPE/DALTCP and RTI International. For additional information about this subject, you can visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officers, Helen Lamont, Laurel Fuller and Judith Dey, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201; Helen.Lamont@hhs.gov, Laurell.Fuller@hhs.gov, Judith.Dey@hhs.gov.

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACA	Patient Protection and Affordable Care Act
ARTS	Addiction Recovery Treatment Service
ASAM	American Society of Addiction Medicine
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BDAS	New Hampshire Bureau of Drug and Alcohol Services
BH	Behavioral Health
CARA	Comprehensive Addiction and Recovery Act
CCBHC	Certified Community Behavioral Health Clinic
CDC	HHS Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CIMOR	Customer Information Management, Outcomes and Reporting
CMS	HHS Centers for Medicare & Medicaid Services
CSB	Community Service Board
DATA 2000	Drug Addiction Treatment Act of 2000
DBHDS	Virginia Department of Behavioral Health Developmental Services
DEA	DoJ Drug Enforcement Administration
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMH	Missouri Department of Mental Health
DoJ	U.S. Department of Justice
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency Department
FDA	HHS Food and Drug Administration
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HHS	U.S. Department of Health and Human Services
HRSA	HHS Health Resources and Services Administration
IDN	Integrated Delivery Network
JAMA	Journal of the American Medical Association
LADC	Licensed Alcohol and Drug Counselor

MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MU	Medication Unit
NHHPP	New Hampshire Health Protection Program
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NP	Nurse Practitioner
NSDUH	National Survey of Drug Use and Health
NTP	Narcotic Treatment Program
OBOT	Office-Based Opioid Treatment
ODS	Organized Delivery System
OMHAS	Ohio Mental Health and Addiction Services
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
P.L.	Public Law
PA	Physician Assistant
PCSS	Provider's Clinical Support System
PDOA	Prescription Drug and Opioid Addiction
PPS	Prospective Payment System
QHP	Qualified Health Plan
SAMHSA	HH Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SSA	Single State Agency
STR	State Targeted Response
SUD	Substance Use Disorder

EXECUTIVE SUMMARY

Objective

This report summarizes financing and workforce policies that can be used by states to expand treatment access and capacity for opioid use disorder (OUD), focusing especially on medication-assisted treatment (MAT). Our evaluation team used a case-study approach and conducted an environmental scan and stakeholder interviews for five states: California, Missouri, New Hampshire, Ohio, and Virginia. The results highlight key levers each state is using to expand or improve access to MAT, summarize common themes among financing and workforce policies, and map the policy levers to different settings in which a patient could start MAT, describing ways to build local capacity.

Why Medication-Assisted Treatment?

Since 2000, drug overdose death rates increased by 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioid pain relievers and heroin.[1,2] Nearly every state has a rate of OUD that eclipses treatment capacity.[3] There is a large range of treatment options for individuals with OUD, including individual and group counseling or behavioral therapy, abstinence and 12-step fellowships, inpatient or residential treatment, intensive outpatient treatment, case or care management, peer or recovery supports, and pharmacotherapy, such as MAT.[4]

MAT is a combination of medication, counseling and behavioral therapy that has shown to be effective in treating alcohol and opioid dependency. Currently, there are three medications approved by the U.S. Department of Health and Human Services Food and Drug Administration for OUD treatment: (1) methadone, (2) naltrexone, and (3) buprenorphine. MAT for OUD is effective in reducing opioid use and opioid-related overdose deaths and endorsed by the National Institutes of Health[5-8] and the World Health Organization.[8] Despite its effectiveness, many patients encounter barriers accessing evidence-based MAT for OUD, including coverage, limited behavioral health workforce, and lack of perceived need for treatment, among others.[9-11]

Paths to Treatment for Opioid Use Disorder

Individuals with OUD can access MAT in various settings. Methadone can only be dispensed at a certified Opioid Treatment Program (OTP). Buprenorphine can be prescribed by a licensed medical provider (i.e., a physician, psychiatrist, physician assistant [PA], or nurse practitioner [NP]) with a U.S. Department of Justice Drug Enforcement Administration registration and a buprenorphine waiver. Naltrexone can be prescribed by any licensed medical provider. Therefore, patients can be treated with buprenorphine and naltrexone through most medical facilities, including office-based physician practices, Federally Qualified Health Centers,

hospitals and emergency departments, and other specialized settings including OTPs, residential substance abuse facilities, or outpatient behavioral health organizations.

Clinical guidelines recommend a formal assessment before starting MAT, and the appropriate treatment will depend on the severity of the diagnosis, comorbid factors, current clinical context (i.e., in withdrawal or recovering from overdose), patient preferences, and the supply of providers licensed to provide these therapies. Many medical facilities do not have the expertise to conduct formal assessments, and the linkage between medical and substance use disorder (SUD) settings is not generally a strong one, which creates a barrier for many patients and medical providers. Many states have relatively low numbers of OTPs or waived providers to meet patient demand, especially in rural areas.[3]

Access to MAT and other SUD treatment often depends on health insurance coverage. Not all Medicaid programs and private insurers cover all three types of MAT. Medicaid and private insurers often require prior authorizations before starting MAT, causing administrative delays and denials for patients. Some insurance plans also require co-payment or patient cost-sharing for SUD services, which may be challenging for some patients to meet.

Levers Used by States to Expand Treatment and Recovery Capacity

Based on an environmental scan of policies in five states and discussions with a total of 15 stakeholders in those states, the following policy levers were commonly cited to expand MAT provision:

- Expand Medicaid coverage and access to MAT by expanding services covered under the optional Medicaid benefits; expand Medicaid access to low-income, childless adults to increase access to SUD treatment services; or use Medicaid waivers to expand or develop enhanced SUD systems of care.

- Develop systems of care in which a central specialty SUD provider (or hub) has expertise to start patients on MAT, treat severely ill patients, and provide consultation and support to less experienced office-based prescribers of MAT (spoke).

    - Hubs are clinics that provide specialized expertise in opioid treatment by assessing opioid users, determining the most optimal medication, initiating MAT treatment, providing ongoing care, and transferring stable patients back into primary care.
    - Spokes serve as a regional network of MAT prescribers that manage medication maintenance and provide recovery support or counseling services.
    - Spokes can implement MAT support teams to ensure medications are being appropriately prescribed, conduct patient assessments, and coordinate medical and social services.

- Use targeted grant funds for start-up and to address service gaps.

- Increase the number of providers with a waiver to prescribe buprenorphine by subsidizing training, expanding the scope of practice for NPs and physician's assistants, and through targeted recruiting.

- Modify regulations that impede MAT delivery, such as reducing prior authorization requirements and barriers to entry for private OTPs.

- Implement programs that combat stigma and resistance, such as training, coordinated outreach, and the Screening, Brief Intervention and Referral for Treatment program.

Endnotes

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