Report on existing barriers to effective treatment for and recovery from substance use disorders, including addictions to opioids and opiates

As required by 2018 House Bill 4143

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TABLE OF CONTENTS

TABLE OF FIGURES

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-

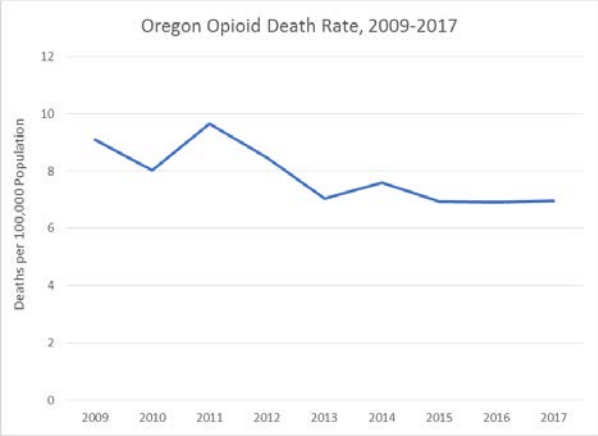
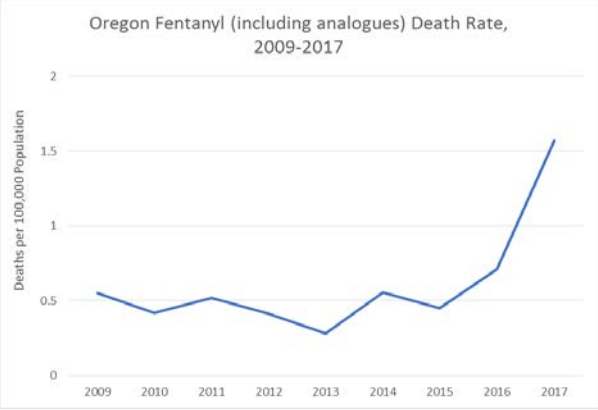


Figure 2. Oregon Overdose Deaths, Fentanyl, 2009-



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).

pathways." Through improving our addiction treatment system in Oregon, we can help more Oregonians struggling with addiction, as well as future generations, begin the journey toward recovery.

BACKGROUND: MEDICATION-ASSISTED TREATMENT

Neurochemistry and Recovery

Before discussing the barriers and recommendations to medication-assisted treatment (MAT), a primer on what MAT means in this context is necessary. The disease model of addiction is based on the concept that addiction is a condition rooted in a person's physiology, genes that govern brain functioning, and environmental factors. The American Society of Addiction Medicine (ASAM) notes that addiction is a "chronic disease of brain reward, motivation, memory, and related circuitry."[15]

Opioid addiction and dependence flow from how the brain reacts to the substance. In the brain's natural state, it converts a high-energy molecule the body uses for energy transfer called adenosine triphosphate through an intermediate reaction[16] into a substance called noradrenaline.[17] Among other things, noradrenaline regulates a person's alertness. When a person takes an opioid, it binds with certain receptors in the neurons (the mu receptors) and inhibits the production of noradrenaline.[18] This produces the sedate effects commonly attributed to opioids. As the brain adapts to the repeated suppression of noradrenaline, it produces more of the substance to try to normalize a person's alertness.[19] This has the effect of creating tolerance to increased amounts of the drug. The brain in this dependence loop of addiction needs more and more opioids to return to that suppressed state.[20]

If a person stops using opioids, the drug no longer mediates the production of noradrenaline. This over-production of noradrenaline leads to the physical symptoms of withdrawal.[21] Eventually, a person's brain will normalize production of noradrenaline and the physical symptoms will subside. But in that time, a person in recovery is at high risk of relapse.

Thus, medication-assisted treatment is meant to "normalize brain chemistry, block the euphoric effects of [the drug], relieve physiological cravings, and normalize body functions without the negative effects of the abused drug."[22] The prescription medication used to help recovery mediates this chemical imbalance.[23] and increases the likelihood that an individual will remain in treatment, boosting the effectiveness of counseling for a full recovery. Medications are used in the treatment of opioid use disorder (OUD) to accomplish two primary goals – to relieve physical symptoms of withdrawals and cravings and achieve stability. Three medications are used today to treat opioid use disorder: methadone,

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[15] *See* American Society of Addiction Medicine, *National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use* 3 (2015) (available at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf).
[16] The intermediate reaction produces a substance called cyclic adenosine monophosphate (cAMP). *See* note 4, *supra.*
[17] *See* note 4, *supra; see also* https://pubchem.ncbi.nlm.nih.gov/compound/Adenosine_triphosphate
[18] *Ibid.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *See* SAMHSA, *Medication and Counseling Treatment*, (available at https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat) (last visited 7/2/2018).
[23] *Ibid.*

a full agonist opioid, buprenorphine, a partial agonist opioid, and opioid antagonists (the long-acting naltrexone and the short-acting naloxone).

Buprenorphine

Buprenorphine is what the federal Substance Abuse and Mental Health Services Administration (SAMHSA) terms as an "opioid partial agonist," because it partially attaches to the mu receptors in the brain.[24] Since it is still technically an opioid, it still produces effects such as euphoria and respiratory depression, but its strength is weaker than other opioids such as heroin and methadone.[25] Buprenorphine also has a "ceiling effect," which means that the drug effectively levels off at moderate doses.[26] This effect lowers the risk of misuse, dependency, and side effects including overdose and death. Buprenorphine' effects are also more long lasting, meaning that patients may not have to take it every day.[27]

Opioid Antagonists: Naltrexone & Naloxone

Unlike buprenorphine, long-acting naltrexone is not an opioid, but an opioid antagonist; it inhibits the effects of opioids by blocking the interaction between an opioid and the brain's mu receptors.[28] While naltrexone itself cannot be abused or diverted to illicit channels, it does reduce tolerance to opioids, when the blocking effects of the medicine wear off.[29] A period of detoxification from opioids is necessary for individuals being treated with naltrexone before they receive their first dose. Failure to do this can precipitate withdrawal in individuals who are still physically dependent on opioids.

Thus, one risk with the use of naltrexone is that a person who takes a previously accustomed dose of opioids can overdose more easily, with any interruptions in treatment.[30] Naltrexone can be administered monthly through an intramuscular injection, in the formation known as Vivitrol, or extended release (ER) naltrexone. This drug remains the only opioid antagonist approved by the Food and Drug Administration (FDA) for maintenance treatment of opioid use disorder.

In contrast, the short-acting opioid antagonist naloxone is used as an opioid reversal medication with individuals experiencing the effects of an opioid overdose. Naloxone works to reverse withdrawal by attaching to the brain's opioid receptors and essentially removing the opioids attached to the receptors, reversing the opioid effects, which can lead to respiratory depression and death at high doses. In most cases, administration of naloxone will induce withdrawal symptoms, much like longer acting naltrexone will in opioid dependent individuals who have not been detoxified from opioids. However, as a short acting opioid antagonist, the effects of the medication will wear off quickly after administration in the case of an opioid overdose, and emergency medical attention needs to be accessed quickly.

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[24] *See* SAMHSA, *Buprenorphine*, (available at https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine) (last visited 7/2/2018).
[25] *Ibid.*
[26] *Id.*
[27] *Id.*
[28] *See* SAMHSA, *Naltrexone*, (available at https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone) (last visited 7/2/2018).
[29] *Ibid.*
[30] *Id.*

Methadone

Methadone has been used since the mid 1950's for treatment of opioid dependence. A full opioid agonist, methadone fully attaches to the mu receptors in the brain and relives cravings and withdrawals for opioid dependent people being treating with it. As opposed to other full agonists, such as heroin or other commonly abuse opioid painkillers, which are short acting, methadone is a long acting opioid. When used for treatment of addiction, methadone relives cravings and withdrawal symptoms for a longer period of time than the short acting opioids, and only needs to be administered once daily.

Methadone maintenance therapy, when administered in the appropriate setting, removes the need for the individual to continue to take short acting, often illicit opioids, to relieve their withdrawal symptoms, and can be restore them to a higher level of functioning. In Oregon, as in the rest of the United States, methadone for the treatment of addictive disorders can only be dispensed at state- and federally-licensed opioid treatment programs (OTPs).

Patients can earn "take-home" medications as long as they exhibit periods of stability and meet certain requirements set in federal law. Methadone is the most highly regulated form of addiction treatment in the United States and the most widely researched and studied form of substance abuse treatment in history. Decades of evidence have shown methadone treatment to highly effective in reducing infectious disease rates, illicit drug use, criminal activity, and improving overall quality of life in individuals being treated with it.

SUBSTANCE USE DISORDER: A CHRONIC CONDITION

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

Addiction, specifically alcoholism, was first recognized as a medical condition in 1956 by the American Medical Association (AMA).[31] By 1991, the medical community recognized addiction as both a psychological and a medical condition. The American Psychiatric Association (APA) and the World Health Organization (WHO) both define addiction as a "chronic, tenacious pattern of substance abuse, along with related problems associated with this usage."[32]

Substance use disorder is a chronic condition, however addiction treatment traditionally focuses on addressing the immediate and visible acute episodes and symptoms – and, to a lesser extent, the chronic conditions. Patients are traditionally assessed, treated, and then discharged in episodes of care ranging from a few days to a few months. [33] Studies have suggested that individuals in publicly funded addiction treatment programs cycle in and out of treatment, relapsing multiple times before achieving stable

[31] Alcohol use disorder is currently defined in the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

[32] See Dennis, M. L., & Scott, C. K., *Managing Addiction as a Chronic Condition*, 4(1) NIDA Science and Practice Perspectives 45-55 (2007).

