



THE OPIOID CRISIS IN AMERICA
Domestic and International Dimensions

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**State approaches to
tackling the opioid
crisis through the
health care system**

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BROOKINGS

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Executive Summary

The breadth, depth, and dynamic evolution of the opioid crisis have left states exploring a plethora of strategies to reduce the supply, inappropriate use, and harm caused by prescription opioid analgesics and illicit opioids. While considerable research has focused on the impact of various supply strategies and prescribing practices, significant structural changes affecting the treatment of substance use disorder—enabled and advanced by states’ policy decisions—have received far less attention.

In this paper, we discuss three broad strategies states are taking, through a variety of policy levers, to enhance the quality of and access to treatment for opioid use disorder (OUD). The first and most well-known strategy involves increasing insurance coverage and payment for OUD treatment services. States have pursued this strategy by expanding Medicaid benefit coverage to include methadone, buprenorphine, and other non-pharmacological treatments for OUD; turning on reimbursement codes for screening, brief interventions, and referrals to treatment; and expanding eligibility criteria for Medicaid enrollment.

Second, states have sought to improve treatment access by expanding the existing treatment capacity for individuals with OUD. Residential treatment capacity has been expanded through pursuit of both federal block grant funding and Medicaid Section 1115 IMD exclusion waivers, which enable Medicaid patients in states with these waivers to receive care in residential facilities specializing in mental health disorders. In addition, states have sought to increase outpatient treatment capacity by incentivizing providers to obtain Drug Enforcement Administration (DEA) waivers to prescribe buprenorphine to patients suffering from OUD, as well as by increasing reimbursements rates for these services.

Third, states have engaged in various initiatives, commonly supported by funding in the Affordable Care Act, to develop more comprehensive and integrated treatment networks that link specialty substance use disorder treatment services with primary care and case management. By supporting information technology development and alternative payment models for care, states have been nudging providers to expand enhanced chronic disease management and care management practices which better meet the needs of individuals with opioid use disorder.

While recent evaluations have considered the incremental impact of some of these policies individually, evaluations frequently ignore the other important steps states have taken to enhance the transition and integration an archaic and frequently siloed substance use disorder treatment system. Payment reforms and delivery integration have the potential to fundamentally modify the type of care patients receive, not just for OUD, but for substance use disorders more generally. While the transition has been slow, incremental, and largely hidden from the public in ways that other opioid policies have not, the net effect of these changes will likely be quite substantial and enduring in the long run.

Introduction

The evolving opioid crisis is taking its toll on America through deaths, emergency department visits, poison center calls, foster care admissions, neonatal opioid withdrawal syndrome, infectious disease transmission, and more.¹⁻⁷ A confluence of factors that have been described

in detail elsewhere⁸⁻¹¹ led to an increase in the prescribing of opioid analgesics. Over two decades, this increase has substantially enlarged the population exposed to a medically prescribed opioid analgesic, those at risk of opioid dependence (due to an increase in the exposed population), and those willing to obtain opioids through the black market when supply through medical markets dramatically changed.¹⁰⁻¹² We will refer to the use of any opioid, legal or illicit, without the supervision of a physician as “nonmedical use.”

The breadth, depth, and evolution of the opioid crisis have also led to complicated policy responses. States have tried a plethora of strategies targeting a range of behaviors and actors, including those using nonmedically or struggling with an opioid use disorder as well as those engaged in various systems that deal with these individuals (e.g. the health care system, specialty substance use disorder treatment system, criminal justice system, or public safety system). Given the myriad of policies and approaches, in our own work we tend to group them in terms of their targeted objectives, as shown in Figure 1. This figure provides examples of policies in each general domain and should not be considered exhaustive; it simply illustrates the point that particular policies in each domain have received considerably more research attention than others.

