EXECUTIVE SUMMARY

The opioid crisis in the United States is pervasive and devastating. According to the National Institutes of Health, 115 people a day die from overdoses linked to opioids.[1] The use of opioids may even be attributable to declines in life expectancy for Americans.[2] Even though the trend in Oregon indicates opioid-related deaths are decreasing, 245 people in Oregon died from overdoses in 2016. In addition, overdoses due to the synthetic opioid fentanyl doubled from 23 in 2016 to 64 in 2017.[3]

Figure 1. Oregon Overdose Deaths, All Opioids, 2009-

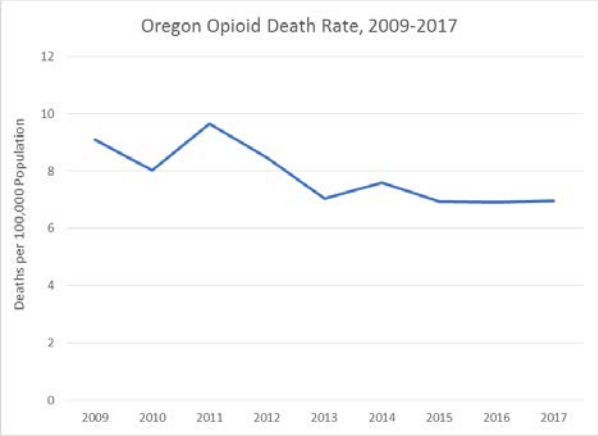
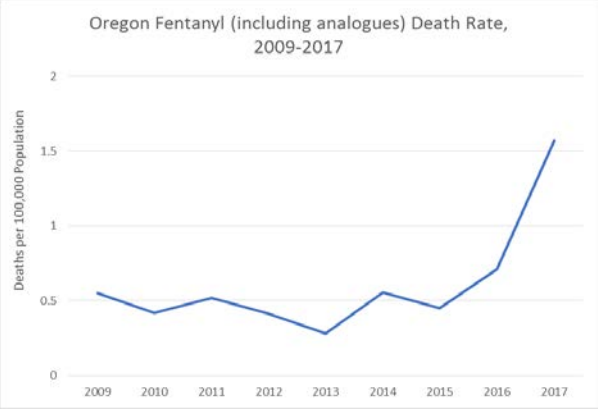


Figure 2. Oregon Overdose Deaths, Fentanyl, 2009-



A number of substances can lead to substance use disorders (SUD); however, opioids pose a special challenge because of their effect on the brains of their users. The molecules in opioid medications attach to receptors in the brain that "reward people with feelings of pleasure when they engage in activities that promote basic life functions."[4] The brain also creates a record of opioid use, creating an association between the drug and the reward.[5] To reverse this substantial and long-term rewiring of the brain pathways of people suffering from opioid addiction, medications can be used in conjunction with other therapies to augment their effectiveness. This approach is known as medication-assisted treatment (MAT).[6]

Oregon's comprehensive, four-pronged response to the opioid crisis has begun to show promising results. Recently, the federal Centers for Disease Control reported that deaths from prescription opioids dropped 17 percentage points between 2015 and 2016, the steepest decline in the nation. This progress demonstrates the impact the state can have working closely in collaboration with health care practitioners, pharmacists, local health public health

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[1] *See* Nat'l Inst. Of Health, *Opioid Overdose Crisis* (available at https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis) (last visited July 11, 2018).
[2] *See* Lenny Bernstein and Christopher Ingraham, *Fueled by drug crisis, U.S. life expectancy declines for a second straight year*, The Washington Post, December 21, 2017.
[3] Data derived from the Oregon Health Authority Opioid Data Dashboard (available at https://www.oregon.gov/oha/ph/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx)
[4] Kosten & George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, Sci. Pract. Perspect. (2002) (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851054/).
[5] *Ibid.*
[6] *See* SAMHSA, *Medication and Counseling Treatment* (available at https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat).

officials, community non-profits and other partners. Yet hurdles and challenges remain. For example, even though MAT has long been the gold standard for treating opioid use disorder, significant barriers to accessing MAT exist, including stigma, cost, lack of capacity, insurance coverage issues, and lack of provider support.