[33] *See* McLellan, A. T., O'Brien, C. P., Lewis, D. & Kleber, H. D. *Drug addiction as a chronic medical illness: implications for treatment, insurance and evaluation*. Journal of the American Medical Association, *284*, 1689–-1695 (2000).

recovery from substance use.[34] This data indicates that a continued focus on acute treatment of substance use disorder is inefficient and may prevent successful recoveries.[35]

As a chronic condition, addiction remains unique in that it often requires a specific external input to cause initial symptoms (i.e., alcohol or drug use). The continuation of the behaviors that cause these symptoms can be directly tied to changes in brain function over time. Chronic substance use is associated with physical changes in the brain that can affect neurobiological functioning and emotional regulation. [36] Neuroimaging of the brain can detect patterns related to cravings, cue reactivity (or triggers), cause withdrawal from dependence-inducing substances, and increase tolerance for the drug.[37] The vast majority of adults with the most severe substance use disorders generally began heavy or maladaptive substance use patterns well before the age of 18.[38]

As illustrated in Figure 3, compared to other chronic conditions, individuals with substance use disorders tend to observe treatment regimens less often and relapse at similar rates as other chronic conditions.

Figure 3. Adherence to Treatment and Relapse by Condition

Disease	Adherence	Relapse
Hypertension	≥ 60%	50%-60%
Diabetes	≥ 50%	30%-60%
Asthma	≥ 30%	60%-80%
Substance Use Disorder	30-50%	50%-60%

Source: McLellan, T., PowerPoint Presentation, "How Can Treatment be more Accountable and Effective? Lessons from Mainstream Healthcare." San Antonio, TX, 2005.

While some progress has been made in achieving parity for not only substance use disorders, but also mental health conditions, the acute care model still dominates the delivery and payment of services. For virtually all other chronic conditions, providers engage in, and are paid for, providing aftercare, follow-up, and maintenance services designed to reduce or prevent acute episodes. The focus of acute treatment of substance use disorder contributes to the limited funding for long-term management and recovery services. Balancing the need for acute care in the aftermath of a relapse or an overdose with ongoing evidenced-based treatment preventing future crises is imperative.

[34] Dennis, M.L., Foss, M.A., Scott, C.K. An 8-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*. *31*(6), 585–612. (2007).
[35] *Ibid.*
[36] *See* note 32, *supra.*
[37] *Ibid.*
[38] *See* Kirkcaldy, B.D., Siefen, G., Surall, D. & Bischoff, R.J., *Predictors of drug and alcohol abuse among children and adolescents*. 36 Personality and Individual Differences, 247–265 (2004).

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.*

CURRENT LANDSCAPE: HOW SUBSTANCE USE TREATMENT IS REIMBURSED IN OREGON

This section provides an overall picture of: (1) access to public and private insurance, (2) reimbursement structures in commercial and public insurance, and (3) conditions on reimbursement for commercial and public payers.

Access to Insurance Coverage and Benefits

According to 2017 data, 94 percent of Oregonians have some form of major medical insurance coverage.[39] In 2017, 47.5 percent of Oregonians had private group health insurance, 26 percent had Medicaid through the Oregon Health Plan, 15.1 percent had Medicare, 5.2 percent had individual private insurance, and 6.2 percent were uninsured.[40]

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.

In the commercial market, treatment for substance use disorders is included within the larger area of mental health coverage. Since 1975, Oregon has required health insurance carriers in the group market to

[39] Oregon Health Auth., *Oregon Health Insurance Survey 2017* (available at http://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2017-OHIS-Early-Release-Results.pdf) (last visited 7/11/2018).
[40] *Ibid.*

provide coverage for mental health. In 2005, Oregon's mental health mandate was expanded to require coverage of substance abuse in that market.[41]

Group health benefit plan coverage requirements were expanded with the passage of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act[42] (MHPAEA), which further defines coverage requirements for mental health and substance use disorders. Although an improvement, the federal law is not a mandate to require coverage, and applies only when mental health/substance use disorder is provided under a group health insurance plan. While the MHPAEA does not directly require parity in benefits based on group size, the essential health benefits provisions of the Affordable Care Act integrate the MHPAEA into ACA-compliant plans. This has the effect of requiring mental health parity in plans for the small group market. It does not apply when a plan does not offer this benefit and entirely exempts individual plans.

ORS 743A.168 requires health plans offered in the commercial insurance market to provide benefits for treatment of chemical dependency at the same level as, and subject to, limitations no more restrictive than, those imposed on coverage or reimbursement of expenses for treatment of other medical conditions. This law is in alignment with requirements of the MHPAEA, but tends to exclude self-insured plans (for which the state is largely pre-empted from regulation under the Employee Retirement Income Security Act) and large-group health insurance plans.

DCBS has investigated and assessed civil penalties for insurance companies found to be out of compliance with mental health parity laws. Efforts are also underway to continue the work of strengthening verification of compliance with the law. In the 2017 session, the Legislative Assembly enacted SB 860, which requires DCBS to undertake an investigation of certain questions related to pay parity among behavioral health and physical health professionals.[43] While that work is ongoing, the same investigative effort could be expanded through enabling legislation as a follow-on to substantive recommendations included in other sections of this report.

Mental health parity also applies to providers in the Oregon Health Plan. In 2016, the Centers for Medicare and Medicaid Services (CMS) released rules on the application of mental health parity to certain Medicaid populations which went into effect in 2017. The OHA is currently leading substantive efforts, in partnership with coordinated care organizations, to assess and mitigate any mental parity issues for Oregon's Medicaid populations. Detailed findings of OHA's analysis and plans for improvement are expected to be available in the fall of 2018.

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[41] *See* ORS 743B.168.
[42] 29 U.S.C. § 1185a.
[43] 2017 Or Laws ch 694.

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.*

Oregon, like all states, operates within a patchwork reimbursement structure. The most heavily regulated segment of the health benefit plans market – individual and small group – make up a small percentage of Oregonians' major medical coverage. An employer may purchase a small group insurance plan if it covers up to 50 employees, and large group employers cover 50 and more employees.[44] Large group coverage does need to comply with the state Insurance Code, though there are significant differences.

Figure 4 shows the number of Oregonians enrolled in individual and small group plans subject to the Insurance Code:

Figure 4. 2018 Enrollment in Commercial Health Benefit Plans

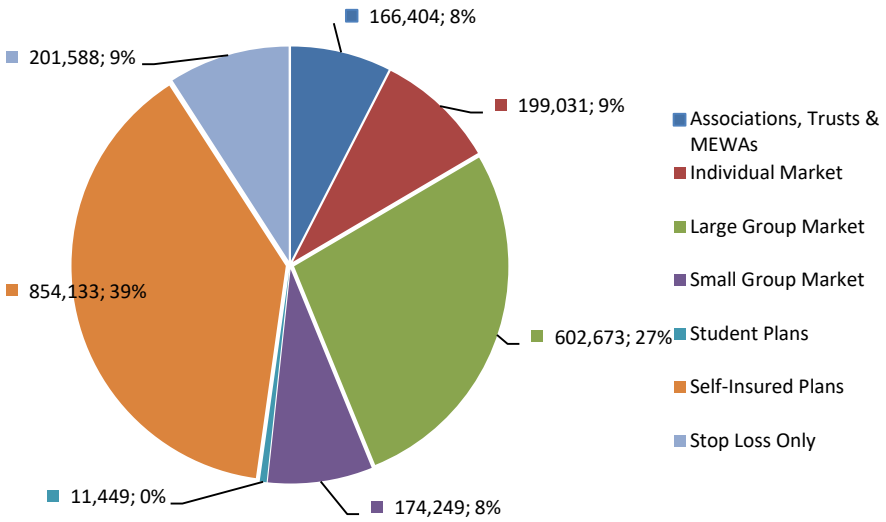
Individual Market Plans		Small Group Market Plans		Large Group Enrollment	
Catastrophic	468	Catastrophic	n/a	Plan details are generally not available for large group market plans.	
Bronze	76,672	Bronze	10,860		
Silver	95,580	Silver	67,443		
Gold	26,194	Gold	66,780		
Platinum	n/a	Platinum	27,244		
Grandfathered/Transitional	117	Grandfathered/Transitional	1,922		
Total	**199,031**	**Total**	**174,249**	**Total:**	602,673

Source: DCBS Enrollment Data

[44] *See* ORS 743B.005, as modified by 2017 Or Laws ch 142 § 1(25) (Enrolled Senate Bill 271).

For context, the overall breakdown of how Oregonians are insured through all private payers is as follows:

Figure 5. Total Private Insurance Market in Oregon



Further complicating the picture, most self-insured plans are exempt from Oregon insurance laws and instead follow federal requirements in the Employee Retirement Income Security Act of 1974 (ERISA).[45] This fragmentation limits the options available to state government to improve access to substance use disorder benefits.

