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State Toolkit to End
the Nation's Drug
Overdose Epidemic:
**Leading-Edge Actions
and Strategies to
Remove Barriers
to Evidence-based
Patient Care**

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About the AMA

The American Medical Association is the powerful ally of and unifying voice for America's physicians, the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden.

For more information, visit ama-assn.org.

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Introduction

The US Centers for Disease Control and Prevention (CDC) reported that the predicted number of drug overdose deaths in the 12-month period ending in April 2021 exceeded 100,000 for the first time ever.¹ Nationally, people aged 15–24 experienced the largest percentage increase in drug overdose death rates between 2019 and 2020 (49%), and deaths overall increased from April 2020 to April 2021 by nearly 30%.² Across the country, 28 states had more than a 30% increase in overdose deaths in 2020 compared to 2019, including 10 that increased by more than 40%.³ Additional state-level reports detail hundreds of examples of how the epidemic has raged.⁴ The simultaneous tragedies of the COVID-19 pandemic and the drug overdose epidemic—two public health crises at once—have widely fed into the categorization of the drug overdose epidemic as “the epidemic inside a pandemic.”⁵

Policymakers and other stakeholders must increase their efforts to end the drug overdose epidemic with targeted, evidence-based interventions and emerging best practices. The American Medical Association (AMA) and Manatt Health released a [national policy roadmap](#) in December 2020 with detailed recommendations for policymakers to take action.⁶ While there are many examples where states and others have taken some steps in the right direction, much more needs to be done to support evidence-based, comprehensive efforts.

The 2020 roadmap highlighted areas with opportunity for improvement, particularly in light of the ongoing and unprecedented public health crisis wrought by the COVID-19 pandemic. During development of this 2022 toolkit, the true extent of COVID-19’s impact on the drug overdose epidemic is just beginning to be realized.

The 2022 AMA-Manatt Toolkit builds on the 2020 roadmap by providing **actionable resources** that states can use to **take specific actions** in six policy areas:

- Increase access to evidence-based treatments to help patients with a substance use disorder (SUD).
- Ensure access to addiction medicine, psychiatry, and other trained physicians.
- Enforce mental health and substance use disorder (SUD) parity laws.
- Improve access to multidisciplinary, multimodal care for patients with pain.
- Expand harm reduction efforts to reduce death and disease.
- Improve monitoring and evaluation.

To achieve this, the toolkit provides:

- **Specific Actions.** We highlight 24 key actions—with at least three in each policy area—that all states should consider.
- **Tangible Resources.** We provide specific resources for each of the recommendations across the six policy areas, with a brief description of the resource and a link to download the “ready to use” resource.
- **Compendium of Detailed Resources.** We then take those resources and build them out into a more extensive compendium that includes detailed resources in each of the six policy areas.

Taken together, stakeholders in every state can use this new resource in the legislature, with regulators and other officials, including governors, attorneys general, Medicaid officials, insurance regulators, and others. These are policies and actions that are working to help patients today. We understand that ending the drug overdose epidemic will not be easy, which is why the AMA and Manatt Health are providing direct access to policies and actions that have worked. It is up to policymakers and key stakeholders to work together to enact and implement these recommendations. For our part, the AMA and Manatt Health stand ready to help accomplish this important work.

In addition to the six major policy areas, this toolkit also identifies key funding streams and funding opportunities that are beginning to take shape. Between federal appropriations and funds from opioid-related litigation and settlements, many cities and states have an unprecedented opportunity to fund evidence-based programs to reduce mortality and improve patient outcomes. The final section of this toolkit highlights key opportunities along with specific policy recommendations and legislative actions that can be taken to ensure funds are spent on ending the epidemic.

I. Increase access to evidence-based treatments to help patients with a substance use disorder

This section addresses the importance of expanding access to evidence-based SUD treatment on an equitable basis for all populations and ensuring that coverage standards are clinically based.

Every state can take action to expand access to evidence-based SUD treatment. To ensure access to equitable, evidence-based treatment and ensure coverage standards are clinically based, has your state:

- 1** Expanded access and coverage for medications to treat opioid use disorder (MOUD) in Medicaid (as is now required under federal law) and commercial insurance and removed treatment barriers, such as prior authorization and other utilization management policies?
- 2** Required access to the full continuum of evidence-based care as determined by medical experts, such as the American Society of Addiction Medicine (ASAM)?
- 3** Required insurers to base coverage decisions on medical standards developed by medical experts, such as ASAM?
- 4** Addressed disparities and the needs of all patients equitably, including vulnerable populations, such as justice-involved individuals and pregnant, parenting and postpartum individuals and families?
- 5** Ensured patient access to both MOUD and SUD treatment?

“Ending the epidemic requires improved enforcement of laws and policies to ensure access to medications to treat opioid use disorder, and care for co-occurring mental illness. Particular emphasis must be placed on ensuring protections for justice-involved individuals and for youth, peripartum, pregnant, postpartum and parenting individuals. This includes working to keep families together safely and eliminating health inequities that disproportionately harm marginalized and minoritized communities.”

Gerald E. Harmon, MD,
President, American Medical Association

What resources are available to your state to ensure access to evidence-based treatment? Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/RESOURCE	HOW IT WORKS
MEDICAID COVERAGE AND ACCESS		
Expand Medicaid coverage of MOUD.	Centers for Medicare & Medicaid Services Guidance on Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment (2020)	Outlines how states must comply with the requirement in federal law to cover all Food and Drug Administration (FDA)-approved forms of MOUD (methadone, buprenorphine and naltrexone) and includes information to help states expand their opioid use disorder (OUD) service continuum.
Eliminate prior authorization and utilization management barriers for MOUD.	District of Columbia Department of Health Care Finance Removal of Prior Authorization Requirements for Medication-Assisted Treatment in Medicaid (2019)	Removes prior authorization requirements for MOUD.
Support policies that increase access to methadone and opioid treatment programs (OTPs).	Spokane, Washington adoption of federal flexibility for take-home methadone	An OTP increased use of take-home methadone pursuant to federal law without an increase in negative outcomes.
COMMERCIAL INSURANCE COVERAGE AND ACCESS		
Require all payers to eliminate prior authorization and utilization management requirements for MOUD.	New York Insurance Law §§ 3216(i)(31-a); 3221(l)(7-a); 4303(l-1) (2020) and related laws for Medicaid fee-for-service and Medicaid managed care	Prohibits Medicaid, Medicaid managed care, and commercial insurers in New York from requiring prior authorization for medication for the treatment of SUD, including all buprenorphine products, methadone, or long-acting, injectable naltrexone.
Insurers and pharmacy benefit managers (PBMs) must place MOUD on the lowest cost-sharing tier of the drug formulary.	Pennsylvania voluntary agreement (2018)	Provides that MOUD will be covered at the lowest patient cost tier on the plan's pharmacy benefit, as applicable, in a voluntary agreement with seven of Pennsylvania's largest commercial insurers.
State attorneys general can also promote access to MOUD.	New York Attorney General settlements, including letters from Anthem (2017) and Cigna (2016)	States national health plans' commitments to end prior authorization for MOUD nationwide.

RECOMMENDATION	SELECTED EXAMPLE/RESOURCE	HOW IT WORKS
CONTINUUM OF CARE/COLLABORATIVE CARE		
Promote programs that help ensure a full continuum of care.	Shatterproof's Collaborative Care Model for SUD provides specific G-codes and Current Procedural Terminology (CPT®) codes, multiple Medicaid 1115 waiver examples	Outlines a tested and validated model for intervention and collaborative care delivery through a team of primary care providers, care management staff, and psychiatric consultants to provide integrated care and track patient progress through validated clinic rating scales.
Ensure Medicaid encompasses the complete ASAM continuum of SUD treatment.	North Carolina 1115 SUD Waiver, SUD Implementation Plan Protocol (2019)	Outlines North Carolina's plan to complete its coverage of the full ASAM continuum under Medicaid by adding new ASAM levels of care and expanding coverage of existing SUD services under its 1115 waiver.
MEDICAL CRITERIA FOR COVERAGE		
Require use of clinical guidelines to assess medical necessity.	Speaking the Same Language: A Toolkit for Strengthening Patient-Centered Addiction Care in the United States	Provides strategies for integrating <i>The ASAM Criteria</i> , the most widely used set of evidence-based guidelines for patient placement, continued stay, and transfer of patients, into state approaches to SUD services.
	California SB 855 (2020)	Requires payer utilization of policies and procedures that are fully consistent with <i>The ASAM Criteria</i> for medical necessity determinations.
Enforce medical standards of care.	Virginia standardized client intake tool	Requires providers to use a standardized client assessment tool based on the ASAM client assessment and program standards.
ADDRESS DISPARITIES		
Address disparities by ensuring data by race and ethnicity is widely available.	Minnesota Opioid Dashboard	Contains specific (although limited) information about race-specific overdose rates as well as age, gender, and other metrics.
Address disparities through innovative partnerships.	The Detroit Recovery Project (DRP)	An example of an effective, targeted, multi-service effort designed to support Black individuals with an SUD. This program brings together university partners, public safety officials, churches, local public schools, the Department of Health and Human Services and others, to increase community reach and awareness and provide coordinated efforts through culturally relevant community events.

RECOMMENDATION	SELECTED EXAMPLE/RESOURCE	HOW IT WORKS
JUSTICE-INVOLVED POPULATIONS AND PREGNANT, POSTPARTUM AND PARENTING INDIVIDUALS		
Provide evidence-based medical care, including MOUD, to justice-involved populations.	<p>28 Vermont Statutes Annotated § 801b (2018)</p> <p>Smith v. Aroostook County (2018)</p>	<p>Requires inmates in correctional facilities to be screened for SUD as part of the initial and ongoing substance use screening and assessment process within 24 hours. Specifies that inmates in a correctional facility shall be entitled to continue MOUD as long as medically necessary.</p> <p>Finds that denial of access to medication-assisted treatment (MAT) for incarcerated people is in violation of the Americans with Disabilities Act and the Eighth Amendment of the US Constitution.</p>
Implement Plans of Safe Care for pregnant, peripartum, and parenting individuals.	<p>New Mexico Statutes § 32A-4-3 (2019)</p>	<p>Requires hospitals to identify all infants with exposure to maternal drug use and develop a plan of safe care that delineates the specific after-hospital care needed for the infant without automatically triggering a report of child abuse or neglect.</p>
Remove criminal and other penalties for pregnant, postpartum, and parenting women utilizing MOUD.	<p>Montana Code Annotated § 50-32-609 (2019)</p>	<p>Provides safe harbor for pregnant women seeking or receiving evaluation, treatment, or support services for a substance use disorder.</p>
TREATMENT POLICIES		
Eliminate policies that condition treatment access and participation on non-use of MOUD.	<p>California Senate Bill No. 992 (signed by the governor September 2018)</p>	<p>Prohibits residential treatment facilities from denying admission to potential patients or discharging current patients because of a valid prescription for an FDA-approved medication for MOUD.</p>
Require treatment facilities to ensure access to or continuation of MOUD as a condition of receiving public funding.	<p>Missouri Department of Mental Health (DMH) Memo: MAT Certification Requirements (2016)</p>	<p>Requires that for agencies and providers to remain certified and contracted with the Missouri DMH, an agency must not only offer or arrange for all forms of MOUD, but offer or arrange for MOUD to be delivered in an evidence-based way.</p>

II. Ensure access to addiction medicine, psychiatry, and other trained physicians

This chapter addresses the importance of ensuring that provider networks are sufficient in numbers and expertise to meet patient needs and that those networks are organized in ways that support front-line providers and give them the tools they need to serve patient needs.

Every state can take action to ensure patient access to providers for the treatment of SUD. To bolster provider networks that are equipped to meet the needs of patients with SUD, has your state:

- 1 Developed network adequacy standards and reporting requirements that identify gaps in coverage and require corrective action?
- 2 Employed innovative models (eg, hub-and-spoke, emergency department interventions) to connect SUD patients to the appropriate medical professionals and treatment options?
- 3 Leveraged telehealth to enhance both patient access and provider training on SUD treatment options?