Gov. Kate Brown convened the Opioid Epidemic Task Force in 2017. The task force works to elevate policy actions in four different priority areas: better pain management, fewer pills, better access to treatment, and data/education.[7] As part of the task force's work in the area of better access to treatment, the members recommended that the Oregon insurance commissioner produce a report on access to medication-assisted treatment for substance use disorder. This recommendation ultimately ended up as section 1 of enrolled House Bill 4143.[8]

This evaluation reinforces what many in the substance use disorder research and treatment community know: substance use disorder is a chronic condition that requires both acute treatment and long-term management, much like heart disease or diabetes. However, the outdated substance use disorder treatment and payment system create barriers that keep individuals in recovery from receiving holistic, integrated care. Above all, OHA and DCBS recommend Oregon prioritize the integration of substance use disorder treatment in primary care settings. A special focus should be paid to providing continued multi-disciplinary support to recovering individuals, even after their conditions have stabilized, to prevent relapse and achieve long-term success and quality of life.

Primarily, this report returns answers to the questions posed by House Bill 4143. This report is structured to address the following topics:

- Substance use disorder, which may present with an acute life-threatening event, is in fact a chronic illness, which has implications for treatment.
- A study of the existing structures for reimbursement of substance use disorder treatment from both the commercial and public payer perspectives.
- The impact of the commercial and public payer reimbursement systems, rules and requirements on access to treatment, and recovery services for substance use disorders, including access to evidence-based treatment and medication-assisted treatment.
- Existing structures for reimbursement of substance use disorder treatment, including the use of the least costly treatment option before any other treatment options.
- How access to medication-assisted treatment for substance use disorders in rural and underserved areas of the state is affected by existing structures, as well as how infrastructure plays a role in the delivery of these treatment options.
- Special considerations for certain populations (inmates and parolees)
- Substance use disorder treatment options other than medication-assisted treatment.

[7] https://www.oregon.gov/gov/policy/Documents/OETF%20Minutes_9.19.17.pdf
[8] 2018 Or Laws ch 45.

While the report does make recommendations about how to address identified barriers, policymakers should engage further with the task force and other stakeholders on concrete solutions and implementation strategies.

Although the report makes recommendations to be taken at a state level, the report does not exist in a vacuum. There are a number of federal bills that the Department of Consumer and Business Services staff members are monitoring, which could affect the recommendations. See the section "Pending Federal Legislation" for a list of the federal bills addressing medication-assisted therapies.

Recommendations

The following is a collation of the barriers and recommendations interspersed throughout the main report.

Substance Use Disorder: A Chronic Condition

Barrier: Substance use disorder is typically treated as an acute condition.

Recommendations:

- *A formal recognition by the Oregon Legislature and Governor that substance use disorder is a chronic condition that requires continued multi-disciplinary and coordinated care.*
- *Explore with the Oregon Health Authority and the Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee the opportunity to revise relevant existing PCPCH standards, or create new PCPCH standards, relating to coordination of care and continuum of care for individuals with substance use disorders, recognizing that substance use disorder is a chronic condition that should be proactively addressed in a primary care setting.*
- *Payers to provide ongoing care and services for substance use disorder without requiring acute symptoms or relapse as a basis for coverage to trigger treatment, recognizing that this is directly related to access to treatment.*
- *Support the development and implementation of behavioral health homes (BHH), and encourage the adoption of the BHH standards and encourage coordinated care organizations to use behavioral health homes.*

Access to Insurance Coverage and Benefits

Mental Health Parity

Barrier: Further investigation is needed to examine and address potential compliance issues related to mental health parity within both the commercial and public insurance markets.

Recommendations:

- *Continue and expand the scope of SB 860 (2017) to authorize DCBS to investigate whether insurance carriers are fully complying with mental health parity laws when assessing medication-assisted treatment claims for substance use disorders.*
- *Add a requirement for DCBS to report on the findings of investigations under the SB 860 framework.*

- *The Oregon Health Authority will continue its work to be compliant with mental health parity for Medicaid populations.*

Private Insurance Access, Affordability, and Coverages

Barrier:

- *State regulation of health insurance is fragmented, and DCBS has a limited ability to engage all sectors of the private insurance market.*
- *Plan pricing also continues to create challenges for coverage.*
- *Despite DCBS's efforts, plan offerings are not widely distributed across all geographic regions of the state.*

Recommendations:

- *Direct DCBS to study and report back to the Legislative Assembly on whether large-group insurance coverage is also meeting substance use disorder requirements.*
- *Direct DCBS to study and report back to the Legislative Assembly on the feasibility, successes, and challenges associated with greater regulation of the large group insurance market.*
- *Direct DCBS to engage with the United States Department of Labor, whether individually or through associations, on potential insurance reforms in the self-insured market around substance use disorders generally and specifically for medication-assisted treatment.*

Reimbursement Structures in Commercial and Public Insurance

Delivery of Care: Provider Networks

Provider Networks Established by Private Insurance Carriers.