For those markets Oregon actively regulates, plan pricing remains a considerable barrier. Premiums have continued a steady rise since the beginning of the ACA.[46] Once covered on a commercial health benefit plan, members face additional co-insurance costs[47] that must be met before any benefits are paid for either treatment or medications. Even the relatively generous standard silver plan requires that a $2,500 deductible be met before payment of treatment benefits.[48]

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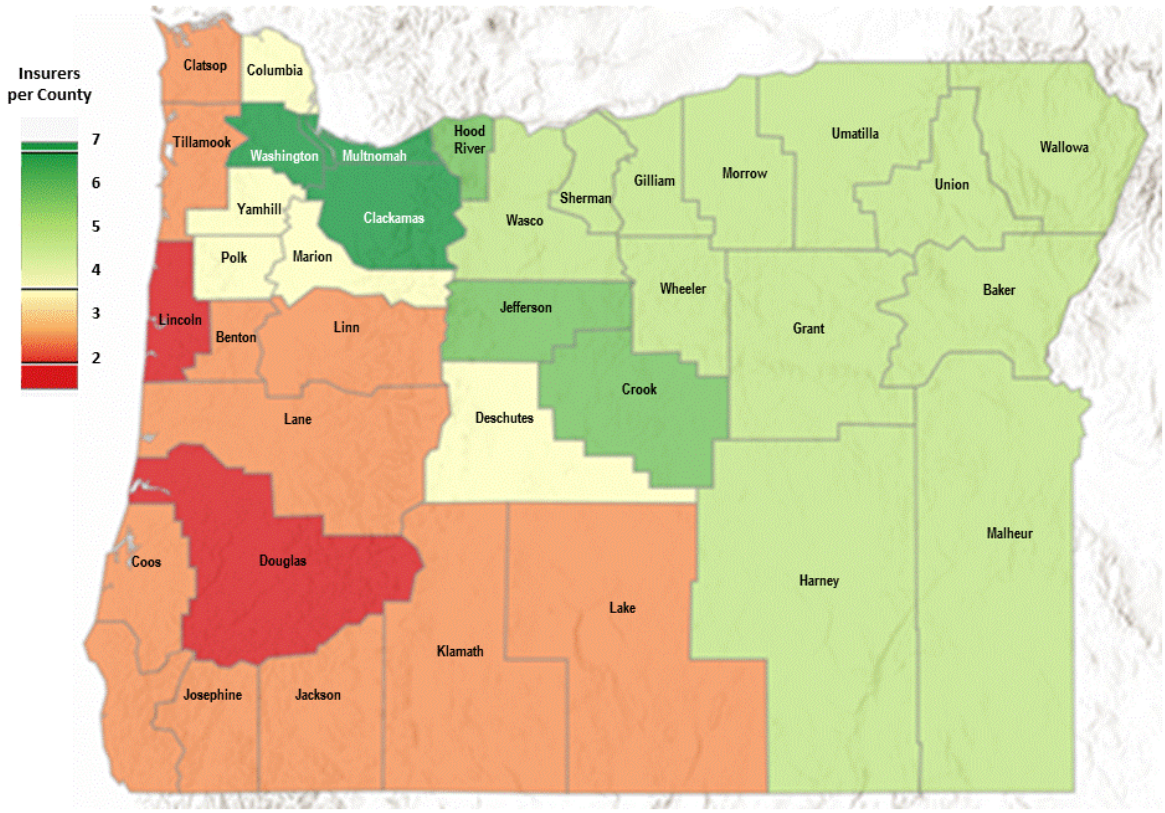
[45] Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 829 (codified at 29 U.S.C. 1001 *et seq*).
[46] *See* Dept. of Consumer and Bus. Svcs., *2018 Final Rate Decisions* (November 2017) (available at http://dfr.oregon.gov/healthrates/Documents/2018-fnl-rates.pdf); *see also* Dept. of Consumer and Bus. Svcs., *Oregon standardized health plans: Summary of Coverage* (June 2018) (available at http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf).
[47] Metal tier plans are defined in federal law and relate to a plan's actuarial value. Actuarial value means a general average of what percentage of each dollar spent on benefits is covered by the plan a member is insured under. Bronze=60 percent; Silver=70 percent; Gold=80 percent; Platinum=90 percent; and catastrophic=50 percent(this last plan type is (available only to members younger than 30 years old).
[48] Dept. of Consumer and Bus. Svcs., *Oregon standardized health plans: Summary of Coverage* (June 2018) (available at http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf).

Another factor that limits access to plans in the commercial market is where people live. In general, fewer plans are available for purchase from fewer carriers the further away from the Portland metropolitan area a person lives. In large areas along the coast and eastern part of the state, there are no more than two carriers offering plans, typically one on and one off the health insurance exchange.[49]

Figure 6. 2018 County Coverage Heat Map – Number of Plans per County



[49] For a tabulated list, please see Dept. of Consumer and Bus. Svcs., *2018 Individual Coverage - County* (available at http://dfr.oregon.gov/healthrates/Documents/2018-individual-coverage.pdf).

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

Reimbursement structures for both private and public payers of health insurance can generally be combined into several common categories:

- Payers generally establish networks of providers that will administer covered services
- Payers establish what kinds of drugs may be reimbursed and at what rates (e.g., a formulary)
- Payers require upfront checks on how treatments must proceed for reimbursement (e.g., utilization management)

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.

The requirement to provide adequate coverage and for parity between medical and mental health/substance use disorder benefits has improved access to care. However, these requirements do not fully address the issue of access as insurers retain considerable latitude in managing access to care through provider and facility contracting.

Under Oregon law, anyone offering a health benefit plan must ensure that the networks of providers are sufficient to deliver the coverage the insurance carrier offers without unreasonable delay.[50] This includes ensuring that adequate networks of pharmacies, whether chain or independent, are included in the network. However, this does not mean that anyone is required to be allowed to join a carrier's network of providers. For those carriers that offer qualified health plans, the federal regulations around network

[50] ORS 743B.505(1)(a).

adequacy specifically require the networks to maintain sufficient mental health/substance use disorder providers.[51]

Most legal protections found in MHPAEA, Oregon law, and the ACA are limited to in-network benefits. In 2018, ACA individual market plans either offer no out-of-network benefits (aside from emergency services), or out-of-network benefits subject to out-of-pocket limits far in excess of in-network limits.[52]

In order to access coverage from out-of-network providers or facilities, members must either pay for services out of pocket or demonstrate there are an insufficient number of providers with the necessary specialty in their area. Although all health benefit plans include some provision to temporarily credential providers on a single-case basis, this process may lead to more treatment delays.

Insurers complying with network adequacy requirements via a nationally recognized standard adhere to time and distance standards for access to care demonstrating that 90 percent of enrollees within the network are within the time and distance standards for a given type of provider.

While the Oregon Office of Rural Health defines rural areas of the state as any place located more than 10 miles from the center of a city that has at least 40,000 people, the Centers for Medicaid and Medicare Services a different approach is used for determining whether networks provide adequate access to care. Population and density parameters are used to place counties into each of the following categories:

- Large Metro
- Metro
- Micro
- Rural
- CEAC (Counties with extreme access conditions)[53]

Time and distance standards are associated with each category of county. Examples of the 2018 Medicare Advantage nationally recognized standards for primary care providers and psychiatrists are shown in the table below:

Figure 7. Medicare Advantage Time-and-Distance Standards for Primary Care

Type of County	Primary Care		Psychiatrist	
	Time	Distance	Time	Distance
Large Metro	10 minutes	5 miles	20 minutes	10 miles
Metro	15 minutes	10 miles	45 minutes	30 miles
Micro	30 minutes	20 miles	60 minutes	45 miles
Rural	40 minutes	30 miles	75 minutes	60 miles
CEAC	70 minutes	60 miles	110 minutes	100 miles

Source: CMS HSD Reference File; available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/HSDReferenceFile_01-10-18.xlsx

[51] *See* 45 CFR §§ 156.200 & 156.230.
[52] Data via ACA in-network vs out of network maximum out-of-pocket from 2018 binder filings (available at https://filingaccess.serff.com/sfa/home/OR).
[53] For population and density parameters, please see Ctr. for Medicare & Medicaid Svcs., *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance* (February 20, 2018) (available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf) (last visited July 10, 2018).

Depending on population density, counties falling within the Metro, Micro, Rural, or CEAC categories could meet the Office of Rural Health's definition of a rural county. The lack of providers authorized to provide medication-assisted treatment within rural areas of Oregon presents a challenge for the development of provider networks that meet the time and distance requirements noted above or to ensure care can be provided to enrollees by out-of-network medication-assisted treatment providers through the use of single-case agreements.

The level of reimbursement that carriers are willing to pay providers for substance use disorder treatment also acts as a barrier to care. Providers have indicated that the low level of reimbursement is leading to fewer people willing to enter or remain in this profession in Oregon. The reimbursement issue might also contribute to the low number of providers located in rural areas of the state.

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.

The Oregon Health Authority delivers managed care through a coordinated care model established by the CMS § 1115 Managed Care waiver.[54] Each Coordinated Care Organization (CCO) contracts with the Oregon Health Authority to provide services for its members, for a wide range of healthcare needs. Included in this menu of required, covered services is substance use disorder treatment, including outpatient treatment services, residential treatment services, gender and culturally specific treatment, and specialty services such as medication assisted treatment. The treatment providers delivering these services, which include tribal and urban Indian providers as well, must be licensed and/or certified by OHA in order to be eligible for reimbursement by either a CCO or OHP fee for service (FFS), directly. Other requirements exist as well, including requirements to provide services to priority populations, including intravenous drug users and pregnant women, within a specified time frame.