“State actions to end the epidemic need to confront wide disparities in access to in-network care; prior authorization and other utilization management hurdles both for providers and medication; difficulties in determining which in-network providers are accepting new patients; and cost-sharing decisions that may place some medications or other treatments out of reach.”

Bobby Mukkamala, MD, Chair, AMA Board of Trustees; Chair, AMA Substance Use and Pain Care Task Force

What resources are available to your state to ensure access to providers? Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
NETWORK ADEQUACY		
<p>Leverage Medicaid managed care contracting to establish and enforce robust network adequacy requirements.</p>	<p>Ohio Medicaid Managed Care Contracts</p>	<p>Requires Medicaid Managed Care Organizations (MCOs) to contract with a minimum number of MOUD providers per county and all willing Opioid Treatment Programs (OTPs) licensed by the state.</p>
<p>Require insurer reporting on network capacity to provide MOUD.</p>	<p>Colorado Insurance Regulation 4-2-75 Concerning Requirements for Reporting Medication-Assisted Treatment Coverage (based on 2019 Colorado state law)</p>	<p>Sets new standards for evaluating behavioral health and SUD treatment networks by requiring insurers to report the number of physicians and other health care professionals who are authorized to provide MOUD and who are in-network and accepting new patients.</p>
<p>Require reporting on the number of patients being treated with MOUD.</p>	<p>Colorado Insurance Regulation 4-2-75 Concerning Requirements for Reporting Medication-Assisted Treatment Coverage</p>	<p>Requires insurers to report on the number of patients being seen for SUD and OUD and the number of patients receiving MOUD to help assess network adequacy and patient access to in-network providers treating patients with MOUD.</p>
<p>Address the inequities faced by Black, Hispanic, American Indian, and other historically marginalized and minoritized populations to ensure network adequacy to evidence-based care.</p>	<p>California Tribal MAT Expansion Project</p>	<p>Leverages resources from Tribal communities, urban Tribal health centers, and the State to provide collaborative, culturally appropriate approaches to care and improve the availability and provision of MOUD.</p>
EVIDENCE-BASED TREATMENT INFRASTRUCTURE		
<p>Enhance access to medical, social, and other behavioral care services and providers through hub-and-spoke models.</p>	<p>Pennsylvania Coordinated Medication-Assisted Treatment Centers (PacMAT Centers)</p>	<p>Utilizes a hub-and-spoke model to provide MOUD by coordinating an addiction medicine specialist at the hub providing treatment to patients at eight PacMAT centers.</p>

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
Coordinate efforts with emergency departments to connect nonfatal overdose patients to treatment options.	California Bridge Model	Provides in a blueprint paper a step-by-step guide on how to set up a MOUD intervention program in the emergency department of an acute care hospital.
Invest in mobile methadone units to help increase access to MOUD and other services.	Drug Enforcement Administration's (DEA's) final rule, "Registration Requirements for Narcotic Treatment Programs with Mobile Components" American Association for the Treatment of Opioid Dependence Webinar	Adds a mobile component to existing registrations for narcotic treatment programs per DEA measures finalized in June 2021 to improve access to MOUD in "rural and underserved areas with limited treatment options." Provides a "how to" webinar to provide information on how OTPs "can expand their blueprint throughout the country by expanding the use of mobile vans."
TELEHEALTH		
Leverage telehealth to improve access on a permanent basis.	Virginia's Department of Medical Assistance Services	Allows the counseling component of MOUD to be provided via telehealth or telephone communication to Medicaid participants.
Enhance provider capacity through telehealth training.	New Mexico TeleECHO (Extension for Community Healthcare Outcomes)	Leverages a hub-and-spoke knowledge-sharing approach to improve provider capacity in rural and underserved areas.
Adopt federal flexibilities to initiate buprenorphine for SUD via audio-only telehealth.	Pennsylvania Telemedicine Waiver for Opioid Treatment adopting federal flexibility (2020)	The Pennsylvania waiver allowed for suspension of state law requiring an in-person physical exam as a condition of prescribing buprenorphine for the treatment of OUD.

"When networks are limited, consumers are forced to wait or travel long distances for care, pay higher costs for treatment from a non-network provider, or forgo care altogether. Network gaps for mental health (MH) and substance use disorder (SUD) providers are particularly problematic."

Legal Action Center

Source: www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services

III. Enforce mental health and substance use disorder parity laws

This chapter addresses the importance of enforcing mental health and SUD parity laws with regulations and a full continuum of oversight strategies (eg, attestations, data calls, market conduct exams) that ensure compliance with parity requirements.

Every state can take action to enforce mental health and SUD parity laws. To further parity enforcement and ensure compliance, has your state:

- 1 Updated your parity laws and regulations to reflect the most recent developments in enforcing parity requirements?
- 2 Required health insurers to document their compliance with regulatory requirements (eg, attestations for comparative analyses, parity checklists for rate and form filings)?
- 3 Used the full continuum of enforcement tools (eg, complaint tracking, data calls, market conduct examinations) and made the results publicly available?
- 4 Participated in the National Association of Insurance Commissioner's (NAIC's) Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Working Group by sharing best practices from your state and following best practices from other states?

"Our exams and investigations, as well as analysis of consumer complaints, indicate that mental health parity noncompliance persists."

Jessica Altman, Commissioner,
Pennsylvania Insurance
Department

What resources are available to your state to advance mental health and SUD parity? Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
PARITY LAWS		
<p>Review model mental health and substance use disorder parity laws and upgrade state laws.</p>	<p>American Psychiatric Association (APA) Mental Health and Substance Use Disorder Insurance Coverage and Model Legislation Illinois Public Act 102-0579 (see also Illinois Public Act 99-480)</p>	<p>Provides state-by-state model language customized to state legislative drafting conventions, drawing on the Kennedy Forum model and regularly updated based on state developments.</p> <p>Illinois' law is one of the nation's most comprehensive to ensure that evidence-based standards put forward by professional medical organizations are used to ensure patients' access to care. Includes strong prohibitions against related prior authorization and step therapy practices by insurers.</p>
ATTESTATION AND CHECKLISTS		
<p>Require insurers to attest to compliance.</p>	<p>Title 40, Pennsylvania Consolidated Statutes and Pennsylvania Law 682, No. 284</p>	<p>Requires insurers to perform and document parity analyses for all treatment limitations and file annual attestations of parity compliance.</p>
<p>Conduct rate and form reviews. Rate and form review is an annual process through which Divisions of Insurance (DOIs) review insurer products to ensure they comply with legal standards, including parity requirements.</p>	<p>North Carolina Department of Insurance Mental Health Parity and Addiction Equity Act Compliance Checklist</p>	<p>Requires insurers to document compliance with parity requirements as part of the annual approval process for their health benefit plans.</p>
ENFORCEMENT CONTINUUM		
<p>Analyze consumer complaints.</p>	<p>Florida Statutes § 624.36, § 627.4215, and § 641.31085</p>	<p>Requires insurers to report annually on behavioral health complaints (number, nature, and disposition) and make recommendations for improving access and affordability of services.</p>
<p>Issue data calls. DOIs generally have the authority to make requests for certain data (eg, "data calls") from insurers and other regulated entities to conduct certain analyses, such as market scans.</p>	<p>Washington report on parity compliance (2019)</p>	<p>Summarizes the findings from a set of insurer data calls conducted by Washington insurance regulators and the University of Washington.</p>

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
<p>Conduct market conduct exams and issue corrective actions.</p> <p>DOIs generally have the authority to conduct market conduct exams to assess regulated entities' compliance with state laws and regulations, such as mental health parity.⁷ The exam process is established by statute, with specific timeframes and opportunities for the regulated entity to review and comment on findings.</p>	<p>Rhode Island Market Conduct Exam Reports, Delaware 2020 and 2021 Mental Health Parity Examinations, New Hampshire Mental Health Parity Examinations, Pennsylvania and New York's extensive market conduct exams</p>	<p>Many states publish exams on carriers, their responses to exam findings, and compliance orders with penalties assessed.</p>
<p>Take legal action to enforce parity rights.</p>	<p>Colorado Annual Mental Health Parity Report (2020)</p>	<p>Colorado's 2020 report summarizes the state's experience with inadequate parity exams and the commissioner's actions to upgrade exam standards and initiate a new round of exams.</p>
<p>Continually update consumer education.</p>	<p>Massachusetts' Attorney General action</p>	<p>Exemplifies the role that state attorneys general can play in enforcing parity and holding health insurers' accountable for violations.</p>
<p>MHPAEA WORKING GROUP</p>	<p>New Hampshire Insurance Department website on Substance Use Disorder Insurance Coverage</p>	<p>Provides targeted information for enrollees with SUDs and shares resources to understand their right to equal treatment and how to secure those rights.</p>
<p>Participate in the working group.</p>	<p>NAIC state resources</p>	<p>Contains a growing list of resources submitted by individual states to provide ideas and models for other states.</p>

"Increasing access to mental health treatment is vital to every Illinoisan, especially now, when the crisis has been made worse by the pandemic. ... This law will ensure families can more easily seek treatment for mental, emotional, nervous or substance use disorders without worrying about insurance coverage." — State Senator Laura Fine

"Our communities are facing mental health and addiction crisis that is only worsening. ... This legislation will increase access to mental health treatment, giving people with mental health and substance use disorders that ability to access treatment sooner and get on the road to recovery." — State Rep. Deb Conroy

Source: www.illinois.gov/news/press-release.23805.html

IV. Improve access to multidisciplinary, multimodal care for patients with pain

This chapter addresses the importance of improving access to multidisciplinary, multimodal pain care with affordable access to alternatives to opioids (ALTOs) and provider discretion to use the full continuum of pain care options, including opioid therapy when clinically indicated.

Every state can take action to improve access to multidisciplinary, multimodal pain care. To ensure patients are provided affordable access to the full spectrum of pain care and treatment options, has your state:

- 1 Required plans to cover pharmacological ALTOs and nonpharmacological treatment options at the lowest cost-sharing tier, without prior authorization or other barriers to access?
- 2 Identified and supported the implementation of evidence-based, interdisciplinary pain management delivery models?
- 3 Ensured that state policies reflect individualized treatment decisions rather than arbitrary thresholds on opioid prescriptions?
- 4 Ensured patient access to a full continuum of treatment options by protecting provider discretion to make patient-centered treatment decisions?

“The nation’s drug overdose epidemic has never been just about prescription opioids, and we encourage the U.S. Centers for Disease Control and Prevention—along with state policymakers—to take a broader view of how to help ensure patients have access to evidence-based comprehensive care that includes multidisciplinary, multimodal pain care options as well as efforts to remove the stigma that patients with pain experience on a regular basis.”

Bobby Mukkamala, MD, Chair, AMA Board of Trustees; Chair, AMA Substance Use and Pain Care Task Force

What resources are available to your state to ensure patients are provided the full spectrum of pain care and treatment options? Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
ALTERNATIVES TO OPIOIDS (ALTOS)		
Increase access to evidence-based pharmacological ALTOS.	Colorado House Bill 21-1276 (signed by the governor June 2021, effective 2023)	Requires plans that provide prescription drug benefits to provide coverage for at least one atypical opioid that is FDA-approved for the treatment of acute or chronic pain and specifies that the coverage must be at the lowest cost-sharing tier of the carrier's formulary with no requirement for step therapy or prior authorization.
Increase access to evidence-based nonpharmacological ALTOS.	Colorado House Bill 21-1276 (signed by the governor June 2021, effective 2023)	Requires plans to provide a cost-sharing benefit for nonpharmacological treatment where an opioid might be prescribed. The required cost-sharing benefit must include a cost-sharing amount not to exceed the cost-sharing amount for a primary care visit for nonpreventive services.
MULTIMODAL PAIN CARE		
Promote access to evidence-based interdisciplinary pain management delivery models.	The Swedish Hospital System's Structured Functional Restoration Program (SFRP)	Provides a "pain boot camp" involving intensive coordination of care by a number of pain specialists and providers, including pain management specialists, pain psychologists, physical and/or occupational therapists, relaxation therapists, and pain nurse educators.
Advance medical education curriculum focused on evidence-based, compassionate care for patients with pain.	International Association for the Study of Pain (IASP) Curriculum Outline on Pain for Medicine (2018)	Outlines medical school curriculum to embed pain care and education into medical training.