Barrier: Insurance coverage is delivered through "adequate" networks of providers. Networks may not be adequate to actually deliver medication-assisted treatment services in all areas of the state. Whether this is because of lack of provider availability or network construction is an open question.

Recommendation: Direct DCBS to convene a rulemaking advisory committee tasked with modifying the administrative rules implementing network adequacy standards under House Bill 2468 (2015) with specific focus on time and distance standards for substance use disorder treatment.

Provider Networks Established under the Oregon Health Plan.

Barrier: Creation of adequate capacity within the substance use disorder treatment system/provider network to address the needs of the affected population covered through OHP/Medicaid. Some factors which contribute to this barrier include low rates, federally mandated limitations in capacity, and lack of comprehensive provider network assessments to identify specific areas of need and gaps.

Recommendations:

- *Direct the OHA to continue its assessment of the behavioral health workforce and to implement the appropriate recommendations concerning recruitment and retention of a well trained workforce.*
- *Through the CCO 2.0 process, the OHA works with the Coordinated Care Organizations to: develop a diverse behavioral health workforce who can provide culturally and linguistically appropriate care.*
- *Implement the recommendations of the Traditional Health Workers Commission.*
- *Develop a mechanism to assess adequacy of behavioral health provider network.*
- *Require CCOs to perform comprehensive evaluation reports on the "state of addiction" in their service coverage areas, to determine individual needs in each service area, and use this as a blueprint to identify specific needs and barriers.*
- *Require payers to identify clear "continuum of care" services for SUD that are provided and reimbursed for through their plans, including assessment, evaluation, a variety of treatment services, as well as aftercare/ongoing recovery supports which are provided and covered.*
- *Incentivize providers at all levels of addiction treatment services to engage in treating this population by providing educational and other financial incentives to increase workforce capacity, possibly under the auspices of a "rural behavioral healthcare initiative."*
- *Request OHA to research potential strategies to reduce barriers and increase accountability in covering a variety of SUD services which may include payment and funding strategies and/or inclusion in the CCO metrics for the 2020 CCO contract.*
- *Expand current Project ECHO model for additional Primary Care Addiction/Substance Use Disorders in Ambulatory Care (including medication assisted treatment). Current (2017-2019) project includes: Project ECHO across the state with special focus on rural and frontier regions. Provider type expanded to nurse practitioners, PAs, and hospitalists.*
- *Legislative action to incentivize SUD specialty treatment providers to provide MAT services, especially in rural and underserved areas of Oregon. Incentives may include State Loan Repayment program, student loan repayments, stipends, financial incentives for treatment providers to offer services in underserved areas, relocation assistance for treatment professionals moving to rural, frontier or other underserved areas, educational opportunities and direct financial support for telemedicine equipment and training. Of note: NHSC just released funds ($105 million) to incentivize providers in rural regions who offer OTP, OBOT, and SUD services.*

Formularies and Preferred Lists for Prescription Drugs

Formulary Construction by Commercial Payers.

Barrier: While DCBS receives information on formulary construction in initial rate filings, insurance carriers modify formularies throughout a plan year. Medications used to treat substance use disorder may move into higher-cost tiers without warning.

Recommendations:

- *Include mid-year tiering reports for substance use disorder medications as part of the data gathered by the DCBS prescription drug transparency program under HB 4005 (2018).*
- *Give DCBS the statutory ability to regulate insurance carriers' and pharmacy benefit managers' practice of making mid-year tiering changes for substance use disorder medications.*

Preferred Drug Lists Established under the Oregon Health Plan.

Barriers: Currently there are 15 CCOs and a fee-for-service program that pay for services and medications under the Medicaid system in Oregon. Each CCO and the FFS program can have varying coverage criteria and different preferred medications. This creates regional variability and inconsistencies that providers and patients must navigate. This does impact substance use disorder and medication-assisted treatment medications as it does with other medications.