While CCOs and OHP and FFS programs are required to cover these services and CCOs are required to develop adequate networks to meet the needs in their service areas, large gaps remain. For example, federal law restricts Medicaid payments for treatment services delivered within the context of what is defined as an "institution for mental disease," which is any treatment facility that houses more than 16

[54] *See* 42 U.S.C. § 1315(a). Text of the waiver approval is available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf.

people at any one time.[55] Despite the continued need for this higher level of care, this restriction not only is a disincentive for providers to expand services, especially in rural and underserved areas, it also creates a financial burden for the state, as general fund and other monies are used to bridge the gap between covered and non-covered services for the Medicaid substance use disorder population accessing treatment in these facilities.

While Oregon has come a long way in coordination of care and integration through the state health system transformation, there are still many barriers to be addressed, particularly for substance use disorder treatment programs. Individuals with substance use disorders are often clinically complex, with a variety of co-occurring physical and mental health disorders which accompany their substance use diagnosis; many providers lack the resources or are otherwise unable to adequately coordinate services across the health care spectrum, which results in increasingly poor outcomes for this population following treatment episodes. For example, the majority of publicly funded substance use disorder treatment programs do not have the capacity or have other systemic and/or philosophical barriers to adopting evidenced based substance use disorder treatment practices, such as medication assisted treatment. This factor, combined with ongoing systemic issues such as stigma in primary care settings related to individuals presenting with substance use disorders, the lack of adequate, effective coordination between physical and behavioral healthcare providers, and ongoing workforce capacity issues, especially in rural and frontier Oregon, presents an enormous challenge to establishing an effective continuum of care around substance use disorders.

Despite efforts to increase substance use disorder treatment capacity in Oregon, including supporting the opening of three new OTPs and training for additional waivered providers, within the last year, it continues to be insufficient to meet the care needs for those affected by substance use disorders. This has resulted in an unbalanced spectrum of care for substance use disorders in Oregon, where few providers have the ability to adequately and effectively treat individuals who present for services at various points on the substance use disorder diagnostic spectrum. For example, many individuals are required to travel long distances to access higher levels of care, such as residential services, despite living in areas where there are a number of providers who could meet that patient's needs locally. This lack of an effective continuum of care around SUDs conversely results in patients being moved into higher levels of care in many cases, when based on their diagnostic criteria they may be able to be adequately served at a lower level of care, and supported through effective and cost efficient recovery supports and aftercare services.

Failure to establish the foundation for an effective continuum of care for SUD throughout the health care system has created numerous challenges, including untreated or individuals misplaced in the SUD system accessing much more costly health care services (including emergency departments in hospital settings), multiple treatment episodes for individuals at often higher levels of SUD care (including residential care/treatment) despite a lack of evidence showing any significant positive outcomes, and a lack of on-going services to increase the health and well-being of this population, including effective aftercare and recovery support services.

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[55] 42 U.S.C. § 1396d (a)(29)(B). States can use federal Medicaid funds for inpatient hospital and nursing facility services in IMDs for individuals age 65 and older and inpatient psychiatric hospital services for individuals under age 21. 42 U.S.C. § 1396d (a)(14) and (16)(A).

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.

Generally speaking, health insurance companies construct – either alone or in concert with pharmacy benefit managers – a formulary that dictates consumer cost sharing for prescription drugs.[56] A formulary is a list of medicines, generic and brand name, grouped into cost-sharing tiers. Formularies are included as part of the rate filings DCBS receives and reviews annually for the individual and small group markets. This review is meant to ensure that the formularies are not designed in a discriminatory manner. After approval, insurance carriers may alter formularies through so-called mid-year tiering changes are not required to be submitted to DCBS and are therefore not reviewed. Mid-year tiering changes may occur if:

- The plan no longer covers a drug
- A new drug is added
- A drug is moved to a different cost-sharing tier
- A drug is removed from the market

Current treatments for substance use disorders rely on prescription medications. DCBS's review of data requested from health insurers did not reveal apparent barriers to medications. Given that federal rules contain a number of legal requirements intended to ensure access to necessary medications and control costs, this should not be a surprise. Federal regulations require coverage for anti-addiction/substance abuse treatment agents and opioid dependence treatment medications. The ACA specifies that formulary drug counts match the state's benchmark plan and requires that formularies be filed and approved with the state.[57] All health insurance carriers provide some variant of the full range of recommended medications. These plans also contain high-level requirements related to medication cost tiers.

From the DCBS data call, all carriers report covering the following recommended opioid use disorder treatment medications in at least one formulation:

- Buprenorphine
- Buprenorphine and Naloxone combined
- Methadone
- Naloxone
- Naltrexone

With the exception of buprenorphine, carriers include generic options placed in favorable co-insurance tiers. However, DCBS found that most carriers placed buprenorphine in one of the two highest-cost tiers. The question of the effect of pharmaceutical prices on all insurance coverage is of great interest to

[56] *See* 45 CFR §§ 156.122 & 156.125.
[57] *Ibid. See also* OAR 836-053-0013(8)(h) (certain benefits for bronze and silver metal-tier health benefit plans).

policymakers right now. DCBS is involved in several parallel efforts to address the price of prescription drugs, from rulemaking to implement House Bill 4005 (2018) to the Task Force on the Fair Pricing of Prescription Drugs. Certainly, drugs used to treat substance use disorder are not immune from price pressures, though a recent data call did not reveal that any of the prescription drugs used for medication-assisted treatment constituted the top 15 prescription drugs reimbursed by commercial payers.[58]

What is less clear is how large group insurance plans craft formularies. Not only do large group plans not contain coverage for "essential health benefits," insurance carriers do not report formulary details to DCBS.[59] This results in formularies being filed at the carriers' discretion, which is seldom. Like ACA plans, there are no coverage requirements for specific medications and large group plans also lack requirements related to cost containment.

Plans that lacked necessary medications for medication-assisted treatment or substance use disorder may be deemed out of compliance with MHPAEA, but members may be forced to challenge denials based on formulary limitations before learning of their rights under state and federal law.

While coverage for these medications is required for ACA-compliant plans, insurers are also focused on reducing access to opioids. Reducing access to opioids is one of the core issues the task force identified, and appropriately so as it is widely understood that overprescribing helped create the crisis.[60] For carriers, a reduction in opioid prescribing reduces upfront prescription costs with the hope that the need for substance use disorder treatment will also decline.

For example, UnitedHealthcare uses data analytics to determine when a person is at risk of developing dependence "due to a high number of prescriptions from multiple doctors and pharmacies."[61] Cambia Health Solutions took a different approach by using point-of-sale messaging that alerts pharmacists of the potential for misuse, analyzing claims data for better clinical decisions, sharing data with provider groups, and expanding an online toolkit for opioids and pain management.[62]

However, opioids remain the front-line treatment for pain management, and non-opioid-based strategies are not widely used. The effect of a rapid reduction to opioid-based pain management is not understood.[63]

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[58] https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/148992
https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/148992
[59] Please note, however, that coverage for substance use disorder is nonetheless required as a function of mental health parity. *See* Mental Health Parity, *supra*.
[60] *See, e.g.*, National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain: https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf
[61] UnitedHealthcare, *Addressing the Opioid Epidemic* (available at https://www.uhc.com/news-room/opioid-epidemic) (last visited July 11, 2018).
[62] *See* Portland Business Journal, How Regence reduced opioid prescriptions by 22%, Feb 6, 2018 (available at https://www.bizjournals.com/portland/news/2018/02/06/how-regence-reduced-opioid-prescriptions-by-22.html).
[63] *See* note 60, *supra*, *at* 14 (fn. 24-26).

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.

The Oregon Health Plan, Oregon's Medicaid Program, includes the pharmacy benefit for Medicaid recipients as part of the fee-for-service (FFS) or coordinated care organization delivery system. Each of these systems have slightly different processes for managing the pharmacy benefit. The primary way pharmacy benefits are managed is through the use of preferred drug lists and prior authorization criteria. The fee-for-service delivery system utilizes what is called the Practitioner Managed Prescription Drug Program (PMPDP), which was created by SB 819 in 2001. [64]

The PMPDP serves as a preferred drug list for the fee-for-service population. OHA creates the fee-for service preferred drug list through recommendations made by an 11-member Pharmacy and Therapeutics (P&T) Committee. [65] Additionally, the P&T committee, by law, is responsible for making clinical recommendations based on review of available evidence for the purposes of establishing prior authorization criteria and for preferred and non-preferred medication recommendations. The PMPDP ensures fee-for-service clients have access to the safest and most effective prescription drugs available at the best possible price by encouraging use of "preferred" products. For a non-preferred product to be covered, the prescriber must decline to switch to the preferred option.

Coordinated care organizations are also responsible for the administration of a comparable pharmacy benefit for the Medicaid recipients they serve. Each CCO utilizes their own P&T committee to similarly determine the highest value medications to place on its preferred drug list and established prior authorization criteria. Oregon Administrative Rule and federal regulations provide parameters for CCOs to manage their preferred drug list, including provisions that prevent the CCOs from being more limiting than the fee-for-service delivery system.