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
INDIVIDUALIZED TREATMENT		
Protect provider discretion to develop individualized treatment plans.	Oklahoma Senate Bill 57 (signed by the governor June 2021)	Incorporates changes to the state’s Anti-Drug Diversion Act, adding “Nothing in the Anti-Drug Diversion Act shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).”
	New Hampshire House Bill 1639 (signed by the governor in 2020)	Provides that “All decisions regarding the treatment of patients experiencing chronic pain shall be made by the treating practitioner even when the treatment is determined to require the prescribing of opioid analgesics,” and that “Ordering, prescribing, dispensing, administering, or paying for controlled substances, including opioid analgesics, shall not in any way be pre-determined by specific Morphine Milligram Equivalent (MME) guidelines.”

“Unfortunately, some policies and practices purportedly derived from the [CDC opioid prescribing] guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician’s practice.”

US Centers for Disease Control and Prevention

Source: www.nejm.org/doi/full/10.1056/NEJMp1904190

V. Expand harm reduction efforts to reduce death and disease

This chapter addresses the importance of increasing access to naloxone, removing barriers to syringe exchange programs, and taking other actions to reduce drug overdoses and deaths.

Every state can take action to reduce drug overdoses and deaths by advancing harm reduction efforts. To increase access to lifesaving medication and support harm reduction programs and policies, has your state:

- 1** Increased access to naloxone by issuing a statewide standing order authorizing pharmacies to dispense naloxone without a patient-specific prescription and ensuring naloxone is affordable for patients and local entities?
- 2** Reduced/removed barriers to accessing naloxone by prohibiting life insurance companies from taking adverse actions against those who have obtained naloxone?
- 3** Adopted laws and other policies to remove barriers to implementing and/or establishing harm reduction programs and overdose prevention centers?
- 4** Decriminalized fentanyl test strips and other drug checking supplies?

“Needle and syringe exchange services, overdose prevention sites and naloxone are just a few of the types of harm reduction efforts that help reduce mortality and the spread of infectious disease, but they also have demonstrated success in connecting individuals to treatment and distributing naloxone to people who use drugs.”

Patrice A. Harris, MD, MA,
former AMA President and
Chair, AMA Task Force

What resources are available to your state to ensure broad access to naloxone and support harm reduction programs and policies? Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/RESOURCE	HOW IT WORKS
NALOXONE ACCESS		
Reduce pricing and increase access for local entities to purchase naloxone.	Massachusetts Bulk Purchasing of Naloxone Program through the State Office of Pharmacy Services (SOPS)	The state negotiates with a wholesaler, allowing eligible entities to purchase naloxone at the negotiated rate as long as they have an active Massachusetts Controlled Substance Registration.
Issue a standing order for naloxone.	Illinois' Standing Order/Naloxone Standardized Procedure (2017)	Permits pharmacies, pharmacists, and opioid overdose education and naloxone distribution programs to use a standing order to distribute naloxone.
Remove prior authorization for naloxone.	Missouri Annotated Statutes § 191.1165	Naloxone must be placed on the lowest cost-sharing tier of an insurer's or PBM's formulary, including the Missouri HealthNet program; prohibits any annual or lifetime dollar limitations.
Institute Good Samaritan laws for naloxone administration.	18 Vermont Statutes Annotated § 4254 (2017)	Ensures that the person who administers naloxone and the person to whom it is being administered are not subject to criminal charges.
Disallow evidence of naloxone prescription for life insurance underwriting.	Colorado Division of Insurance Bulletin (January 2020)	Guidance from the state Department of Insurance that does not allow evidence of a naloxone prescription to be used in the process of determining insurance eligibility or premium cost.
HARM REDUCTION		
Decriminalize safe syringe program (SSP) supplies.	Oregon Revised Statutes § 475.525	Clarifies in statute "for purposes of this section [regarding the sale of drug paraphernalia prohibited], 'drug paraphernalia' does not include hypodermic syringes or needles."
Authorize harm reduction centers.	Rhode Island HB-5245 Substitute A	Authorizes a two-year pilot of safe consumption programs in the state of Rhode Island.
Expand personal protective equipment priority to include harm reduction organizations.	CDC Interim Guidance for Syringe Services Programs, 2020	CDC guidance that clarifies "SSPs" should be considered by the state, local, territorial, and tribal jurisdictions as essential public health infrastructure that should continue to operate during the COVID-19 pandemic.
Decriminalized fentanyl test strips and other drug checking supplies	Arizona Senate Bill 1486 (signed into law)	Law removes from the definition of "drug paraphernalia" drug testing products that are used to determine whether a substance contains fentanyl or a fentanyl analog.

"No one should have to suffer the loss of their loved one to addiction or accidental overdose. ...

Illegal drug use can be extremely dangerous, and with the prevalence of fentanyl being laced into other drugs, it can be deadly. We have to make sure families and young Arizonans have the resources needed to prevent a lethal fentanyl overdose, and this legislation will provide an additional tool."

Arizona Senator Christine March, who sponsored AZ SB 1486

Source: <https://thehill.com/homenews/state-watch/554419-arizona-legalizes-test-strips-that-detect-fentanyl?rl=1>

VI. Monitor and evaluate programs

This section addresses the importance of collecting standardized data, reporting through public data dashboards, and using data to evaluate the effectiveness of state programs.

Every state can take action to advance the collection and reporting of standardized data to support program evaluation. To expand and support efforts to evaluate the effectiveness of state programs using standardized program data, has your state:

- 1 Required public reporting of data based on standardized case definitions to ensure consistency in measurement (such as those provided by the Council on State and Territorial Epidemiologists (CSTE))?
- 2 Implemented a reporting system to accurately monitor and evaluate trends based on these clear, evidence-based case definitions and reported this data publicly?
- 3 Required comprehensive and timely reporting of information to monitor trends, identify populations or geographic areas at high risk, formulate and assess prevention and control strategies, and formulate public health policies?
- 4 Reviewed data collection policy to monitor data collection policies' effectiveness?

Particular emphasis must be placed on collecting adequate, standardized data to eliminate inequities for historically marginalized and minoritized populations. Additional work must be done to address the increased complexity of access and treatment to SUD care as a result of the nation's growing polysubstance use, overdose and death epidemic.

Recommendation of the AMA Substance Use and Pain Care Task Force

What resources are available to your state to support data collection, reporting, and program evaluation?

Below are selected examples of state resources your state can use to take action.

RECOMMENDATION	SELECTED EXAMPLE/ RESOURCE	HOW IT WORKS
DATA COLLECTION AND REPORTING REQUIREMENTS		
Standardize data reporting.	Recommended CSTE Surveillance Indicators for Substance Abuse and Mental Health (Version 3) CDC National Notifiable Diseases Surveillance System (NNDSS)	<p>Provides standardized definitions to facilitate consistent reporting of substance use and mental health surveillance indicators for use by state and local public health departments. Regular collection of these indicators will provide an opportunity to routinely analyze and disseminate results.</p> <p>Provides additional resources for data reporting, including standardized case definitions to classify and count cases consistently across reporting jurisdictions.</p>
SURVEILLANCE SYSTEMS AND DASHBOARDS		
Create publicly available data dashboards.	New Jersey Drug Overdose Dashboard	Reports on a comprehensive list of metrics through a dashboard that aggregates data from multiple state agencies to create a comprehensive picture of OUD in the state.
Capture data with comprehensive information.	Indiana Drug Data Dashboard	Reports county-by-county data on a dashboard that includes overdose deaths (with an option to select drug type), emergency department (ED) visits and hospital discharges (with an option to select drug type), and naloxone distribution (including a heat map). The naloxone heat map, for instance, tracks emergency medical services data in order for officials to identify areas of high incidence of overdose.
Stand up a State Unintentional Drug Overdose Reporting Surveillance (SUDORS) system.	North Carolina Opioid Action Plan Data Dashboard	Reports on county-level metrics, including hepatitis C data, deaths, ED visits and MAT. Critically, it also includes resources for each metric that counties are required to report upon and corresponding local actions to direct community involvement and customization.
POLICY EVALUATION		
Conduct evaluations at set intervals using state and federal data.	Medicaid Outcomes Distributed Research Network (MODRN) West Virginia State Opioid Response Grant Program Evaluation	<p>Assess OUD treatment quality and outcomes in Medicaid through a collaboration between Academy Health's Evidence-Informed State Health Policy Institute and Data Coordinating Center and a group of state Medicaid agencies and state universities that adopt a common data model, contribute to a common analytic plan, and conduct analysis locally on their own Medicaid data using standardized code developed by a data coordinating center.</p> <p>West Virginia's State Opioid Response Grant is funding West Virginia University researchers to track the impact of policy changes adopted at the state level.</p>

Current state and national data are largely incomplete, not standardized for comparison, not as timely as needed and widely variable from location to location. Difficulties also remain in accessing comprehensive, standardized data. While metrics are generally available for drug-related overdose, data for non-fatal overdose and other key indicators are not widely collected or standardized across states and communities. These data gaps greatly hinder understanding local, state and national situations to advance prevention, treatment and harm reduction efforts. Much more must be done to improve public health and other surveillance to reduce mortality and improve patient outcomes.

State and federal funding to end the drug overdose epidemic

Using this toolkit to enact laws and direct policies to help end the drug overdose epidemic is essential. Funding the programs to do this is another essential task for state action. This includes ensuring that funds are “being targeted to communities most affected by the epidemic.”⁸ This appendix outlines the sources of several recently available resources and provides best practices on how communities may access and distribute these resources to best meet the needs of their populations.

Prioritizing allocation of funding from opioid-related litigation

Significant payments resulting from opioid litigation settlements are beginning to flow to states. Across the country, litigation against opioid manufacturers and distributors is generating new funding and is likely to result in billions of dollars in funding for both state and local governments. “The opioid lawsuits” broadly refer to several categories of legal actions:

- City and county governments and Tribal sovereign nations have filed more than 2,000 civil lawsuits against pharmaceuticals, referred to as multidistrict litigations or MDLs.
- Civil lawsuits by state attorneys general against pharmaceutical defendants are another class of MDL.⁹
- Two major manufacturers filed civil bankruptcy cases, offering a lump sum amount as part of their Chapter 11 filing to settle outstanding claims.¹⁰
- A number of civil enforcement actions and criminal prosecutions have been brought by attorneys for state and federal governments against an array of defendants, ranging from pharmaceutical corporations to individual doctors and pill mills.

“We are still deep in the midst of an overdose crisis. . . . We don’t want to see a repeat of what happened with the tobacco litigation settlements where the vast majority of the funds weren’t used to address the actual public health issue at hand.”