Figure 1: State policy approaches for tackling OUD and the opioid crisis

Risk mitigation & better pain management	Treatment & recovery	Harm reduction
<ul style="list-style-type: none"> • Community & school based prevention • Prescription limits (days, morphine equivalent doses (MED), etc) • Prescription monitoring programs • Physical examination requirements • Safe storage & disposal rules on Rx • Physician & pharmacy education • Pain clinic regulations • Mail-order Rx bans • Policies targeting high risk populations • Insurance utilization review • Lock in programs • Doctor shopping and pharmacy shopping laws • Drug formulary design • Insurance coverage for non-pain alternatives • Fail first policies • Patient monitoring requirements • Required HIV/Hepatitis C screening 	<ul style="list-style-type: none"> • Insurance expansions, particularly within Medicaid • Funding to expand treatment (with or without medication, in or out of criminal justice) • Funding of collaborative care models • Mandate insurance coverage for treatment services • Turning on reimbursement codes • Scope of practice laws 	<ul style="list-style-type: none"> • Naloxone distribution laws • Good Samaritan laws • Safe consumption rooms • Fentanyl test limits • Needle exchange programs • Community awareness of fentanyl outbreaks • Funding to support Emergency Medical Treatment (EMT)

In this paper we discuss a broad range of state health reforms that influence access to and delivery of opioid use disorder (OUD) treatment. While policy researchers has tended to focus on just a few treatment policy levers (e.g., Affordable Care Act Medicaid expansion, number of buprenorphine waived providers), states have adopted several strategies to improve both access to and delivery of high quality OUD treatment that often get ignored in evaluations. This can lead to bias in estimated effects of the narrower policies evaluated and a lack of appreciation for funding mechanisms that have been used to create these changes. We group these state strategies into three categories: (1) strategies aimed at increasing insurance coverage and payment for substance use disorder treatment services; (2) strategies designed to directly increase the capacity of substance use disorder treatment services; and (3) strategies primarily designed to improve the quality of substance use disorder treatment services provided. While the focus in this paper is on treatment policies, we do not mean to negate the importance or effectiveness of other policy targets, particularly those aimed at improving pain management. These are indeed very important objectives worthy of consideration; however, limited space precludes us from discussing them all.

The significance of state strategies targeting OUD treatment can only be understood within the context of the historical structure of the substance use disorder (SUD) treatment system, so we begin by providing a high-level overview of treatment prior to the public health declaration of an opioid crisis.

Brief background on the pre-opioid crisis substance use disorder treatment system

Due to a variety of historical, social, and cultural factors, the treatment of substance use disorders, including opioid abuse and addiction, has been traditionally delivered within a specialty treatment system, siloed from the mainstream health care system. Factors that drove this separation include the stigma associated with addiction; the prevalence of mental health issues among those with SUD; insufficient numbers of specialty substance use providers; the wide variability in the nature and uncertain quality of SUD treatment services; and the complicated relationship between treatment and other systems, such as the criminal justice, child welfare, and public housing systems.

In 2008, a few years before the peak of opioid prescribing and around the time politicians in Washington began fiercely debating the Affordable Care Act (ACA), more than three-quarters of the funding for SUD treatment services came from public sources, not private health insurance.¹³ Moreover, the majority of SUD treatment services were provided in stand-alone nonprofit or government-operated specialty facilities, where the daily patient census was fewer than 50 patients.^{14,15} The vast majority of these facilities lacked the administrative and computer technical infrastructure support necessary to meet the requirements of more mainstream health care financing and management systems.¹⁶ Furthermore, there was little incentive for them to improve such systems, as 40 percent of the nonprofit treatment facilities did not accept either private insurance or Medicaid¹⁵ and 1 in 3 patients receiving care within the specialty sector reported either paying out-of-pocket or receiving services for free.¹⁷ It is against this backdrop of the U.S. SUD treatment delivery system and an emerging opioid crisis that states—with nudging from the federal government—began to take action.