Within Oregon there are 15 different regional CCOs. This can mean that access to a particular medication-assisted treatment or other medications used in supporting substance use disorder treatment,

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[64] 2001 Or Laws ch 897 (codified at ORS 414.330 – 414.337).
[65] *See* ORS 414.334 – ORS 414.353.

may differ regionally based on a CCO's preferred drug list and criteria for coverage. These differences in access are usually the result of decisions made by practitioners serving on pharmacy and therapeutic committees based on regional experience, evidence interpretation, safety concerns, and lastly cost of medication. Prior authorization is often used in both the fee-for-service and CCO pharmacy benefit management to ensure safety, medical appropriateness, and use of cost effective medications. Prior authorization is not a tool to incent the use of one product over another solely based on cost.

Work is currently underway to explore alignment of preferred drug lists (PDLs) between the FFS program and CCOs. This includes a third-party analysis to be delivered in August 2018 to OHA and the Oregon Health Policy Board that will include a set of PDL alignment recommendations to consider. Although any recommendations will not be specific to medications used in MAT, there is potential that alignment solutions for MAT could be addressed through these recommendations.

Finally, it is noteworthy to recognize the leadership Oregon has contributed by participating in the National Governors Association task force that targeted pharmacy purchasing in the face of public health crises such as the opioid epidemic. The recent efforts of over 10 states have culminated in a soon to be released document from the National Governors Association that outline various strategies, such as bulk pharmacy purchasing, that could prove beneficial for all state agencies struggling with pharmacy costs. OHA will continue to explore these strategies for possible application in our state.

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.

Unlike commercial payers, the requirements of HB 3440 (2016) did not apply to the Medicaid program. This permits the Oregon Health Plan's fee-for-service delivery system to establish a preferred drug list and prior authorization criteria for medications connected to medication assisted treatment under recommendations from the P&T Committee. Similarly, CCOs can develop their own preferred drug options and coverage-applicable criteria. Through the use of preferred drug list and prior authorization criteria, the fee-for-service program restricts the use of buprenorphine products to the management of opioid use disorder and restricts use of oral trans-mucosal buprenorphine monotherapy products (without naloxone) to pregnant patients or women actively trying to conceive.

Other drugs that could also count as medication assisted treatment options, though some are specific to alcohol abuse include:

- Methadone (for treatment of addiction – available to be dispensed only through a state and federally licensed opioid treatment program)
- Acomprosate calcium
- Disulfiram (including Antabuse)
- Naltrexone and naltrexone microspheres (Vivitrol)

There are no co-payments or co-insurance amounts applicable to the Medicaid population. Pharmacy services administrative organizations are engaged in Oregon and negotiate with pharmacy benefit managers on behalf of pharmacies, usually smaller independent retail pharmacies. There are 15 CCOs conducting business with pharmacy benefit managers to provide a pharmacy network for their enrolled populations. There are various contractual relationships in place with CCOs with different pharmacy benefit managers. Some CCOs use different levels of pharmacy management services from their pharmacy benefit managers and this can influence cost to the CCOs. Typically, all CCOs operate their own P&T committees and establish their preferred lists based on best available commercial rates offered by their pharmacy benefit managers.

CCOs are required to post their preferred drug lists as described in OAR 410-141-3070(4): CCOs shall publish up-to-date, accurate, and complete lists of all covered drugs on their preferred drug lists, including any tiering structures, that have been adopted and any restrictions on the manner in which certain drugs may be obtained.

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

All payers may legitimately set conditions in advance before they provide reimbursement for a drug or treatment. For example, a payer may want to know that a procedure is medically necessary and appropriate for a particular individual before signing off on treatment. Generally, these conditions take the form of (1) prior authorizations, (2) step therapies and prioritized lists, and (3) fee-for-service fee schedules in the public payer space.

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.*

In the commercial market, Oregon law allows carriers to apply utilization controls on most benefits, including substance use disorder treatments. [66] In some cases, insurers contract with outside vendors to administer mental health and substance use disorder benefits. Case management, through utilization review and prior authorization of services, is performed in conjunction with guidelines and standards of care developed by entities such as the American Society of Addiction Medicine. Many insurers require prior authorization for residential treatment, partial hospitalization, and intensive outpatient treatment programs. These processes are typically overseen by licensed behavioral health professionals.

Another method of managing prescription benefits is through the use of "step therapy." Step therapy is the process of requiring a lower-cost medicine to be tried before a more expensive medicine will be approved. At least for medication-assisted treatment drugs, carriers do not use step therapy in relation to medicine prescribed for substance use disorders. If they did use step therapy, insurers generally have an exception process in place that allows providers to request a medication that is not included on the formulary to be covered by the plan.

All of Oregon's health benefit plan carriers require prior authorization[67] for substance use disorder services, as well as for residential treatment. Half of the carriers require prior authorization for outpatient treatment. All carriers require ongoing utilization management to ensure that care is progressing and least costly alternatives are employed.

Figure 8. Utilization Management by Oregon Domestic Health Insurance Carriers

Carrier[68]	Prior authorization requirements	Step Therapy requirements	Utilization review
Carrier A	Partial: in-patient only	No	Follows SAMHSA guidelines
Carrier B	Yes	No	Full
Carrier C	Yes	No	Full
Carrier D	Partial: in-patient only	no	Inpatient treatment only
Carrier E	Partial: in-patient only	No, not for MAT meds	Full
Carrier F	Yes	no	Full
Carrier G	Partial: in-patient only	no	Full
Carrier H	Yes	n/a	Full

Source: DCBS Inquiry to Carriers under ORS 731.264; 731.296.

[66] ORS 743B.420 – 743B.425
[67] Prior authorization means that the member or their physician must request and gain approval from the carrier before any benefits are paid.
[68] Due to the way in which DCBS collected the data, carrier names must remain confidential. *See* ORS 731.264.

However, it is clear from the DCBS data that carriers are not using step therapy requirements to control access to the needed medications. Instead, it appears that health benefit plan issuers are focused on controlling access to opioids and many have targets in place to reduce opioid prescribing by a set amount.

Prior authorization requirements for substance use further changed in 2017 with the passage of HB 3440, which prohibits insurers from requiring prior authorization of payment for medication prescribed for the purpose of treating opioid or opiate withdrawals during the first 30 days of treatment.[69] An insurer can still require prior authorization, but only for medical management purposes or for the treatment of opioid or opiate abuse or addiction. It is important to note, however, that HB 3440 did not extend prohibitions on prior authorization for the first 30 days of treatment beyond commercial payers.[70] Although OHA has encouraged open access to these medications without prior authorization, coordinated care organizations have discretion to develop their own preferred drug lists and prior authorization criteria, as recommended by their own drug utilization review advisory boards.

Somewhat similar to utilization management on the commercial payer side of the equation, the Oregon Health Plan prioritizes health care conditions and treatment pairs based on clinical effectiveness, cost-effectiveness and other factors impacting individual and population health. The ranking results in the Prioritized List of Health Services, developed by the Health Evidence Review Commission (HERC). HERC has prioritized substance use disorder as a top priority (line 4 out of 660). Line 4 includes substance dependence and abuse diagnoses, including when the disorder or addiction is in remission. Medicaid coverage for substance use disorder includes stabilization and evidence-based treatments such as behavioral counseling, medication-assisted treatment, peer services, acupuncture, and intensive outpatient and inpatient treatment.

The prioritized list indicates what is covered under OHP when conditions pair below the funded line. The Legislative Assembly allocates overall funding to the Oregon Health Plan each biennium, which ultimately determines the line of covered services included on the prioritized list (aka "below the line"). The Oregon Health Evidence Review Commission (HERC) has oversight of the prioritized list. Both OHP members enrolled in a CCO or on an Open Card (fee-for-service) are entitled to the OHP-covered services on the prioritized list.

Substance use disorder treatment services are available on funded line 4 out of 660 – with line 1 considered highest priority – illustrating the importance of substance use disorder treatment services in the care for OHP members. Moreover, CCOs have the flexibility to cover additional services not on the prioritized list, especially if the services would result in better care and better health outcomes for the individual. The Oregon Health Plan currently covers stabilization and treatment services only for individuals with a substance use disorder. Currently, OHP does not cover recovery support services to help consumers maintain a healthy recovery once they are no longer engaged in treatment is a current limitation in coverage on the OHP. In order for an individual to access substance use disorder services, often they must relapse and have a substance use disorder diagnosis in order to be re-enrolled in treatment.

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[69] 2017 Or Laws ch 683 § 4, codified at ORS 743B.425.
[70] Section 4 of HB 3440 only applied to those offering "health benefit plans," which tend to exclude plans offered by public payers. *See* ORS 743B.005(16).

A recommendation can be put forward for the Health Evidence Review Commission, in consultation with clinical and regulatory experts, to consider changes to the Prioritized List based on clinical evidence and expert opinion. Putting these changes into effect may require changes to the State Plan, which would require federal approval. Additionally, any proposed changes would have a budgetary or capitation rate analysis for consideration. Because many of those providing recovery support services are not licensed or working under the supervision of a licensed professional, additional implementation barriers will need to be addressed in order to provide these services as a state plan benefit.