Joshua Sharfstein, MD, Vice Dean for Public Health Practice and Community Engagement, Johns Hopkins Bloomberg School of Public Health

All told, states will soon or can now access unprecedented funding to tackle the drug overdose epidemic. As states and localities consider how to invest this funding, this toolkit provides some background for potential options in which states and communities can invest. In prioritizing these investments, it is critical that states and communities tailor their responses to the unique needs of their populations. Several resources provide examples for how states can maximize these available funds, including:

- **Legislative Analysis and Public Policy Association (LAPPA) Model Opioid Litigation Proceeds Act.** This model law—endorsed in October 2021 by the White House Office of National Drug Control Policy¹¹—will guide states through the establishment of a dedicated fund, separate from the state’s general fund, that is designated for SUD abatement, including prevention, treatment, recovery, and harm reduction infrastructure, programs, services, supports, and resources. The fund will house all of the state’s proceeds from legal claims. In addition to the provisions in the LAPPA Act, the AMA and Manatt urge further focus on efforts to support patients with pain.
- Several states have enacted state laws to establish dedicated opioid funds:
 - A recently enacted **Virginia law** establishes an “opioid abatement” fund for the state to collect any funds secured from ongoing lawsuits and includes a list of conditions and restrictions for the use of the financial support from the fund.^{12, 13} Virginia is one of the first states in the nation to have a “legislatively enacted framework for directing funds from opioid litigation” and can serve as a model for other states.¹⁴
 - **New York** established an opioid settlement fund in June 2021 to ensure that all settlement monies are kept separate from other state funds and dedicated solely to, per the statute, “prevention, treatment, harm reduction, and recovery services related to substance use disorders and co-occurring mental illnesses in New York state.”¹⁵
 - **Kentucky** established its own Opioid Abatement Advisory Commission to manage any funds awarded to the state and fund projects to support the OUD or any co-occurring SUD or mental health issues.¹⁶ The statute lists nearly two pages of eligible programs, including intervention, treatment, and recovery services; transportation to treatment; opioid-abatement-related housing; crisis stabilization centers; and training for health care professionals.
- States also have entered into legal agreements as a condition of settlement of lawsuits. **North Carolina** is one example where all monies, except for legal expenses and related fees,¹⁷ are to be directed for public health uses.¹⁷

FIGURE 1. SUMMARY OF STATE STRATEGIES TO MAXIMIZE USE OF AVAILABLE OPIOID SETTLEMENT FUNDS

STATE	STRATEGY FOR MAXIMIZING AVAILABLE FUNDS
STATE LAWS TO ESTABLISH DEDICATED OPIOID SETTLEMENT FUNDS/ADVISORY COMMISSIONS	
Virginia	Establishes an “opioid abatement” fund for the state to collect any funds secured from ongoing lawsuits and includes a list of conditions and restrictions for use of the financial support from the fund.
New York	Establishes an opioid settlement fund to ensure settlement monies are kept separate from other state funds and dedicated solely to “prevention, treatment, harm reduction, and recovery services related to substance use disorders and co-occurring mental illnesses in New York state.”
Kentucky	Established an Opioid Abatement Advisory Commission to manage any funds awarded to the state and fund projects to support the OUD or any co-occurring SUD or mental health issues
LEGAL AGREEMENTS AS A CONDITION OF SETTLEMENT OF LAWSUITS	
North Carolina	Explicitly directs that all opioid settlement monies, except for legal expenses and related fees, are to be directed for public health uses.

Additionally, a diverse array of stakeholders led by the Johns Hopkins School of Public Health, including the AMA and other medical, patient, public health, research, and advocacy organizations, has endorsed and is encouraging state policymakers to consider the following principles in prioritizing and allocating these resources:¹⁸

- **Supplement current funding.** Despite the dramatic increase in overdose deaths, many state and local governments cut substance use and behavioral health programs in the midst of the economic concerns surrounding the COVID-19 pandemic. Estimates show that less than 20% of those with OUD are receiving any treatment at all.¹⁹ As such, rather than filling holes in budgets, these funds ought to be used to supplement rather than supplant existing spending targeted directly at OUD and SUD treatment.
- **Invest in evidence-based interventions.** Individuals with OUD in many residential treatment facilities are prohibited from being treated with methadone or buprenorphine, despite evidence that these medications reduce the chance of overdose death by 50% or more. In fact, a review by the Legal Action Center found that only 13 states and the District of Columbia (as of April 2020) barred Medicaid programs from requiring prior authorization for at least one of these medications.²⁰ This influx in funding may be leveraged to advance interventions with a strong evidence base—like extending the full array of medication assisted treatments to inpatient facilities. In cases where programs have not been studied, there should be enough financial support to also confirm the effectiveness of models.
- **Target funds to prevention.** Primary, upstream prevention efforts that stop substance use before it is even initiated can interrupt the pathways to addiction and overdose that too many American families are currently experiencing. According to recent studies, an estimated one-half of all people with SUDs start their substance use before age 14.²¹ State investment in evidence-based, effective youth prevention programs is a worthwhile investment that will save states and health systems money in the future.

- **Invest in historically underserved communities.** As with other facets of the health system, historically minoritized and marginalized populations are more likely to face barriers in accessing high-quality treatment and recovery support services. Propagating racial inequities exacerbates treatment disparities. States and communities should identify where inequities and disparities occur as a first step to ensure public health resources can be equitably directed.
- **Act transparently and fairly in allocating litigation funding.** Jurisdictions that receive settlement monies must act responsibly, transparently, and equitably in responding to the needs of their communities. To do so, local and state policymakers must determine areas of need, solicit input from relevant stakeholders that represent the diversity within communities, and ensure that investments are made with accountability in mind.

Making sustainable investments to leverage federal funding

In addition to the opioid litigation funds, billions of dollars in funding have been appropriated by the federal government to help end the drug overdose epidemic, particularly in light of the focus that the COVID-19 pandemic brought to the availability of federal resources to invest in public health at the state and local levels. For example, the epidemic garnered federal attention and funding before the pandemic and led to the passage in 2018 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act with its millions of dollars in newly available federal resources. Today, the level of federal investments as a result of COVID-driven relief legislation is even greater.

Several recent spending bills (including the Coronavirus Aid, Relief and Economic Security (CARES) Act, the Coronavirus Response and Relief Supplemental Appropriations Act, and the American Rescue Plan Act) included billions of dollars to support public health measures and to minimize disruptions in access to SUD treatment. (See Figure 2 below.)

FIGURE 2. FEDERAL LAWS WITH SUD-SPECIFIC FUNDING AND/OR OTHER SELECT SUD-RELATED PROVISIONS

LAW	SUD-SPECIFIC FUNDING	OTHER SELECT PROVISIONS IMPACTING SUD
Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) ²²	\$425 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to remain available through Sept. 30, 2021	The legislation (at Section 3221, <i>Confidentiality and disclosure of records relating to substance use disorder</i>) substantially revised the federal SUD confidentiality regulations (known as 42 CFR Part 2). The provisions changed confidentiality and disclosure of records for patients with SUD.
Coronavirus Response and Relief Supplemental Appropriations Act (P.L. 116-260) ²³	\$4.25 billion for SAMHSA, including: <ul style="list-style-type: none"> • \$1.65 billion for SAMHSA's Community Mental Health Block Grant (MHBG) • \$1.65 billion for SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program (SABG) • \$600 million for Certified Community Behavioral Health Clinics • \$240 million for emergency grants to states 	
American Rescue Plan Act (P.L. 117-2) ²⁴	\$3 billion for SAMHSA's block grant programs, including: <ul style="list-style-type: none"> • \$1.5 billion for MHBG • \$1.5 billion for SABG \$15 million to support the development of community-based mobile crisis interventions \$80 million to develop SAMHSA grant programs for new grant recipients \$100 million for the Behavioral Health Workforce Education and Training Program ²⁵ administered by HRSA	Section 9813, <i>State option for community-based mobile crisis interventions</i> , authorizes states to claim Medicaid matching funds for community-based mobile crisis intervention services for Medicaid beneficiaries experiencing a mental health or SUD crisis.

According to the Department of Health and Human Services' (HHS) Tracking Accountability in Government Grants System, SAMHSA alone has distributed more than 2,600 grants totaling more than \$7.7 billion in COVID relief funding.²⁶ Yet, as noted by the Bipartisan Policy Center, the expansion of federal funds has not been matched by a concomitant effort to track or evaluate the impact of those funds:

"Since FY2017, the federal government has invested billions of dollars to curb the opioid epidemic. However, rates of annual overdose death are the sole public measure for the effectiveness of these expenditures. Given the size of this investment, publicly available evidence-based evaluations of each of the streams of federal opioid funding must be conducted. These evaluations should include information on whether the grant is meeting the needs of at-risk populations as well as health equity goals. In addition, evaluations should assess whether federal resources are going to implement evidence-based interventions."²⁷

Detailed Resources

The Detailed Resources section of this toolkit supplements the resources highlighted in prior sections with an extensive compendium of additional resources in each of the six policy areas. It is intended to provide state officials, including governors, insurance regulators, Medicaid officials, attorneys general, and others, with examples of policies and actions that are working to help patients today. These resources range from model laws and state policy guidance across six policy areas, to examples of effective programs and interventions that are evidence-based and are having a positive impact on their communities. The resources listed here are representative of some of the potential interventions that state leaders may pursue. The AMA and Manatt Health continue to encourage state leaders to use these resources to introduce bills, draft regulations, inform policy guidance and implement initiatives to take immediate action in order to end the epidemic and save lives.

I. Increase access to evidence-based treatments to help patients with a substance use disorder

Recommendation: State Medicaid officials should continue to expand Medicaid coverage of medications for opioid use disorder (MOUD) of all types and all formulations, eliminate prior authorization and utilization management barriers, and revisit state requirements that limit or deny the availability of methadone and OTP access for patients seeking care.

Expand Medicaid coverage of MOUD

- [CMS Guidance Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment \(2020\)](#)
 - CMS issued guidance about newly required Medicaid coverage for treatment of opioid use disorder added under the SUPPORT Act. The guidance includes information to help states expand their OUD service continuum.
 - The SUPPORT Act amended the Social Security Act to require state Medicaid plans to include coverage of MOUD for all those eligible to enroll in the state plan or waiver of state plan.
 - CMS interprets Section 1905(ee)(1) of the Act to require that states include as part of the new mandatory benefit all forms of drugs and biologicals that the Food and Drug Administration (FDA) has approved or licensed for MOUD to treat OUD.
 - The FDA has approved methadone, buprenorphine and naltrexone for MOUD to treat OUD.
 - Currently, all state Medicaid programs cover some form of buprenorphine and extended-release naltrexone for treatment of OUD.

Eliminate PA and UM barriers for MOUD

- [District of Columbia Department of Health Care Finance Removal of Prior Authorization Requirements for Medication-Assisted Treatment in Medicaid \(2019\)](#)
 - In April 2019, D.C. issued Medicaid policy guidance that removes prior authorization requirements for medication-assisted treatment for opioid use disorder for all medication providers and MCOs.
- [Maryland Code, Ins. § 15-851](#)
 - Insurers and nonprofit health service plans that provide coverage for SUD benefits or prescription drugs under individual, group, or blanket health insurance policies and HMOs may not apply a prior authorization requirement for a prescription drug when used for treatment of an OUD.
 - Provides essential protections for removing prior authorization of MOUD.
- [New Jersey Medicaid Removes Prior Authorization Requirements for Opioid Addiction Treatment Medication \(2019\)](#)
 - In April 2019, the New Jersey Department of Human Services (DHS) announced Medicaid patients would no longer need prior approval of Medicaid before starting MOUD.
 - DHS required all addiction treatment facilities that accept Medicaid to offer MOUD as an option, starting July 1, 2019.
- [Iowa House File 623](#)
 - Iowa House File 623 removes prior authorization under Medicaid fee-for-service and managed care administration for at least one form of MOUD: methadone, buprenorphine, naloxone, buprenorphine-naloxone combination products and naltrexone.
- [Legislation Limiting the Use of Prior Authorization for Substance Use Disorder Services and Medications](#)
 - As of April 2020, 21 states and D.C. have enacted laws that limit public and/or private insurers from imposing prior authorization requirements on an SUD service or medication. (Fifteen states have enacted laws since 2019.)
 - Seventeen states have laws that limit state-regulated commercial plans from imposing prior authorization on SUD medications, and 13 states and D.C. limit Medicaid from doing so.
 - Ten states limit state-regulated commercial plans from imposing prior authorization on SUD services, and five states limit Medicaid's use of prior authorization for such services.