State strategies to improve health insurance coverage for treatment services

The ability to pay for SUD treatment is frequently cited as a critical barrier to receiving care.^{18,19} Opioid use disorder, like other addictions, is a chronic relapsing medical condition frequently requiring many rounds of treatment. A single treatment episode can be too costly for many, not just because of the medical expenses, but also because of the need for residential care, time away from work and family responsibilities, and ongoing medication costs. Health insurance has long been used to make effective medical services more affordable, particularly when those services might not otherwise be used and the absence of treatment generates high societal costs. Despite a social cost exceeding \$78.5 billion for opioids²⁰ and \$249 billion for alcohol,²¹ SUD treatment had not typically been included as a covered health benefit in insurance, until the 2008 Mental Health Parity Addiction Equity Act and the 2010 ACA.²²

In light of the high costs associated with the opioid crisis, and given the evident effectiveness of medication for opioid use disorder with or without psychosocial counseling,^{23-25,26} many

states started expanding Medicaid insurance coverage to include methadone and buprenorphine, two FDA-approved medications for treating OUD.^{27,28} Some states have also expanded coverage of non-pharmacologic components of such treatment. Today, methadone is available to Medicaid enrollees in most states, and buprenorphine is accessible to at least some Medicaid-enrollees in all states.²⁹ Despite this progress, estimates from various states show that less than half of Medicaid enrollees diagnosed with an opioid use disorder receive some form of medication treatment for that opioid use disorder.³⁰

States also made it possible for providers to receive payment for specific services through existing insurance mechanisms. For example, many states turned on reimbursement codes for screening, brief interventions, and referrals to treatment (“SBIRT”). These service codes were created under the Bush Administration, but few states had turned them on (which is necessary for them to be used) by the close of 2008.²² For years, potentially viable entry points for identifying individuals misusing or dependent on substances—such as emergency departments or primary care settings—were discouraged from identifying such people because the additional time needed to conduct screenings and brief interventions was not reimbursable by payers. Under the Obama Administration, a more concerted push was made to get states to turn them on.

Some states have also raised provider reimbursement rates for buprenorphine. Inadequate reimbursement from public and private payers has been frequently cited by clinicians as a reason why they are hesitant to provide buprenorphine.³¹⁻³⁴

States have also pursued general insurance expansions that provide greater coverage to individuals at high risk of OUD, including those living in poverty and young adults. Medicaid insurance expansions as part of the ACA,²² initially through Section §1115 waivers and then through the 2014 funded expansions,³⁵ have been shown to increase utilization of treatment, both among low-income individuals diagnosed with opioid use disorder and among children.³⁶⁻³⁹ State expansions of the dependent care coverage beyond the federal age of 26 have also been pursued in a few states, but these expansions targeting coverage for young adults have had mixed results in terms of their effects on receipt of SUD treatment and spending in various settings.^{19,40-42}

State strategies to increase physical access to addiction services

Insufficient treatment capacity had been a long-standing challenge for states. Prior to the opioid crisis, many drew on federal block grants to support services at specialty treatment facilities, given limited commercial and public insurance coverage for substance use disorders. Even in states where commercial and public insurance supported some forms of treatment, there remained insufficient capacity in many areas, particularly rural communities.

In recent years, states have tried a variety of new approaches to quickly expand treatment capacity, particularly for patients with a complex mix of conditions. One such approach is through Section §1115 waivers. For decades, Federal law has prohibited Medicaid payments for substance use disorder treatment in residential behavioral health treatment facilities with more than 16 beds, which are deemed Institutions for Mental Diseases, or IMDs. A 2013-2014 survey of state Medicaid agencies found that 21 states provided no short- or long-term residential services to enrollees suffering from a substance use disorder, in part because of their inability to use such facilities.⁴³ As part of the ACA final rule, Medicaid managed care

organizations were provided an exception to the IMD payment exclusion starting in 2016⁴⁴; as of January 2020, 27 states have obtained IMD payment exclusion waivers for SUD treatment.ⁱ

Access to these facilities, which specialize in treating those with multiple, complex behavioral health conditions, is expected to improve access and the quality of care for some patients, although formal analyses have yet to confirm this. A few states have also used Section §1115 waivers to expand community-based benefits, such as supportive housing, job coaching, and peer recovery coaching. Evaluations of these efforts are ongoing.