After initial treatment phase, the following services are proven recovery supports in remission, are part of line 4, and should be covered by Medicaid. HERC should make a clear recommendation that the following services be recommended in remission:

- Physician services
- Medication
- Medication-assisted treatment services
- Methadone services
- Acupuncture
- Psychotherapy/counseling
- Drug treatment programs
- Family counseling
- Alcohol and drug services (group counseling, case management, detox, intensive outpatient treatment, residential
- Treatment plan development by non-physician
- Self-help/peer services
- Comprehensive medication management services
- Psych health facility service
- Hospital services

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

The Oregon Health Authority maintains a behavioral health fee schedule. The fee schedule includes the list of covered services within the prioritized list. Over the past 10 years, substance use disorder treatment

services under OHP have expanded to include peer-delivered services, case management, withdrawal management (previously known as detoxification), and residential treatment.

Although these services have been recently added to OHP, the reimbursement rates for residential treatment were not established based on current costs to deliver the care. Reimbursement for residential substance use disorder treatment services did receive an insignificant rate increase in 2014. However, even with that increase, according to a rate study in January 2014, showed the rate increase from $100 to $120 per day was not an adequate reimbursement rate. Depending upon the level of care, OHP reimbursement rates at the time of the study should have been set between $229 per day and $308 per day. Other substance use disorder services have not seen a rate increase in more than a decade. Some services that were already underpaid saw a rate reduction due to OHA budgetary shortfalls.[71]

Many coordinated care organizations use the OHP fee schedule to establish their own fee schedule to determine reimbursement rates for their participating providers. Therefore, it is critical that the OHP fee-for-service establishes rates that are sustainable and accurately reflect the cost to deliver the care.

> *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.*

Setting aside all the challenges associated with insurance cost and coverage, provider networks, and utilization management, the core issue is whether services can be delivered to populations throughout the state. In other words, even if one were to streamline reimbursement systems, the physical ability to deliver services stands out as a critical issue. A review of state and federal data shows that providers of medication-assisted treatment for substance use disorders are not evenly distributed across the state, and are scarce in many areas of high need. Physical location of medication-assisted treatment is important because this care requires close monitoring by the prescribing clinician, including, in some cases, administering each dose to the patient in person.

The Oregon Office of Rural Health defines rural areas as any place located more than 10 miles from the center of a city that has at least 40,000 people. By that definition, there are rural areas in every Oregon county, and all but 10 counties are completely rural. Every county outside of the Interstate 5 corridor (and some inside that corridor) is rural.

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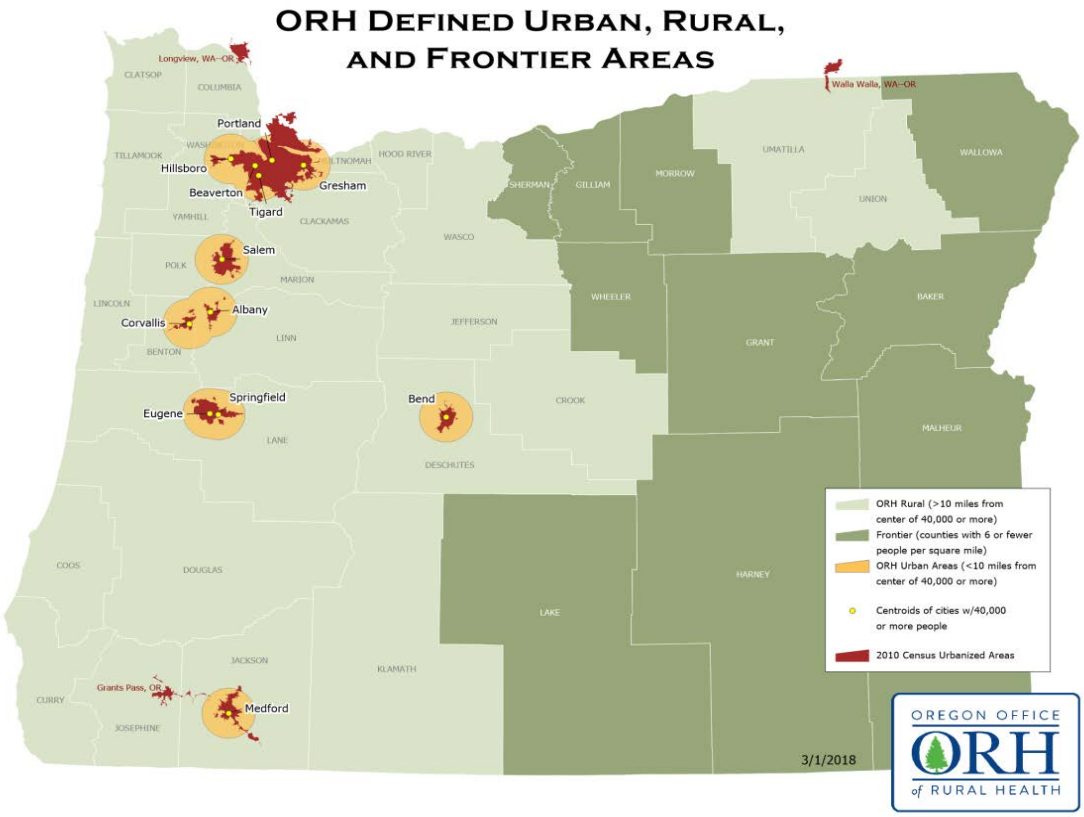
[71] In the commercial payer space, contracted reimbursement rates are considered proprietary information and outside the authority of rate review. An apples-to-apples comparison of commercial and OHP rates is impracticable.

Figure 9. Map of Defined Urban, Rural and Frontier Areas



Estimating Treatment Needs.

Data on opioid overdose deaths, self-reported nonmedical use of pain relievers, and self-reported unmet need for treatment for illicit drug use all help estimate the relative need for opioid treatment, including medication-assisted treatment access in areas across the state. Using opioid overdose deaths per 100,000 people as an indicator of each county's opioid abuse severity, and comparing it to the number of buprenorphine prescribers per county, suggests that the counties with the greatest unmet need for medication-assisted treatment options are Tillamook and Crook. These counties have zero buprenorphine prescribers but 13.42 (Tillamook) and 9.51 (Crook) deaths per 100,000 from opioids. Neither of these counties has an opioid treatment program. Umatilla County has an opioid death rate of 3.14 per 100,000, and will go from zero to one opioid treatment program this summer, when a new facility opens.

By comparison, Multnomah County – the least rural county in the state – has 159 buprenorphine prescribers and seven opioid treatment programs, with an opioid death rate of 10.29 per 100,000 people.

Four of the counties with the lowest number of prescribers in comparison to the abuse estimate (deaths per 100,000 people) are clustered on or near the Oregon coast. They are Clatsop, Columbia, Coos, and Lincoln counties. Others with few prescribers compared to the abuse indicator are Linn and Malheur counties.

Figure 10. Opioid Deaths, Buprenorphine Prescribers, and Treatment Programs by County			
County	Opioid Deaths per 100,000 Population[72], 2012-2016	Buprenorphine Prescribers in County[73]	Opioid Treatment Programs in County[74]
Baker	*	3	0
Benton	4.59	5	0
Clackamas	5.68	24	1
Clatsop	7.48	6	0
Columbia	7.28	7	0
Coos	2.56	1	0[75]
Crook	9.51	0	0
Curry	*	4	0
Deschutes	5.29	13	1
Douglas	7.1	15	1
Gilliam	*	0	0
Grant	*	1	0
Harney	*	0	0
Hood River	*	6	0
Jackson	7.51	24	1
Jefferson	*	3	0
Josephine	5.98	6	1
Klamath	3.67	9	0
Lake	*	4	0
Lane	9.26	28	4[76]
Lincoln	10.81	8	0
Linn	8.05	6	0
Malheur	7.91	1	0
Marion	4.06	21	2
Morrow	*	0	0
Multnomah	10.29	159	7
Polk	3.84	7	0
Sherman	*	0	0
Tillamook	13.42	0	0
Umatilla	3.14	0	0[77]
Union	5.46	9	0
Wallowa	*	4	0
Wasco	*	9	0
Washington	4.27	41	1
Wheeler	*	0	0
Yamhill	5.29	6	0

**Not enough data to estimate.*

[72] As indicated in vital records. Source: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

[73] https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=OR

[74] http://dpt2.samhsa.gov/treatment/directory.aspx

[75] One opioid treatment program in Coos County (Coos Bay) is slated to open in summer of 2018, per OHA press release

[76] One of these opioid treatment programs in Lane County (Springfield) is new, per OHA press release http://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspxhttp://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspx

[77] An opioid treatment program is slated to open in Umatilla County (Pendleton) soon, per OHA press release http://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspxhttp://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspx

Self-Reporting Surveys as Indicator of an Area's Treatment Needs.

Using an alternate indicator of treatment need – SAMHSA's survey of nonmedical use of pain relievers and needing, but not receiving, treatment for illicit drug use – a different pattern emerges, but the takeaway is similar: There is unmet need for treatment in rural areas.

Using the survey reports as a measure of substance use disorders, Multnomah County, the most urban county in Oregon, has the highest incidence of substance abuse. However, it also has the greatest number of treatment providers, and those treatment providers are located in a relatively small geographic area, lowering the travel burden for patients.

For other areas of the state, the Substance Abuse and Mental Health Services Administration reports this survey data by region instead of county. That means the prevalence of drug abuse shown in the chart below is compared to the treatment resources available across much larger areas. Even in regions where treatment resources are available, a person's distance from the provider or program may be so great that getting access is all but impossible, regardless of the regional ratio of treatment resources to those dealing with substance use disorders.