Support policies that increase access to methadone and opioid treatment programs (OTPs)

- [Spokane, Washington Adoption of Federal Flexibility for Take-Home Methadone, The American Journal of Drug and Alcohol Abuse \(October 2021\)](#)
 - A study examining an OTP that increased the use of take-home methadone pursuant to federal law found that the increased take-home medication led to a decrease in emergency department visits, and no significant change in overdose or negative urine drug tests.
 - The study concluded, “Despite a near-doubling of take-home methadone doses during the COVID-19 exemption period, the increase in take-home doses was not associated with negative treatment outcomes in methadone-adherent clients.”
- [A View From the States: Key Medicaid Policy Changes: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020, KFF \(October 2019\)](#)
 - As of 2019, multiple states did not cover methadone under Medicaid for purposes of MOUD, including Idaho, Kansas, Kentucky, Louisiana, Nebraska, Tennessee and Wyoming.
 - Idaho, Kansas, Kentucky, Louisiana, Nebraska and Tennessee planned to add coverage for methadone in FY 2020.
 - The Louisiana Legislature is [urging](#) the State Department of Health to increase access to OTPs and all forms of FDA-approved MOUD.
 - [New federal rules](#) allow for greater use of mobile methadone vans, but states must invest (search for “mobile” [here](#) for examples).

RACIAL DISPARITIES IN RATES OF SUBSTANCE USE DISORDERS AND OVERDOSE – A SNAPSHOT

- Death rates relating to synthetic opioids [increased by 617 percent](#) among Hispanic individuals from 2014 to 2017, second only to the 818 percent increase among Black people.
- The National Institutes of Health [reports](#) that overdose deaths were nearly 40 percent higher for non-Hispanic Black individuals compared with other races and ethnicities in 2019, and more than [10 percent](#) of American Indian/Alaskan Natives had a substance use disorder in 2019.
- The CDC [reports](#) that in both 2019 and 2020, rates of drug overdose deaths were highest for non-Hispanic American Indian or Alaska Native (AIAN) people (30.5 and 42.5 per 100,000, respectively) and lowest for non-Hispanic Asian people (3.3 and 4.6).
- The CDC [also reports](#) that among all race and Hispanic-origin groups, the largest percentage increases (44%) in drug overdose death rates from 2019 to 2020 were seen in non-Hispanic Black (from 24.8 to 35.8) and non-Hispanic Native Hawaiian or Other Pacific Islander (NHOPI) (from 9.5 to 13.7) people.
- According to a 2020 study on the association of racial/ethnic segregation with treatment capacity for opioid use disorder in counties in the United States, counties with highly segregated African American and Hispanic/Latino communities had [more facilities to provide methadone per capita](#), while counties with highly segregated white communities had more facilities to provide buprenorphine per capita.

Recommendation: States should require commercial insurers to eliminate prior authorization requirements and other burdensome utilization management practices for MOUD. MOUD should be placed on the lowest cost-sharing tier of health insurer/pharmacy benefit manager (PBM) formularies to help increase access to affordable MOUD options. In states that have taken these steps, state insurance regulators and attorneys general should conduct a meaningful review to ensure that health insurers and PBMs are complying with the law and fulfilling plan benefits.

Require all payers to remove PA and UM for MOUD

- [New York Laws Prohibiting All Plans From Requiring Prior Authorization \(PA\) for MOUD](#)
 - [New York Insurance Law §§ 3216\(i\)\(31-a\); 3221\(l\)\(7-a\); 4303\(l-1\) \(2020\)](#)
 - Prohibits commercial plans from imposing PA for an initial or renewal prescription for all buprenorphine products, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of an SUD.
 - [New York Social Services Law § 364-j\(26-b\) \(2019\); New York Public Health Law § 273\(10\) \(2019\)](#)
 - Prohibits Medicaid managed care and fee-for-service plans from requiring PA for preferred and formulary forms of buprenorphine or injectable naltrexone for detoxification or maintenance treatment of an SUD.
 - [New York S. 7506-B/A. 9506-B \(Signed by the Governor in April 2020\)](#)
 - To be codified at New York Social Services Law § 364-j(26-c); New York Public Health Law § 273(10).
 - Prohibits Medicaid managed care and fee-for-service providers from requiring PA for methadone when used for opioid use disorder and administered or dispensed in an opioid treatment program.
- [Spotlight on Legislation Limiting the Use of Prior Authorization \(PA\) for Substance Use Disorder Services and Medications, Legal Action Center and Partnership to End Addiction \(April 2020\)](#)
 - Ten states prevent state-regulated commercial plans from imposing prior authorization on SUD services.
 - Eleven states limit prior authorization for SUD medications in both Medicaid and commercial plans: Arkansas, Colorado, Delaware, Illinois, Maine, Massachusetts, Missouri, New Jersey, New York, Oregon and Washington.
 - Seven states limit prior authorization for SUD medications in commercial plans only: Arizona, Maryland, Montana, New Hampshire, Vermont, Virginia and West Virginia.

Require insurers and PBMs to place MOUD on lowest cost-sharing tier of the drug formulary

- [Pennsylvania Voluntary Agreement \(2018\)](#)
 - Agreement with seven of Pennsylvania's largest commercial insurers to align prior-authorization process for opioid prescriptions to protect patient health and safety while ensuring patients have unrestricted access to MOUD when combating opioid addiction.
 - Guidelines provide that MOUD will be covered at the lowest patient cost-sharing tier on the plan's pharmacy benefit, as applicable.
 - Commercial insurers will also cover MOUD without prior authorization in the following ways:
 - Coverage of at least one buprenorphine/naloxone combination product.
 - Coverage of methadone as MOUD.
 - Coverage of injectable and oral naltrexone.

Ensure compliance with law and fulfillment of plan benefits

- **New York AG Settlements:** Departments of Insurance (DOIs) and/or state attorneys general (AGs) should revisit prior compliance actions to ensure continued compliance.
 - [Anthem letter commits to ending prior authorization for MOUD nationwide \(2017\)](#)
 - This settlement required Anthem, including Empire BCBS in the New York service area, to end its policy of requiring prior authorization for MOUD, resolving the attorney general's investigation of prior authorization practices and network adequacy for MOUD treatment.
 - [Cigna letter commits to ending prior authorization for MOUD nationwide \(2016\)](#)
 - "Effective as of October 15, 2016, Cigna will end its use of prior authorization for MAT medications to treat opioid use disorder (including, but not limited to, buprenorphine and buprenorphine/naloxone) when prescribed by a MAT-authorized provider."

Recommendation: States should promote access to the full continuum of care for those with a substance use disorder.

Promote programs that support the full continuum of care

- [Shatterproof's Collaborative Care Model for SUD](#)
 - Outlines a tested and validated model for intervention and collaborative care delivery through a team of primary care providers, care management staff, and psychiatric consultants to provide integrated care and track patient progress through validated clinic rating scales.

Ensure Medicaid encompasses the continuum of SUD treatment

- [North Carolina Section 1115 SUD Waiver, SUD Implementation Plan Protocol \(2019\)](#)
 - Outlines North Carolina's plan to complete its coverage of the full American Society of Addiction Medicine (ASAM) continuum under Medicaid by adding new ASAM levels of care and expanding coverage of existing SUD services under its Section 1115 waiver.
- [California Section 1115 SUD Waiver to Support Contingency Management for Stimulant Use Disorder \(2022\)](#)
 - Contingency management (CM) is an evidence-based treatment that provides incentives for evidence of positive behavioral change and may be used to treat people with stimulant use disorder and support their path to recovery.
 - According to the California Department of Health Care Services (DHCS), "California is the first state in the country to receive federal approval of contingency management as a benefit in the Medicaid program (Section 1115 waiver)."
 - DHCS will pilot Medicaid coverage of contingency management in select counties beginning July 1, 2022, as part of its California Advancing and Innovating Medi-Cal (CalAIM) demonstration.

Recommendation: States should require the use of clinical guidelines to assess medical necessity and enforce medical standards of care, such as those recommended by the American Society of Addiction Medicine.

Require use of clinical guidelines to assess medical necessity

- [Speaking the Same Language: A Toolkit for Strengthening Patient-Centered Addiction Care in the United States, American Society of Addiction Medicine \(ASAM\) and Well Being Trust \(November 2021\)](#)
 - Provides strategies for integrating *The ASAM Criteria*®, the most widely used set of evidence-based guidelines for patient placement, continued stay and transfer of patients, into state approaches to SUD services.
- [California Senate Bill No. 855 \(Signed by the Governor in September 2020\)](#)
 - Broadly, SB 855 revises provisions of California's Health and Safety Codes and Insurance Code to mandate health insurance companies to provide full coverage for all mental health conditions and substance use disorders, implementing parity requirements into state law.
 - This law specifically incorporates a requirement for insurers to use *The ASAM Criteria*® for medical criteria under the principle that medical decisions should be guided by medical experts.
- [Illinois Law \(Public Act 99-480\)](#)
 - This law includes provisions that extend and clarify coverage, educate consumers about their rights, require minimum treatment benefits, and improve enforcement. The law establishes that medical necessity determinations for substance use disorders must be made using the criteria established by the American Society of Addiction Medicine.
 - **See also:**
 - [Educational guide](#) on implementation of the law.
 - The Kennedy Forum [brief](#) on the law.
- [State Health and Value Strategies: Implementing *The ASAM Criteria*® for SUD Treatment Through Medicaid Managed Care](#)
 - California (through its Drug Medi-Cal Organized Delivery System) designates providers' ASAM levels of care based on their completion of a questionnaire and supplemental documents on the staffing qualifications, hours of treatment, and clinical services they are able to provide.
 - [Massachusetts](#) (through its Section 1115 SUD demonstration) mandates that MCOs provide specific acute treatment, stabilization and residential recovery services based on *The ASAM Criteria*® without prior authorization.

Enforcing medical standards of care

- [Virginia Department of Medical Assistance Services Medicaid Memo \(2018\)](#)
 - Through its Addiction Recovery and Treatment Services (ARTS) Delivery Transformation waiver, Virginia requires providers to use a standardized client assessment tool based on the ASAM client assessment and program standards. Providers attest to the level of care they provide, and this is submitted to MCOs to ensure providers' credentials are consistent with the available ASAM level of care.
 - **See also:**
 - Virginia Department of Medical Assistance Services' Provider Service Authorization Forms, available [here](#).
- [Maryland's Section 1115 Demonstration, Maryland HealthChoice](#)
 - Through Maryland's Section 1115 SUD demonstration, the state requires further review by an Administrative Services Organization (ASO) Medical Director when an ASO clinical team denies an SUD service authorization that does not meet ASAM Criteria. ASOs in the state also offer technical assistance to providers who consistently submit authorizations insufficient to determine clients' placement based on ASAM Criteria.

Recommendation: States should ensure that public and commercial payers collect, analyze, and make public provider and treatment utilization data disaggregated by race and ethnicity; ensure that racial and ethnic disparities are meaningfully addressed in providing equitable access to and utilization of SUD treatment and support; and take an active role in engaging the community and advocating for policy changes that advance equity and access to culturally appropriate care.

Address disparities by ensuring data by race and ethnicity is widely available

- [Minnesota Opioid Dashboard](#)
 - Contains specific (although limited) information about race-specific overdose rates as well as age, gender and other metrics.

Address disparities through innovative partnerships

- [The Detroit Recovery Project \(DRP\)](#)
 - An example of an effective, targeted, multi-service effort designed to support Black individuals with an SUD. This program brings together university partners, public safety officials, churches, local public schools, the Department of Health and Human Services, and others to increase community reach and awareness and provide coordinated efforts through culturally relevant community events.

Recommendation: States should provide evidence-based medical care to incarcerated populations, including continuing, initiating and ensuring access to MOUD. States should remove criminal and other penalties for pregnant, postpartum, and parenting women for whom MOUD is part of treatment for an opioid use disorder.

Evidence-based care for justice-involved populations

STATE RESOURCES

- [28 Vermont Statutes Annotated § 801b \(2018\)](#)
 - Inmates in correctional facilities must be screened for SUD within 24 hours as part of the initial and ongoing substance use screening and assessment process.
 - An inmate in a correction facility shall be entitled to continue MOUD as long as medically necessary.
- [Maine Department of Corrections Makes MOUD Available at All Jails and Prisons](#)
 - After a pilot program showing the efficacy of implementing MOUD in the state's carceral settings, the state committed to providing MOUD at all correctional facilities in the state. Maine's commitment can be a blueprint for all states.

LEGAL RESOURCES

The *Smith* and *Pesce* cases described below, including the orders, motions and supporting documents, can provide a framework for any state to support a patient's right to MOUD while incarcerated.