Recommendations:

- *Continue to explore potential benefits of and strategies for alignment of PDLs across FFS and CCOs, and consider the impact for MAT coverage.*
- *Consider the benefit and opportunity for adoption of strategies that will be included in the forthcoming recommendations from the National Governors Association task force focused on pharmacy purchasing in the face of public health crises.*

Fee-For-Service Preferred Drug List & Medication Assisted Treatment.

Barrier: Although Oregon's Medicaid program is conscious of prior authorizations creating barriers to timely access, there are criteria in place to ensure safety, and appropriate use. Additionally preferred drug lists drive utilization to cost-effective agents within the medication-assisted treatment space. However, advocates and some providers view any prior authorization as restrictive and a significant barrier to timely treatment. This is particularly an issue when payers create "fail first" criteria for substance use disorder treatment medications.

Recommendations:

- *Mandate one medication-assisted treatment medication preferred drug list and coverage criteria alignment to minimize variability within the statewide Medicaid delivery system.*
- *Expand HB 3440's reach to the Medicaid program, and require no prior authorization for the first 30 days of medication-assisted treatment medications.*

Utilization Management

Prior Authorizations, Step Therapies, and Prioritized Lists

Barriers:

- *Prescription drugs, being expensive to administer, generally are dispensed and paid for after providers take certain steps to control how these drugs are used. In theory, this could make dispensing medications for substance use disorder more costly.*
- *OHP does not currently cover recovery support services after substance use disorder treatment is completed.*

Recommendations:

- *DCBS should convene a meeting with carriers to discuss ways of ensuring that prior authorization processes and utilization review are medically appropriate, fully complies with SAMHSA guidelines, and are uniform across carriers. DCBS should report back to the Legislative Assembly on the feasibility of codifying the findings of the workgroup into rules, or if further legislation is necessary.*
- *OHA to ask HERC to add procedure codes representing recovery services to the SUD line of the Prioritized List of Health Services, to be followed by necessary administrative actions by OHA to provide them as a covered OHP benefit.*

OHP Fee Schedule: Fee-For-Service

Barriers: Lack of regular and ongoing review of the behavioral health fee-for-service rates.

Recommendation: The Oregon Health Authority complete a review of the fee-for-service behavioral health rates to ensure the rates are adequate and based on sound rationale and data.

Access to Treatment in Underserved Areas/By Underserved Populations

Rural Disparities in Access to Treatment

Barriers: Providers of medication-assisted treatments are scarce, and the need is greater in underserved and rural parts of the state.

Recommendations:

- *Require payers to develop a user-friendly, comprehensive list of substance use disorder treatment providers that include details regarding what services they are trained and authorized to provide and whether they are available to new patients, including Medicaid.*
- *Encourage, with financial incentives, the Drug Addiction Treatment Act (DATA) waivered providers to partner with existing substance use disorder treatment facilities, and offer services to their clients, to build on current capacity, enhance the menu of services provided and encourage medication-assisted treatment integration into traditional substance use disorder treatment settings.*

- *Require rural health care centers to have at least some capacity to offer medication-assisted treatment services through DATA-waivered providers, and link those centers to opioid treatment programs, encouraging the natural development of a "hub-and-spoke" system of opioid use disorder treatment.*

- *Expand regional opioid summits to include learning collaboratives where providers can access locally based education and patient-specific case consultation to increase their ability to serve these patients effectively and promote better outcomes and better retention in treatment*

Other Groups Facing Barriers to Treatment for Substance Use Disorders

Barriers: Lack of access to coverage and scarce information seen in certain populations.

Veterans

Recommendations: *The Oregon Health Insurance Marketplace should increase outreach to veterans who do not have access to U.S. Department of Veterans Affairs health benefits and help them access other coverage.*

Native Americans in Oregon

Barriers: Medication-assisted treatment implementation with the native population requires integrating into traditional healing approaches and frameworks, some barriers to implementation involve unique cultural considerations.