Figure 11. Self-Reporting Surveys of Treatment Need

Area	Nonmedical use of pain relievers in the last year[78]	Needing, but not receiving, treatment for illicit drug use[79]	Sum of buprenorphine prescribers in counties	Sum of OTPs in counties
Region 1 (Multnomah)	5.53%	3.18%	159	7
Region 2 (Washington and Clackamas)	4.83%	2.60%	65	2
Region 3 (Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill)	5.18%	3.13%	94	6[80]
Region 4 (Coos, Curry, Douglas, Jackson, Josephine, and Klamath)	5.01%	2.43%	61	0[81]
Region 5 (Crook, Deschutes, and Jefferson)	4.90%	2.31%	16	1
Region 6 (Baker, Gilliam, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler)	4.76%	2.56%	37	0[82]

[78] https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateExcelTabs2014/NSDUHsubstateExcelTabs-2014.xlsx
[79] *Ibid.*
[80] One of these opioid treatment program in Lane County (Springfield) is new. *See* http://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspx
[81] One opioid treatment program is slated to open in Coos County (Coos Bay) in summer of 2018, per OHA press release http://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspxhttp://www.oregon.gov/oha/ERD/Pages/NewOpioidTreatmentProgramsServeRuralOregon.aspx
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Expanding Medication-Assisted Treatment Capacity in Rural Oregon.

Two federally funded grant programs in Oregon are expanding treatment options in Oregon.

The Oregon State Medication Assisted Treatment-Prescription Drug and Opioid Addiction Project is designed to increase capacity in office-based and opioid treatment program settings and increase the number of Oregon physicians with the necessary waivers to prescribe buprenorphine and who are actively prescribing it. This program is the driving force behind a new treatment program that opened in Springfield in April, and other programs that will soon open in Coos Bay and Pendleton.

The Oregon State Targeted Response to the Opioid Crisis program also works to raise the number of Oregon providers with waivers to prescribe FDA-approved medication to treat opioid use disorders. In addition, the grant program is working to enhance peer support services that improve treatment participation and retention and support long-term recovery. Special program focus is on treatment transition and coverage for patients re-entering the community from the criminal justice system, on rural and very rural (frontier) areas of the state, and on Native American communities in Oregon.

Federally-funded initiatives are the Medication Assisted Treatment and Prescription Drug Opioid Addiction grant (MAT-PDOA), also known as the MAT TCE – Targeted Capacity Enhancement grant, a competitive three-to-four-year grant awarded in Oregon in 2016, and the Opioid State Targeted Response grant, a one-time, two-year appropriation of funding to lower the impact of opioid use and misuse in Oregon as authorized by the Comprehensive Addictions and Recovery Act (CARA), which passed Congress in 2016 and signed by former President Obama in July 2016.[83]

[83] Pub.L. 114-198, 130 Stat. 695 (2016).

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.

Some populations face particular barriers to substance abuse treatment. These groups include veterans and Native Americans.[84]

Veterans

Oregon is home to more than 310,000 veterans.[85] National data on substance use disorders among veterans is mixed, indicating that prevalence of the disorder varies among subgroups of that population. For example, one recent study reports:

> "…age is an important predictor of SUD prevalence, with higher rates of SUDs associated with younger age. It is important to keep in mind that many estimates lump together all age groups despite significant variation by age. For example, a recent epidemiological study found that among male veterans, the overall prevalence of substance abuse was lower than rates of civilian substance use when all ages were examined together. However, when looking at the pattern for

[84] For more on individuals transitioning out of the correctional system, please see Special Considerations: Department of Corrections, *infra.*
[85] *See* Ore. Dept. of Veterans Affairs, *Cadence Forward, 2017 Annual Report* (available at https://issuu.com/odva/docs/2017_odva_annual_report_final).

male veterans aged 18-25 years only, the rates of substance abuse were higher in veterans compared with civilians."[86]

The same report mentions that in the overall population, men and young people tend to have higher rates of substance use disorder and gender, rather than military experience, may be behind increased incidence of the problem among young veterans. In Oregon, more than 91 percent of veterans are men, though only 8 percent are age 20 to 34.[87]

Researchers are clearer on certain barriers to treatment among veterans. Substance use treatment is available through Veterans Affairs medical centers, but access can be challenging, especially in rural areas.[88] Nationally, 41 percent of veterans live in rural areas.[89] In addition, only about one-third of Oregon's veteran population receives VA health care,[90] leaving them to face at least as many barriers to treatment as Oregon civilians.

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.

OHA acknowledges that the Tribes and Native American Rehabilitation Association (NARA) require unique considerations with respect to implementing MAT, such as those related to being sovereign nations and an Urban Indian Health Program, respectively. However, in preparing for a federally funded grant, State Targeted Response to the Opioid Crisis (STR), to improve access to substance use disorder treatment, the Oregon Health Authority observed that Native American populations in Oregon are disproportionately affected by opioid use disorders. It is not clear, however, what underlying issues are driving that disparity or what potential solutions may serve the community.

Close collaboration with Oregon tribes, conducting a needs assessment and developing targeted responses, are key aspects of OHA work under the MAT-PDOA/CARA grants. Grant activities include close coordination with tribes on a public information campaign on opioid use disorders, including medication-assisted treatment, and expanding access to the treatment. Work performed under the STR is ongoing with needs assessment results anticipated for summer 2019.

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[86] *See* Jenni B Teeters, Cynthia L Lancaster, Delisa G. Brown and Sudie Back, *Substance use disorders in military veterans: prevalence and treatment challenges*, 8 Sub. Abuse. Rehab. 69–77 (2017) (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5587184/).
[87] *See* note 85, *supra*.
[88] *See* note 86, *supra*.
[89] *Ibid.*
[90] *See* note 85, *supra*.

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.*

When considering the treatment of addiction and paths to recovery in correctional settings, there are many issues, barriers, and needs to consider. In 2008, voters in Oregon passed Measure 57, which required the Department of Corrections to provide appropriate treatment services to drug-addicted people who are medium or high risk of reoffending. Modalities such as medication-assisted treatment have not been used within the Oregon Department of Corrections and implementing any such program would come with special challenges.

The following outlines the needs, barriers, and challenges related to the potential startup of a medication-assisted treatment program within a correctional setting. It takes into consideration the unique population served, the physical structure of institutions, and the safety and security components that shape most of the work we do.

Resources/Funding.

Resources such as staff, equipment, space, and supplies, including the necessary pharmaceuticals, are critical budget drivers affecting implementation of medication-assisted treatment programs. Availability of necessary funding for these resources is essential to ensure good clinical outcomes. The Department of Corrections cannot implement a program without the funding for these critical pieces.

Currently, the Department of Corrections is allocated General Fund dollars to provide constitutionally-mandated health care to adults in custody. The department uses General Fund dollars to deliver treatment services to adults in custody based on community standards of care and evidence-based practices.

The department is self-funded and not subject to reimbursement systems of coordinated care organizations or third-party payers.

Continuity of Care.

State officials estimate that in Oregon, more than half the people incarcerated have significant drug abuse issues.[91] The American Society of Addiction Medicine estimates that, nationally, 17 percent to 19 percent of individuals in jail and the state prison systems have regularly used heroin or opioids before incarceration.[92] When they are released from prisons and jails, people struggle to find stable housing, employment, and health care. According to the Urban Institute, leaving incarceration can mean disrupting medical care they had been receiving, returning to drug use, and a 12-fold increase in the risk of death in the two weeks following release.[93]

The transition from community to corrections and then back to community is a key element of the work done in the Department of Corrections. The careful treatment planning of patients as they enter corrections involves more than their first experiences at intake. Care must be planned and followed throughout the entire spectrum to ensure good clinical outcomes. When coordinating the implementation of a medication-assisted treatment program, we must consider what resources, barriers, and risks exist all along this continuum. Infrastructure and protocols would be necessary to manage care. Under the current paper system, it would be difficult to follow patients. An electronic health record would allow the Department of Corrections to follow patients closely during this and other treatments patients may be prescribed. A significant barrier to the department implementing medication-assisted treatment is the lack of available resources in the community to provide ongoing treatment, particularly rural areas.

The department currently treats substance use disorder as an acute condition and provides treatment programming to adults near the end of their custody sentences. This allows the programs to teach important skills that will be helpful in the adults in custody transition back to the community. However, treating adults in custody at the end of their sentence does not address their substance use disorder throughout their incarceration. There are many financial barriers to addressing substance use disorders at the beginning of sentences. Then, there are barriers providing the appropriate level of continuing care services throughout their incarceration, and connecting adults in custody to community-based services when they are released.

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[91] Data derived from the Oregon State Targeted Response to the Opioid Crisis (OR-Opioid STR) grant application. Information on the award specific to Oregon is available at https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf.

[92] Amer. Correctional Ass'n & Amer. Society of Addiction Med, *Joint Public Correctional Policy on the Treatment of Opioid Use Disorders for Justice Involved Individuals* (January 9, 2018) (available at https://www.asam.org/docs/default-source/public-policy-statements/2018-joint-public-correctional-policy-on-the-treatment-of-opioid-use-disorders-for-justice-involved-individuals.pdf?sfvrsn=26de41c2_2).