- [Smith v. Aroostook County](#)
 - Charges denial of access to MOUD for incarcerated people as a violation of the Americans with Disabilities Act and the Eighth Amendment of the U.S. Constitution.
 - The federal appeals court [upheld](#) the district court ruling that ordered Aroostook County Jail to provide Brenda Smith with access to MOUD for her opioid use disorder during her 40-day jail sentence.

- “Based on the evidence offered by the Plaintiff’s experts, the available scientific evidence, and Ms. Smith’s medical history, I find that forcing Ms. Smith to withdraw from her buprenorphine would cause her to suffer painful physical consequences and would increase her risk of relapse, overdose, and death.”
 - [Order on Plaintiff’s Motion for a Preliminary Injunction](#)
- [Pesce v. Coppinger](#)
 - Preliminary injunction issued in 2018 requiring correctional authorities to provide access to methadone for continued treatment of the individual’s opioid use disorder while incarcerated.
 - Recognizes right to treatment for opioid use disorder, finds violation of right to be cruel and unusual punishment in violation of the Eighth Amendment.

ADDITIONAL RESOURCES

- [The Sequential Intercept Model](#)
 - A graphical depiction of the “intercepts” that can be used as an effective strategic planning tool for states and communities in addressing the needs of the justice-involved. States should engage local wardens and departments of corrections to establish a sequential intercept program.

Implement plans of safe care for pregnant, peripartum and parenting individuals

STATE RESOURCES

- [New Mexico Statute § 32A-4-3 \(2019\)](#)
 - Requires hospitals to identify all infants with exposure to maternal drug use and to develop a plan of safe care that delineates the specific after-hospital care needed for the infant.
- [Illinois Medicaid Postpartum Waiver \(2021\)](#)
 - Section 1115 waiver that extends Illinois’ Medicaid program to low-income women up to one year after they give birth.

ADDITIONAL RESOURCES

- [Plans for Safe Care Learning Modules, National Center on Substance Abuse and Child Welfare](#)
 - The five-part series aims to guide state, tribal, and local collaborative partners on improving systems and services for infants affected by prenatal substance exposure.
- [A Collaborative Approach to the Treatment of Pregnant Women With Opioid Use Disorders: Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers, SAMHSA \(2016\)](#)

- A guidance document from the Substance Abuse and Mental Health Services Administration (SAMHSA) that provides background information on the treatment of pregnant women with opioid use disorders, summarizes key aspects of guidelines that have been adopted by professional organizations across many disciplines, presents a comprehensive framework to organize these efforts in communities, and provides a collaborative practice guide for community planning to improve outcomes for these families.
- [ACOG Committee Opinion, Opioid Use and Opioid Use Disorder in Pregnancy \(2017\)](#)
 - The American College of Obstetricians and Gynecologists (ACOG), in collaboration with ASAM, put forth a committee opinion that outlines several recommendations and conclusions with regard to opioid use and OUD in pregnancy, noting, “Early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and OUD improve maternal and infant outcomes. In general, a coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.”

Remove penalties for pregnant, parenting and postpartum women utilizing MOUD

- [Montana Code Annotated § 50-32-609 \(2019\)](#)
 - Provides safe harbor for pregnant women seeking or receiving evaluation, treatment, or support services for a substance use disorder.

Recommendation: States should ensure that public and commercial payers eliminate treatment policies that impede access to MOUD, such as policies that condition access on participating in counseling or abstaining from use of other drugs. Residential treatment facilities should be required to ensure access to MOUD for new and current patients as a condition of receiving public funding.

Eliminate policies that condition treatment access and participation on abstinence from use of MOUD

- [California Senate Bill No. 992](#) (Signed by the Governor in September 2018)
 - California law states that residential treatment facilities are not allowed to deny admission to potential patients, or discharge current patients, because of a valid prescription for an FDA-approved medication for MOUD.

Require treatment facilities to ensure access to or continuation of MOUD as a condition of receiving public funding

- [Missouri Department of Mental Health \(DMH\) Memo: MOUD Certification Requirements](#) (2016)
 - Requires that agencies and providers, in order to remain certified and contracted with the Missouri DMH, must offer or arrange not only for all forms of MOUD but also for MOUD to be delivered in an evidence-based way.

Additional Resources

- [New York State Office of Addiction Services and Supports Guidance on Standards for Person-Centered Medication Treatment](#) (February 2020)
 - **Psychosocial treatment and counseling.** New York guidance states that regardless of patients' willingness or ability to engage in psychosocial treatment, MOUD services must be offered because MOUD is an effective and lifesaving treatment for individuals. Further, individuals may be more willing to engage in such services after a period of stabilization on MOUD.
 - **Continued substance use and poly-drug use.** New York State guidance states that even in the context of continued substance use and/or poly-drug use, patients should be kept on MOUD treatment. Evidence shows that keeping patients on MOUD for treatment regardless of continued substance use and/or poly-drug use is safer and leads to better outcomes long-term.
- [AMA Issue Brief: The Nation's Drug Overdose Epidemic: Considerations for Employers](#) (April 2021)
 - Outlines concrete actions employers can take to end the epidemic, including:
 - Ensure employees and their families have access to evidence-based care for substance use disorders and mental illness.
 - Review and revise internal policies to support comprehensive, compassionate care for patients with pain.
 - Promote harm reduction at work.
 - Reduce stigma associated with pain, drug use, harm reduction and treatment.

II. Ensure access to addiction medicine, psychiatry and other trained physicians

Recommendation: States should measure and monitor network adequacy to ensure that patients have timely access to addiction medicine physicians and other health care providers who provide evidence-based care for OUD. Payers must measure and disclose multiple areas, including:

- The number and location of physicians and other health care professionals in each network who —through either [an X-waiver](#) or [a notification of intent pathway](#)—are authorized to provide buprenorphine in-office for the treatment of opioid use disorder.
- The number and location of patients those waived providers are able to see (i.e., the patient limit allowed by the waiver).
- The number and location of opioid treatment programs.
- The number of patients currently being treated with buprenorphine and other FDA-approved MOUD.

Leverage Medicaid managed care contracting to establish and enforce robust network adequacy requirements

State Medicaid officials should leverage Medicaid managed care contracting as a tool to enforce robust network adequacy requirements.

- [Ohio Medicaid Managed Care Contracts](#)
 - Ohio requires Medicaid managed care organizations (MCOs) to contract with a minimum number of MOUD providers per county and all willing opioid treatment programs (OTPs) licensed by the state.

Require insurer reporting on network capacity to provide MOUD

- [Colorado Insurance Regulation 4-2-75 Concerning Requirements for Reporting Medication-Assisted Treatment Coverage \(Network Adequacy Regulations\)](#)
 - A 2019 Milliman report found Colorado consumers were eight times more likely to use out-of-network facilities for behavioral health than for medical/surgical treatment.
 - In response, a 2019 [state law](#) (C.R.S. § 10-16-710) required the Colorado Division of Insurance (DOI) to amend its network adequacy regulations to include new standards for evaluating the adequacy of mental health, behavioral health and SUD networks. Insurance carriers are required to submit annual reporting about the number of in-network providers that are federally licensed to provide MOUD for SUD and OUD at both the beginning and end of the calendar year.
 - Per a [May 2021 DOI report](#), this regulation went into effect on June 15, 2021, and carriers were required to provide data to DOI by September 15, 2021.

Require reporting on the number of patients being treated with MOUD

- [Colorado Insurance Regulation 4-2-75 Concerning Requirements for Reporting Medication-Assisted Treatment Coverage](#)
 - The same Colorado regulation that requires disclosure of providers also requires carriers to report on the number of patients being seen for MOUD for SUD and OUD, the number of patients receiving medications to treat opioid use disorder, and the number of prescriptions filled by unique enrollees for MOUD for SUD. This requirement also went into effect in June 2021.
 - Health insurance carriers are required to provide the following information for each network regarding in-network providers that are federally licensed to prescribe MOUD for substance use disorder (SUD) and opioid use disorder:
 - The number of providers (by type) at the beginning of the calendar year.
 - The number of providers (by type) at the end of the calendar year.
 - The number of SUD and opioid treatment programs (OTPs).
 - The number of providers who are authorized to prescribe methadone for the treatment of OUD.
 - The number of providers in each county.
 - The number of providers with a federal waiver to prescribe buprenorphine for the treatment of OUD.
 - A recent update to Colorado's data collection [templates](#), in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), specifically incorporated American Society of Addiction Medicine (ASAM) utilization criteria. The first round of data, which is currently being analyzed by Colorado's Division of Insurance (DOI), will report on providers and availability of treatment on a county-by-county basis.

Address the inequities faced by Black, Hispanic, American Indian, and other historically marginalized and minoritized populations, to ensure network adequacy of evidence-based care

- [California Tribal MAT Project](#)
 - A partnership between the California Department of Health Care Services (DHCS) and the Tribal communities, the Tribal MAT (TMAT) Project was designed to meet the specific OUD prevention, treatment and recovery needs of California's Tribal and Urban Indian communities.
 - The TMAT Project includes several efforts to respond to the needs of communities, including:
 - Regional, in-person training opportunities for Tribal, Urban Indian, and Drug Medi-Cal providers to learn more about culturally driven treatment modalities and best practices.
 - Tribal MOUD Project ECHO (Extension for Community Healthcare Outcomes), which links specialists at an academic medical center with primary care clinicians in Indian Country to deliver MAT.
 - California Indian Opioid Safety Coalitions, a statewide coalition of Native and Native-serving organizations collaborating in an organized response to the opioid epidemic in Indian Country.
- [Great Circle Recovery in Salem, Oregon](#)
 - A 2012 [report](#) in the *American Journal of Drug and Alcohol Abuse* shows Native Americans are twice as likely to become addicted to drugs and alcohol as the general population and three times more likely to die of an overdose.
 - Opened in April 2021, a new opioid treatment center is [Oregon's first tribally owned and operated MOUD facility](#). The providers at the facility are taking a holistic approach, with cultural practices and Native-based programming, to provide treatment to patients battling SUD.
- [Casa Esperanza in Boston, Massachusetts](#)
 - A 2020 [special report](#) from SAMHSA described the issue of uncontrolled opioid use in the Latino community as a "matter of urgency."
 - Casa Esperanza opened Massachusetts' first bilingual/bicultural residential treatment program in 1987 for 25 men, a treatment facility culturally adapted to serve the needs of the Latino community. Since then, the facility has been touted as a national model for substance abuse treatment.
 - Forty percent of all of Casa Esperanza's clients are monolingual Spanish speakers, and another 40 percent have limited English proficiency. Many even lack basic literacy in either language.

Recommendation: States should build infrastructure to enhance access to evidence-based treatment—through developing hub-and-spoke models, utilizing the emergency department and leveraging Medicaid contracts.

States should coordinate efforts in communities among emergency departments (EDs), physicians, other health care and behavioral health service providers, public and private payers, and other community-based stakeholders to comprehensively help treat patients with opioid use disorder. The hub-and-spoke model has been proven to help ensure timely access to evidence-based resources, including resources to support social determinants of health, to help patients with OUD begin treatment or maintain recovery, and to provide essential services to support treatment and recovery, including access to MOUD.

Enhance access to medical, social, and other behavioral care services and providers through hub-and-spoke models

States should meaningfully support community hub-and-spoke model programs that expand provider capacity and link patients—including Medicaid, commercially insured and uninsured populations—to multidisciplinary care.

- [Pennsylvania Hub-and-Spoke Model](#)
 - Pennsylvania’s Coordinated Medication Assisted Treatment (PacMAT) programs utilize a hub-and-spoke model.
 - Across the state, 14 PacMAT programs utilize a hub-and-spoke model to provide MOUD for more than 6,000 individuals.
 - An addiction specialist physician at the center as the hub provides expert guidance and support to primary care physicians in rural and underserved areas of the state. The primary care physicians, who serve as the spokes, provide direct patient care.
 - [Centers of Excellence](#) (COEs) focus on medication-assisted treatment (MAT) and evidence-based practices to coordinate care for Medicaid patients with OUD.
 - Pennsylvania’s COEs have served more than 32,000 people with OUD.
- [Vermont](#)
 - Vermont was divided into five geographic regions, each with a “hub clinic” organized around an existing opioid treatment program. Gradually, hubs were deployed beginning in January 2013 across all five regions. In each of the regions, waived physicians were paired with that region’s hub and designated as spoke providers.
 - Each spoke is supported by an MOUD team consisting of one full-time-equivalent registered nurse and a behavioral health provider.