Recommendations:

- *The Oregon Health Authority should continue its effort to collaborate with Oregon's nine federally recognized tribes, and the Urban Indian Health Program (UIHP) to overcome medication-assisted treatment implementation barriers and continue the effort to bridge the gap between western medicine and traditional native healing.*

- *OHA, in collaboration with the tribes and the Native American Rehabilitation Association, should train medical providers, as needed, in delivering the evidence based MA, so they honor the native population's emphasis on spirituality, holistic healing, and wellness.*

- *Fund scholarships for tribal members or other people of color to become certified addiction counselors in order to develop culturally competent workforce.*

Special Considerations: Department of Corrections

Barriers:

- *The Department of Corrections lacks the funding and resources to implement medication-assisted treatment.*

- *There is a lack of treatment slots available to meet the needs of the adults in custody.*

- *The Department of Corrections uses a paper-based medical records system that is a barrier to providing a continuity of care before, during, and after incarceration.*
- *There is a lack of community-based services for offenders releasing from the Department of Corrections, specifically in rural areas.*

Recommendations:

- *Increase funding for substance use disorder treatment to help close the gap between services available to the adults in custody and their needs. Provide funding for an electronic medical records system.DOC should seek technical assistance to help identify the medication-assisted treatment that will be the most medically appropriate within a correctional setting. Provide funding for medication-assisted treatment to be provided in DOC.*
- *Increase community-based services for continuity of care for offenders releasing from DOC.*

FOREWORD

Substance abuse and addiction remains one of the most pressing and costly public health and societal problems in both Oregon and the United States. According to estimates, substance misuse and substance use disorders cost the United States more than $442 billion annually in crime, health care, and lost productivity.[9] These costs are almost twice as high as the costs associated with diabetes, which is estimated at $245 billion each year.[10] A large and growing body of evidence points toward the conclusion that addiction is a chronic condition requiring coordinated management and care, like diabetes. However, most substance abuse treatment services are delivered in an acute care manner.[11]

This report focuses on what Oregon's addiction treatment system looks like today and what challenges lie ahead in continuing to develop a modern, effective, and evidenced-based system to treat addictive disorders and help Oregonians struggling with addiction. It includes an overview of addiction as a chronic condition, what it means for public policy, and how and where we currently treat addiction is treated in Oregon. Insurance coverage, and how service providers are reimbursed, is a crucial element of ensuring access to care across the state. This report looks at the effect of commercial and publicly funded coverage, specifically as it relates to medication-assisted treatment for opioid use disorder. Finally, the report examines what the addiction treatment system looks like in Oregon's correctional system and the unique dynamics of the overlap between criminal justice, corrections and the Medicaid population.

A multitude of challenges exist in continuing to create an effective and modern treatment system in Oregon, including: unique geographical challenges, long-held beliefs and attitudes regarding addiction, workforce shortages, especially in rural and underserved areas, among others. However, there also remains much to be hopeful about. About 50 percent of adults who once met diagnostic criteria for a substance use disorder — or about 25 million people — are currently in stable remission (one year or longer).[12] In addition, – the number of people who are in remission from a substance use disorder nationwide is approximately 10.3 percent and is greater than the number of people who define themselves as being in recovery, and about 50 percent of adults who once met diagnostic criteria for a substance use disorder – or about 25 million people – are currently in stable remission (one year or longer).[13]

As noted in the *Surgeon General's Report on Alcohol, Drugs, and Health: Facing Addiction in America*[14], "Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, strive to reach their full potential and can be achieved through diverse

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[9] Sacks, J. J., Gonzales, K. R., Bouchery, E. E., Tomedi, L. E., & Brewer, R. D., *2010 national and state costs of excessive alcohol consumption*, American Journal of Preventive Medicine, 49(5), e73-e79. (2015).
[10] Centers for Disease Control and Prevention, *National Diabetes Statistics Report: Estimates of diabetes and its burden in the United States* (2014).
[11] *See* the section *Substance Use Disorder: A Chronic Condition*. *See also* Webster's Third New Int'l Dict. 23 (2002 unabridged ed) (defining "acute" as "*of a pathological process*: having a sudden onset, sharp rise, and short course <~disease> <~imflammation> ─ opposed to chronic[.]")
[12] *See* White, W. *Slaying the dragon: The history of addiction treatment and recovery in America (2nd Ed.)* (2014); Bloomington, IL: Chestnut Health Systems.; Center for Behavioral Health Statistics and Quality. (2016). Results from the 2015 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[13] *Ibid.*
[14] US Department of Health and Human Services, *Facing Addition in America: the Surgeon General's Report on Alcohol, Drugs, and Health* (available at https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf) (last visited July 11, 2018).