[93] Urban Institute, *Strategies for Connecting Justice-Involved Populations to Health Coverage and Care* (March 2018) (available at https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf).

In context outside the correctional system, Oregon has recognized barriers to care for this group and, under a federal grant, is beginning programs to provide transition and coverage for patients re-entering the community from the criminal justice system. The program includes recruiting, training, and supporting peer navigators who develop comprehensive release plans and coordinate recovery support services for former inmates with opioid use disorders.[94] Even with such a program, need for support will remain high among formerly incarcerated people with opioid use disorder, because the grant program expects to serve 200 people over the two-year grant term.

Training.

Expert and licensed training will be essential for staff members at the start and on a continuing basis. Special licensing and compliance with required regulatory bodies such as the Oregon Board of Pharmacy and the Drug Enforcement Agency will need to be considered.

Correctional Environment Considerations.

The unique environment in corrections means we must consider drug diversion. The safety of citizens, staff members, and the inmate population is the department's highest priority. The pharmaceuticals associated with a medication-assisted treatment program may have high value within the inmate population and be at risk for diversion and issues related to contraband. A plan for handling and monitoring by health services and security staff members must be created.

Disparate Issues Related to Medication-Assisted Treatment Options.

It will also be important to acknowledge that different medication-assisted treatment programs have different barriers, risks, and considerations. For example, methadone treatment is less expensive than its alternative, Naltrexone. However, the structure, licensing, and other necessary components create bigger challenges than Naltrexone, which is a significantly more expensive drug. Each medication-assisted treatment would need to be evaluated by examining all factors, including the drug cost. All components related to each medication-assisted treatment option must be examined before implementation. The department has requested technical assistance from the National Institute of Corrections to learn from Centers of Innovation for medication-assisted treatment programs operated by other departments of corrections.

A significant barrier to the department implementing medication-assisted treatment is the lack of available resources, particularly in rural areas. The department provides a variety of levels of abstinence-focused substance use disorder treatment, including outpatient, intensive outpatient, and residential care. A barrier the department faces is the funds to address the need for substance use disorder. In 2017, the Department of Corrections worked with Faye Taxman from George Mason University in Virginia to conduct a gap analysis of the substance abuse treatment and cognitive behavioral needs of the adults in custody versus the number of slots available. In 2018, the average number of adults in custody is approximately 14,800. The average percentage of adults in custody with substance use disorder is 60 percent. Taxman's report found the percentage of adults in custody with a severe substance abuse need

[94] *See* note 91, *supra.*

was 55 percent.[95] The total number of treatment slots in the department is 366. Below is a detailed list of the number and types of treatment slots available:

Figure 12. Number and Types of Substance Use Disorder Treatment Slots Available, DOC System	
Male residential	189
Male intensive-outpatient	50
Male outpatient	25
Female residential	54
Female intensive-outpatient	48
Source: Department of Corrections	

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.*

[95] *See* "Risk-Need-Responsivity in Oregon: A report to the Oregon Department of Corrections" (JanJanuary 2018).

PENDING FEDERAL LEGISLATION

H.R. 6, SUPPORT for Patients and Communities Act [115th Congress (2017-2018)].

Medication-Assisted Treatment Provisions of H.R. 6

Requirements for state Medicaid plans – Sec. 107 (b).

This section adds medication-assisted treatment to the definition of "medical assistance" under the Social Security Act, 42 USC 1396d(a), and adds such treatment to the list of medical assistance services that state Medicaid plans must cover for all recipients under 42 USC 1396a(a)(10)(A). This coverage requirement is time-limited to the years 2020-2025. States can apply to waive these requirements if they can show that it would not be feasible to implement this coverage statewide due to a shortage of qualified providers or facilities that will contract to provide these services.

Medication-assisted treatment is defined for these purposes as coverage of all drugs and biologics – explicitly including (but not limited to) methadone – approved by the U.S. Food and Drug Administration to treat opioid use disorders. It also includes counseling services and behavioral therapy "with respect to the provision of such drugs and biological products."

Allowing for more flexibility with respect to medication-assisted treatment—Sec. 3003.

Under current law, medical practitioners dispensing narcotic drugs intended for the purpose of narcotic treatment or detoxification must register with the Attorney General and follow stringent documentation and security requirements, but there is an exception that requires only an annual notice. This exception is available only if the total number of patients treated does not exceed 30 or the provider demonstrates the need and intent to treat more patients and submits an additional notice at least a year after the initial notice, in which case, the provider can treat up to 100 patients.

These provisions would enable some practitioners to start treating 100 patients right away – specifically, practitioners with additional credentialing in addiction treatment (defined in sec. 8.2 of CFR 42), or who provide medication-assisted treatment using covered medications in a qualified practice setting (defined in sec. 8.615 of CFR 42; requirements include participating in state prescription drug monitoring program). Current law enables nurse practitioners and physician assistants to be qualified practitioners for these purposes only until Oct. 1, 2021; these provisions would make their eligibility permanent. Nurse specialists, nurse anesthetists, and nurse midwives would also be allowed to become qualified practitioners, but only from Oct 1, 2018, to Oct 1, 2023. These provisions also require the U.S. Department of Health and Human Services secretary to produce a report assessing the care provided under these new requirements.

Opioid addiction action plan—Sec. 6031.

The HHS secretary is required to submit a plan by Jan 1, 2019, that must include recommendations for changes to Medicare and Medicaid to encourage the appropriate use of medication-assisted treatment. These changes could include changes to reimbursement rates or new payment and delivery models.

Other Legislation:

S. 2923	Provides grant funds to eligible entities for developing, enhancing, or evaluating family-focused residential treatment programs to increase availability of these programs.

	Funding in the amount of $20 million is anticipated for fiscal year 2019 to remain available through fiscal year 2023.
S. 2898	Removes lifetime limits under state Medicaid programs on medication-assisted treatment for substance use disorders.
S. 2909	Requires the U.S. Government Accountability Office to conduct a study regarding the barriers to providing medication used in the treatment of substance use disorders under Medicaid distribution models such as the "buy-and-bill" model, and options for state Medicaid programs to remove or reduce such barriers. The study shall include analyses of each of the following models of distribution of substance use disorder treatment medications, particularly buprenorphine, naltrexone, and buprenorphine-naloxone combinations: ▪ The purchasing, storing, and administering of substance use disorder treatment medications by providers. ▪ The dispensing of substance use disorder treatment medications by pharmacists. ▪ The ordering, prescribing, and obtaining substance use disorder treatment medications on demand from specialty pharmacies by providers. ▪ For each of the these models, the GAO must evaluate how each model presents barriers or could be used by selected state Medicaid programs to reduce the barriers related to treatment by examining certain information related to Medicaid beneficiaries access to substance use disorder treatment medications, cost, and provider willingness to provide or prescribe these medications. The report is due no later than 15 months after the law is enacted.
S.2892	Peer Support Enhancement and Evaluation Review Act – Requires the comptroller general of the United States to submit a report on the provision of peer support services under the Medicaid program to the House Committee on Energy and Commerce, the Senate Committee on Finance, and the Senate Committee on Health, Education, Labor, and Pensions. The comptroller's report must include information on state coverage of peer support services under Medicaid, including the mechanisms through which states may provide such coverage. The report must also include information on state experiences in providing medical assistance for peer support services under state Medicaid plans, including whether states measure the effects of providing such assistance. The report must include recommendations for legislative and administrative actions related to improving services, including peer support services, and access to peer support services under Medicaid.
S.2904	• Medicaid Substance Use Disorder Treatment via Telehealth Act – Requires the Centers for Medicare and Medicaid Services to issue guidance to states on three topics related to substance use disorder treatment in the Medicaid program. First, CMS must issue guidance on state options for federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders, including assessment, medication-assisted treatment, counseling, and medication management, using telehealth services. This guidance must address furnishing services and treatments to high-risk groups, including American Indians and Alaska Natives, adults younger than age of 40, and individuals with a history of nonfatal overdose. Second, CMS must issue

	guidance on state options for federal reimbursement of expenditures under Medicaid for education directed to providers serving Medicaid beneficiaries with substance use disorders using the hub-and-spoke model, through contracts with managed care entities, through administrative claiming for disease management activities, and under Delivery System Reform Incentive Payment (DSRIP) programs. Finally, CMS must issue guidance on state options for federal reimbursement of expenditures under Medicaid for furnishing services and treatment for substance use disorders for individuals enrolled in Medicaid in a school-based health center using telehealth services.
S. 2912	Opioid Addiction Treatment Programs Enhancement Act – Requires the Health and Human Services secretary to publish a report on the CMS website with comprehensive data on the prevalence of substance use disorders in the Medicaid beneficiary population and services provided for the treatment of substance use disorders under Medicaid. This report must include specified data for each state and be updated annually. The report must use data and definitions from the Transformed Medicaid Statistical Information System (T-MSIS) data set. The bill also requires the secretary to publish in the Federal Register a system of records notice for the data for T-MSIS that protects the security and privacy of the data and that is sufficient for researchers and states to analyze the prevalence and treatment of substance use disorders under Medicaid across all states.
S. 2891	Fighting the Opioid Epidemic with Sunshine – Amends the Sunshine Act to require drug manufacturers to include information regarding payments made to physician assistants, nurse practitioners, and other advance practice nurses.