- [North Carolina](#)
 - A collaboration between the University of North Carolina at Chapel Hill School of Medicine and Mountain Area Health Education Center (MAHEC) led to the state's referral hub-and-spoke network.
 - This partnership has resulted in expanded access to MOUD for low-income individuals, particularly in rural areas.
- [Montana Meadowlark Initiative](#)
 - Montana's Meadowlark Initiative integrates behavioral health and prenatal care by implementing a supportive, team-based approach to prenatal and postpartum care with better coordination between health providers and social service agencies.
 - This [initiative](#)—funded through the Montana Healthcare Foundation and the Montana Department of Public Health and Human Services—provides funding and technical assistance to allow medical practices that provide prenatal and postpartum care to improve outcomes for women with substance use disorders and mental illness.
- [West Virginia](#)
 - West Virginia utilized a modified hub-and-spoke model to build organizational capacity for facilities to use buprenorphine to treat patients.
 - A single coordinating center uses videoconferencing to train hubs and provide ongoing case consultation as well as clinical support, and five regional hubs independently treat patients and are leading MOUD expansion in their local areas by using multidisciplinary MOUD, including group-based medication management and psychosocial therapy.
- [Michigan Primary Care Transformation Project \(MiPCT\)](#)
 - MiPCT is one of the oldest and longest-running multi-payer initiatives for patient-centered medical homes.
 - The foundational goals of this program are:
 - Create patient-centered medical homes.
 - Provide care coordination to improve health care outcomes for individuals requiring intensive support services.
 - Assign community health innovation regions to improve population health.
 - Improve systems of care.
 - Enact system improvements to reduce administrative complexity.
 - Contain health care costs and shift to value-based payment models.

Coordinate efforts with emergency departments (EDs) to connect nonfatal overdose patients to treatment options

- [California Bridge Model](#)
 - The California Bridge Model has been implemented at 52 hospitals across California. Since emergency departments (EDs) provide 24/7 access to care, they offer a unique opportunity to make treatment for SUD universally accessible.
 - The model is based on three pillars:
 - **Treatment:** Provide quick-start, low-barrier access to evidence-based medication for addiction treatment for substance use disorder in all hospital departments.
 - **Connection:** Establish pathways to link patients to outpatient care through active support and follow-up.
 - **Culture:** Create a welcoming, non-stigmatizing hospital culture for people who use drugs that is reflected in patient-facing communications throughout the hospital and an emphasis on human connections that build trust.
 - The California Bridge Model [blueprint paper](#) provides a 31-page step-by-step guide on how to set up an MOUD program in an acute care hospital.
- [University of Colorado Health System](#)
 - When a patient arrives at the ED and is identified as having OUD, a social worker intervenes to conduct an in-depth screening.
 - If clinically indicated, providers can prescribe buprenorphine. The health system also utilized a grant from the Colorado Office of Behavioral Health to develop resources and connections to provide “warm handoffs” to community providers.
 - One emergency department physician in Denver, [Dr. Don Stader](#), emphasized the importance not only of this work to connect patients with appropriate care, but also of ending the stigma of OUD in EDs and enhancing physician understanding of those living with OUD: “Not only was I overprescribing, but I had no idea how to treat people with opioid use disorders. OUD is probably the only medical disease that you learn more about from the media and bias than you do from medical school and training.” Dr. Stader is featured in a [video](#) by AMA’s Opioid Response Network and American College of Emergency Physicians (ACEP) about “reducing the stigma of OUD” by highlighting patient experiences.

ADDITIONAL RESOURCES

- American College of Emergency Physicians (ACEP) [Buprenorphine Use in the Emergency Department Tool](#)
 - The ACEP tool can be used to help all EDs better ensure access to evidence-based care for MOUD.
 - This bedside tool is available to all ACEP members and includes an overview of buprenorphine as well as information on how emergency providers can “BUPE,” as follows:
 - **B) Begin prescribing:** This step provides indications and contraindications for the administration of buprenorphine; information on procedure and administration; dosing information for “acute withdrawal or initiating MAT”; guidelines for management of buprenorphine-precipitated withdrawal; information on nausea and vomiting after buprenorphine administration; and information on “other appropriate withdrawal management medications.”
 - **U) Utilize naloxone:** This tool notes that the ED “is an ideal setting for opioid overdose death prevention through the distribution of (or prescribing of) overdose naloxone rescue kits, overdose prevention and response education.”
 - **P) Provide linkage to treatment:** The tool notes that in an ED setting after treatment of acute opioid withdrawal, “patients may be more receptive to discussing addiction treatment, and referral to a treatment center.” The tool provides key points for providers to highlight for patients and includes discharge instructions, emphasizing the importance of including a referral as needed.
 - **E) Educate on rules and regulations:** The tool provides information for providers and hospitals on the X-waiver (i.e., that “an X-waiver to [a provider’s] DEA registration is NOT required to order/administer a dose of buprenorphine in the hospital, or in the ED”). It also links to additional information for providers on the X-waiver.

Invest in mobile methadone units to help increase access to MOUD and other services

- [Drug Enforcement Administration’s \(DEA’s\) Final Rule, “Registration Requirements for Narcotic Treatment Programs With Mobile Components”](#)
 - Adds a mobile component to existing registrations for narcotic treatment programs per DEA measures [finalized in June 2021](#) to improve access to MOUD in “rural and underserved areas with limited treatment options.”
- [American Association for the Treatment of Opioid Dependence Webinar](#)
 - Provides a “how to” [webinar](#) to provide information on how OTPs “can expand their blueprint throughout the country by expanding the use of mobile vans.”
- [New York Request For Application \(RFA\) for Mobile Methadone Units](#)
 - Entities in New York were provided with up to \$200,000 in state grants for a mobile methadone unit. States can model similar grants on the New York RFA, which includes the RFA, a budget summary and applicant Q/A.

Recommendation: States should increase access to telehealth for those with a substance use disorder or mental illness.

States should work with physician and other health care providers to evaluate the impact of telehealth expansions on patient access to mental health (MH)/substance use disorder (SUD) treatment and to further support those expansions that prove effective beyond the pandemic. Such evaluations should emphasize the importance of continuity of care for MH/SUD patients by ensuring that all network providers have the option of providing telehealth services to their patients, and patients are not directed or incited to seek care from a separate telehealth network.

The AMA continues to support federal flexibilities under the COVID-19 public health emergency to allow increased use of take-home dosing and patient check-ins via telemedicine for existing patients receiving methadone. The AMA also supports the federal flexibility to initiate buprenorphine using audio-only telemedicine. These flexibilities were embraced by physicians and patients and likely have saved thousands of lives, as indicated in an October 2020 [survey report](#) showing a significant utilization of virtual visits (75 percent of more than 1,000 physicians and other health care professionals surveyed who prescribe buprenorphine and other medications to treat OUD report using virtual visits) to help maintain medication to treat OUD and “clear support for continuing telehealth options for providers and their patients.”

Leverage telehealth to improve access on a permanent basis

- [Virginia's Department of Medical Assistance Services](#)
 - Virginia issued guidance to Medicaid participants and programs that allowed the counseling component of MOUD to be provided via telehealth or telephone communication.
- [Iowa Department of Human Services](#)
 - In Iowa, OTPs providing buprenorphine treatment are permitted to render services in the member's home via telecommunication, telehealth, smartphone video conference or “other electronic means.”
- Payment Parity for Telehealth Services
 - In New Hampshire, through state law [HB 1623 \(2020\)](#), the state explicitly provided payment parity for telehealth visits.
 - In 2020, [Oregon](#) permitted providers to be reimbursed at the in-person rate for using telephone communications when barriers to equipment and access exist (e.g., when a patient does not have access to a computer with internet access or video capability).

Enhance provider capacity through telehealth training

- [New Mexico TeleECHO](#) (Extension for Community Healthcare Outcomes)
 - The state established programs that are guided-practice models using a hub-and-spoke knowledge-sharing approach to improve provider capacity in rural and underserved areas.
 - Programs encompass a wide range of trainings, including programs that aim to expand MOUD prescribing in primary care settings through virtual clinic training.

Adopt federal flexibilities to initiate buprenorphine for SUD via audio-only telehealth

- [Pennsylvania Telemedicine Waiver for Opioid Treatment Adopting Federal Flexibility](#) (2020)
 - The Pennsylvania waiver allowed for suspension of a state law requiring an in-person physical exam as a condition of prescribing buprenorphine for the treatment of OUD.

III. Enforce mental health and substance use disorder parity laws

Recommendation: States should strengthen their mental health and substance use disorder parity laws by reviewing the latest model laws, identifying any gaps in state law, and proposing updates.

Review model parity laws and upgrade state laws

MODEL LAWS AND LEGISLATION

- [American Psychiatric Association \(APA\) Mental Health and Substance Use Disorder Insurance Coverage and Model Legislation Adapted to All 50 States and the District of Columbia](#)
 - The American Psychiatric Association, a partner in The Kennedy Forum model law, adapted the model law language to comply with unique state codes. The webpage allows the user to look at model language in each state, and includes additional guidance on related items.
- [Jim Ramstad Model State Legislation to Advance Mental Health and Addiction Equity by Requiring Compliance With Generally Accepted Standards of Care Forum Model Law](#)
 - The Kennedy Forum worked with a number of partners to create a model mental health and substance disorder parity law based on California SB 855.
- [Kennedy Forum Model State Parity Legislation](#)
 - Arizona's [SB 1523/HB 2761](#), adopted March 3, 2020, is based on model state parity legislation developed by The Kennedy Forum. The law requires Arizona to implement and enforce the Federal Parity Law for commercially insured group and individual policies, by (among other requirements):

- Outlining subpoena powers for state regulators.
- Requiring the state's DOI to provide supports for consumers to file appeals or complaints; the DOI phone number must be displayed prominently on insurance cards, and the DOI must publish a webpage with a step-by-step guide to submitting complaints/appeals.
- Requiring insurers to submit reports on each fully insured network type to the DOI every three years, including medical necessity criteria, evidentiary standards, and processes and strategies used to design Non-Quantitative Treatment Limitations (NQTLs).
- Requiring insurers to submit annual updates to the DOI on changes to parity compliance activities as well as an attestation of compliance.
- Forming a mental health parity advisory committee.

STATE LAWS

- [Illinois Public Act 102-0579](#)
 - Illinois' law is one of the nation's most comprehensive to ensure that evidence-based standards put forward by professional medical organizations are used to ensure patients' access to care. It includes strong prohibitions against related prior authorization and step therapy practices by insurers.
- [Illinois Public Act 99-480](#)
 - This law expands upon federal parity law, with provisions focused on assessment and enforcement of parity. Illinois Public Act 99-480 designates the state Department of Insurance (DOI) as the enforcer of state and federal parity law in Illinois. The DOI is required to offer consumer education on parity (including live trainings and a consumer hotline to assist with navigation of the parity process) and report to the General Assembly on the success of the education campaign. In coordination with the Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Human Services (DHS), DOI convenes a working group of insurers and advocacy and physician groups to discuss MH/SUD parity issues.
 - **See also:**
 - [Educational guide](#) on implementation of the law.
 - The Kennedy Forum [brief](#) on the law.
- [Indiana Public Law 103](#) (HB 1092, 2020)
 - This law requires individual and group insurers to submit an annual report to the state DOI on their MH/SUD and medical/surgical (M/S) medical necessity criteria; NQTLs and evidentiary standards used to design NQTLs; and comparative analyses of the processes and strategies used to apply MH/SUD NQTLs.