States have also adopted new strategies for providing evidence-based therapy in outpatient settings by expanding the number of providers who can prescribe buprenorphine. Since buprenorphine was approved by the FDA in 2002, clinicians who complete a brief training can obtain a special DEA waiver to prescribe buprenorphine for OUD treatment. However, uptake of these waivers has been slow.^{32,45} To encourage more physicians to seek waivers, states have offered incentive programs. For example, the Medicaid Partnership Health Plan of California offers a \$500 incentive to providers who complete training and obtain a DEA waiver.⁴⁶ These incentives, particularly when coupled with higher reimbursement to providers for medication treatment⁴⁷ and Medicaid coverage expansion,⁴⁸ are expected to expand access to outpatient services.

A number of states have also expanded OUD treatment access for those in the criminal justice system. An estimated 50 percent of incarcerated individuals have a substance use disorder, and fatal overdoses are the most common cause of death in the first two weeks after release.⁴⁹ Rhode Island implemented a statewide program whereby medication treatment was provided to individuals upon release from prison and efforts were made to connect them to treatment services in the community. The program reduced fatal overdoses by 12 percent statewide, and by 61 percent among the target population.⁵⁰ Vermont created jail diversion programs for individuals in the criminal justice system, whereby nonviolent offenders who screened positive for OUD were referred to treatment instead of facing charges and incarceration.⁵¹ Similar referral systems for nonviolent drug offenders outside of drug courts have emerged in other states, including California. Research findings suggest these efforts, coupled with Medicaid insurance expansion, have expanded access to treatment for those involved in crime.⁵²

State strategies to improve the quality of treatment services delivered

An oft-cited challenge to providing effective treatment to individuals with opioid use disorder is the large number of patients who suffer from co-existing mental health and physical ailments. These patients are more likely to benefit from comprehensive and managed approaches to treatment,^{34,53,54} which is why several states jumped at opportunities provided by the ACA to experiment with innovative delivery models that integrate OUD treatment with primary care.^{22,55} While the specifics of state approaches varied, most address the common challenges primary care providers face in treating these patients, including insufficient access to ongoing expert consultation and a lack of providers to provide behavioral counseling.

ⁱ For an updated listing of states with these waivers, go to: Kaiser Family Foundation, “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” (Washington, DC: Kaiser Family Foundation, April 18, 2019), <https://www.kff.org/medicaid/issue-brief/medicaidwaiver-tracker-approved-and-pending-section-1115-waivers-by-state/>.

For example, Vermont, Rhode Island, and Maryland took advantage of the Medicaid Health Home program⁵⁶ to support enhanced chronic disease management, care management, and integration of behavioral health services. In these three states, participating practices received a per-member-per-month (PMPM) health home payment that could be used flexibly to pay for a variety of things, including case management activities.⁵⁶ Vermont used additional funds available through the ACA to launch its Care Alliance for Opioid Addiction in 2014.⁵⁷ This “Hub & Spoke” treatment system model sets up coordinated care networks in which patients who need more intensive services get OUD care in specialty facilities (the “hubs”) for short periods until they are stabilized, at which point they are referred back to their primary care physician and/or community-based practice (the “spokes”) where they are maintained on buprenorphine and receive ongoing care and support services.⁵¹ Clinicians in the spokes are encouraged to consult with experts in the hubs. The system led to increases in the number of approved buprenorphine prescribers and an expansion in medication treatment throughout the state. Versions of this model are now being refined and implemented in other states.⁵⁸⁻⁶¹

The Massachusetts Nurse Care Manager Program provides another example of a coordinated care model in which federally qualified health centers receive funding from Medicaid to reimburse nurse care managers who support buprenorphine-prescribing physicians. The nurse care managers screen patients for eligibility, refer them to physicians for treatment, and continue to co-manage them through ongoing education and monitoring. Patients identified as more complex and requiring intensive services benefit from expedited referral to specialty treatment facilities. An evaluation of this model has also shown success, with 51 percent of patients either remaining on buprenorphine after 12 months or successfully tapered after six months of adherence.⁶² Of the patients remaining in treatment for 12 months, 95 percent were no longer using opioids or other substances.⁶²

A variety of similar integrative coordinated care models targeting specific high-risk populations have been developed by states as well. For example, New Mexico developed the Extension for Community Healthcare Outcomes (ECHO) program to enhance community treatment of substance use disorder patients with hepatitis.^{63,64} Similarly, numerous states piloted integrated care for OUD and HIV through the Buprenorphine HIV Evaluation and Support (BHIVES) collaborative model.⁶⁵⁻⁷³

A number of other system-based and practice-based models have been identified by the Agency for Healthcare Research and Quality as promising ways to increase access to medications for OUD.^{33,74} Such initiatives are likely to become even more common as states receiving funding under the Substance Abuse and Mental Health Services Administration’s State Targeted Response or State Opioid Response grants are encouraged to adopt such models.⁷⁵ However, funding is commonly time-limited, and sustaining these systems and practice-based models of care will require sustainable funding to continue supporting the necessary infrastructure.

Finally, a few states have also begun to experiment with pay-for-performance (P4P) strategies for substance use treatment. P4P strategies, which involve making additional payments to individual providers that meet quality targets, have been a popular tool in mainstream medical care,⁷⁶⁻⁷⁹ but slow to reach providers of SUD treatment services.⁸⁰ While global performance-based contracting (i.e., value-based purchasing) between state substance abuse agencies and state-funded SUD programs had started to emerge in a few states, these programs applied to an entire treatment program, not individual providers.^{81,82} Some states (California, Pennsylvania, and Oregon) have recently implemented aspects of P4P initiatives for substance use disorder treatment, but formal evaluations have yet to be published.⁸³

Summary

While states have adopted a variety of strategies to tackle the opioid crisis, efforts to enhance the transition and integration of our previously archaic and largely separate substance use disorder treatment system has probably been one of the most promising and enduring areas of policy reform states have undertaken. Thanks to large and sustained investments by the federal government and the willingness of particular states to lead the way, the U.S. SUD treatment system is gradually becoming more closely integrated with the health care system. At the same time, it is adopting new models of integrative care, allowing patients with complex addiction issues to receive higher quality care. States accomplished this using a variety of different policy levers. Given the magnitude of the crisis, the unmet treatment need, and the fact that this treatment system transition is still underway, the immediate effect of these changes on the opioid crisis is likely to be rather modest. However, over the longer term, these changes will better prepare us to meet the needs of the patient population.

While the transition underway in the treatment system has been slow, incremental, and largely hidden from the public in ways that other opioid policies have not, the net effect of these changes will likely be quite substantial in the long run. It is the totality of these changes that make them so significant. Increasing access to treatment through insurance expansion is only helpful when providers are willing to accept new patients and the care received is of high quality. It is only through increased delivery of high quality treatment that we can decrease the frequency and severity of relapse for the millions of Americans suffering from substance use disorders.

The treatment system's transition is far from complete, and efforts to support sustained recovery and fend off the increased use of other substances are far from done. More changes are necessary. There is a need to modernize information systems within the specialty treatment system so they can interact with and bill insurers.¹⁶ The development of integrated health records to enable care coordination across all points of health care access (e.g., emergency department, primary care, urgent care, and specialty provider) would also represent a major improvement. Finally, giving health care providers greater incentives to adopt chronic disease models might encourage more of them to monitor and manage OUD patients as they experience periods of recovery and relapse.

States could have done more with ACA resources to help better integrate substance use treatment programs with health care systems, but substantial progress was made in many states. It will be important to assess whether the funds provided through current federal opioid initiatives will be sufficient to sustain the innovation sparked by the ACA.

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