- The DOI must submit a report to the General Assembly on its implementation of rules and procedures to ensure parity compliance, including the methodology used to assess insurers' compliance, the results of market conduct examinations completed in the prior 12 months, and any educational or corrective actions taken toward insurers by the DOI to ensure parity compliance.

FEDERAL LAW

- [The Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#)
 - This federal law prevents group health plans and health insurers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations than those imposed on medical/surgical benefits.
 - The Substance Abuse and Mental Health Services Administration (SAMHSA) created a guide, [Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States](#), based on interviews from implementation in California, Connecticut, Maryland, Massachusetts, New York, Oregon and Rhode Island.
 - In April 2021, [the Consolidated Appropriations Act amended MHPAEA](#) to require plans and issuers to perform and document their comparative analyses of the design and application of NQTLs on MH/SUD benefits. Further, plans and issuers are required to make their comparative analyses available to the departments or relevant state authorities, upon request, with specific parameters on what information must be provided should the analyses be requested.

Other information

- [American Society of Addiction Medicine \(ASAM\) – State Training on *The ASAM Criteria*[®]](#)
 - *The ASAM Criteria*[®] are a set of national criteria for providing outcome-oriented and results-based care in the treatment of addiction. ASAM allows states to use *The ASAM Criteria*[®] in laws, regulations, and policies free of charge and with no permission agreement. This includes providing education and basic introductory training on the criteria.
 - In 2021, ASAM, Well Being Trust and Manatt Health developed [Speaking the Same Language: A Toolkit for Strengthening Patient-Centered Addiction Care in the United States](#), which offers high-level strategies for integrating *The ASAM Criteria*[®] into a state's approach to SUD services, along with potential implementation vehicles, state examples, and model legislative, regulatory, and contractual language from which states can draw.
- [Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report](#)
 - The Kennedy Forum, along with four partners, published a technical policy analysis comparing and scoring state mental health and substance use parity laws (as of 2018) using a standardized instrument.

- [Spotlight on Mental Health and Substance Use Disorder Parity Compliance Standards: An Analysis of State Compliance Reporting Requirements](#)
 - The Legal Action Center and the Partnership to End Addiction co-created a report that examines state statutory standards requiring state-regulated private health plans to submit information and data that will allow regulators to conduct a parity analysis and requirements for state insurance departments to report on their enforcement activities.
 - Key findings include the following as of July 2020:
 - Fifteen states and the District of Columbia have enacted laws requiring health plans to submit compliance reports and/or quantitative data on the development and application of nonquantitative treatment limitations (NQTs) and quantitative data that identifies disparities in plans' operations.
 - Sixteen states and the District of Columbia have enacted legislation requiring state insurance departments to report on their enforcement activities to their state legislatures.
 - At least 30 states include some level of Parity Act compliance review as part of the insurers' form submissions.

Recommendation: States should require health insurers to document their compliance with parity laws and regulatory requirements.

Require health insurers to prospectively analyze and attest to their compliance with MH/SUD parity law

- [Title 40, Pennsylvania Consolidated Statutes](#)
 - Amended to require annual attestation by health insurers of their compliance with federal MH/SUD parity law.
 - **For regulators:** In 2019, AMA, ASAM and APA partnered to create an [Enhanced Attestation Form](#) for payers to provide information about how they are following the law. The form is based on existing state DOI forms and the MHPAEA itself. Everything in the Enhanced Attestation Form is already required by federal law.
- [Pennsylvania Law 682, No. 284](#)
 - Amended the Insurance Company Law of 1921 to require insurers to perform and document specific parity analyses for every treatment limitation (quantitative and nonquantitative), including a description of the process used to develop it, demonstrate its applicability to the benefits, and ensure this applicability is comparable between MH/SUD and medical/surgical (M/S) benefits. MHPAEA does not require NQTs for MH/SUD and M/S to be the same, but the factors used in determining and defining them must be the same. Insurers must also provide disclosures (as consistent with federal law) to insurance departments and members.

- [New York State Department of Financial Services \(DFS\) 11 NYCRR Part 230 \(Insurance Regulation 218\): Mental Health and Substance Use Disorder Parity Compliance Program](#)
 - On September 30, 2020, the NYS DFS and Department of Health (DOH) promulgated regulations requiring health insurers operating in the state to develop and implement an MH/SUD parity compliance program.
 - The regulations require health plans to adopt traditional elements of a compliance program that are specifically focused on behavioral health parity, including designating a compliance officer; implementing board and management reporting; implementing written policies and procedures; creating a mechanism for reporting, identifying and remediating noncompliance; and annual training of all employees, management, board members and agents.
 - In addition, the regulations require an ongoing assessment of parity compliance, which reflects the requirements of existing state and federal behavioral health parity laws. They also require the review of additional metrics that health plans are likely not currently collecting, and set minimum requirements for health plans to engage in ongoing reviews of behavioral health parity compliance.
 - Health plans are also required to provide written notification to insureds and the DFS or DOH, and to post on the plan's website any parity-related improper practice that they self-identify through their compliance program. The health plan must develop a plan to remediate any improper practice within 60 days of its identification.
- [The Mental Health Treatment and Research Institute \(MHTARI\) Best Practice Examples of Compliant NQTL Analyses Testing and Documentation \(Includes Regulatory Guidance\)](#)
 - Through regulatory and sub-regulatory guidance issued by the Department of Labor (DOL), HHS and the Center for Consumer Information and Insurance Oversight (CCIIO), MHTARI developed an example set of NQTL-compliant analyses, testing and disclosures. These examples focus on the importance of quantitative measures and outcomes data and include references to the associated regulatory guidance throughout.

Conduct rate and form reviews

Rate and form review is a process during which health insurers are required to explain the amount charged for base health insurance premium rates to state insurance departments for review. Health insurers are required to also justify any proposed increases, documenting why an increase is both necessary and appropriate.

- [North Carolina Department of Insurance MHPAEA Compliance Checklist](#)
 - As part of its annual rate and form review process for regulated entities in North Carolina, including insurers, HMOs, municipal cooperative health benefit plans and student health plans, the Department of Insurance requires the submission of an MHPAEA Compliance Checklist.

Recommendation: States should use the full continuum of enforcement tools to ensure compliance with parity laws.

Analyze consumer complaints

STATE LAWS AND REGULATIONS

- [Florida Statutes § 624.36, § 627.4215, and § 641.31085 \(HB No. 701, 2021\)](#)
 - Requires the Department of Financial Services to submit an annual report, beginning in 2022, to the governor, State Senate president and State House speaker using consumer complaints regarding the access and affordability of behavioral health services in regulated health plans. The report must include the number, nature and disposition of complaints.
 - Requires insurers and HMOs to make key information, including federal and state requirements for behavioral health services and instructions on how to make complaints, available to consumers on their websites.
 - Requires insurers and HMOs to send direct notice to consumers annually regarding federal and state requirements for behavioral health services and instructions on how to make complaints.
- [Texas Government Code § 662.115 and Insurance Code § 1355.2571-2572 \(HB No. 2595, 2021\)](#)
 - Establishes an MH/SUD Parity Complaint Portal to ensure consumer complaints are filed and responded to in a timely fashion and to educate consumers on their rights and responsibilities concerning coverage.
 - Requires the Texas Insurance Department and HHS Commission to coordinate annual reporting of key parity metrics, including complaints.
 - Requires the HHS Commission to appoint a liaison to the department to receive complaints through the portal.

OTHER INFORMATION

- [GAO Recommendations for Collaboration With HHS, DOL and Treasury](#)
 - The U.S. Government Accountability Office (GAO) found in a [survey](#) that, from 2017 to 2018, 38 states tracked MH/SUD parity complaints and 12 conducted targeted reviews focused on specific issuers or particular parity concerns, largely initiated by consumer complaints. (States expressed that targeted reviews are more frequently used than market conduct examinations because they focus on a specific issue, rely on more recent data and are generally less time consuming.)
 - Massachusetts responded to consumer complaints by examining the accuracy of information on MH/SUD services in issuers' provider directories compared to medical/surgical information and published a report in 2018.

Issue data calls

DOIs generally have the authority to make requests for certain data (i.e., “data calls”) from insurers and other regulated entities to conduct certain analyses, such as market scans.

- [University of Washington Consultants’ Report of Findings and Recommendations to the Office of the Insurance Commissioner Related to the Access to Behavioral Health Services Project \(2019\)](#)
 - Summarizes the findings from a set of insurer data calls conducted by Washington insurance regulators and the University of Washington.
- [National Association of Insurance Commissioners \(NAIC\) Market Regulation Handbook Guidance on MH/SUD Parity](#)
 - The NAIC reported that most states use its 2019 Market Regulation Handbook, which includes a data collection tool for mental health parity analysis, to guide their market conduct exams.

Conduct market conduct exams, impose civil penalties and issue corrective actions

DOIs generally have the authority to conduct market conduct exams to assess regulated entities’ compliance with state laws and regulations, such as mental health parity. The exam process is established by statute, with specific time frames and opportunities for the regulated entity to review and comment on findings.

- [Rhode Island Market Conduct Exam Reports](#)
 - **See also:**
 - [Blue Cross and Blue Shield of Rhode Island \(BCBSRI\) Market Conduct Exam Report \(September 2018\)](#) – Rhode Island found BCBSRI noncompliant with federal and state law, and BCBSRI agreed to pay \$5 million to expand mental health services ([Kennedy Forum release](#)).
- [Delaware 2020 and 2021 Mental Health Parity Examinations](#)
 - Violations found via additional mental health parity examinations on regulated insurers in Delaware resulted in \$735,000 in fines and significant insurer corrections to create a less discriminatory environment in the future.
 - Combined with two examinations completed in 2020, Delaware’s largest health insurers have been fined a total of \$1,332,000 for not treating mental and behavioral health care equally to other forms of needed care.

- [New Hampshire Mental Health Parity Examinations](#)
 - **See also:**
 - [NHDHHS MH/SUD Parity Proposed Compliance Monitoring Plan, Final Draft: April 23, 2020.](#)
- Pennsylvania and New York Also Have Extensive, Publicly Available Market Conduct Exams
- Colorado 2020 Mental Health Parity Report
 - Discusses the methodology used and the rules promulgated to verify health insurance carrier compliance with state and federal mental health parity laws, market conduct examination activities, and actions taken in 2020 to increase insurer compliance. This report also summarizes other Colorado Division of Insurance (DOI) activities to advance mental health parity, including consumer services and education, state and community partnership development, and more.
 - **See also:**
 - [Colorado 2021 Mental Health Parity Report](#)
 - [Colorado 2019 Mental Health Parity Report](#)

Take legal action to enforce parity rights

- [Massachusetts Attorney General's Office Behavioral Health Parity Agreements](#)
 - In 2020, Massachusetts Attorney General Maura Healey reached agreements with five health insurance companies and two companies that manage behavioral health coverage for insurers following investigations into their compliance with behavioral health parity laws and the accuracy of health insurers' provider directories. In addition to assurances to remediate the identified violations, the companies agreed to pay a combined total of nearly \$1 million to promote initiatives designed to prevent or treat substance use disorders, increase access to behavioral health care services, or otherwise assist Massachusetts behavioral health care patients.

Continually update consumer education

Regulators should be encouraged to provide specific tools to help consumers understand state and federal parity requirements as well as how to file a complaint.

- [New Hampshire Insurance Department Website on Substance Use Disorder Insurance Coverage](#)
 - New Hampshire's Insurance Department webpage has information for New Hampshire residents, health care providers and others interested in learning more about the Insurance Department's focus on how health insurance companies handle claims relating to treatment for mental health and substance use disorders.
 - Provides targeted information for enrollees with SUDs, and shares resources that help them understand their right to equal treatment and how to secure those rights.

- [DOL NQTL Warning Signs](#)
 - The DOL published the brief “Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance” to help stakeholders identify plan provisions that should trigger further analysis of possible noncompliance with MHPAEA NQTL rules. In case of violations, the insurance plan or issuer should provide evidence to the designated investigator to demonstrate compliance.
- [Parity Registry](#)
 - The Kennedy Forum offers this tool for consumers to understand their rights related to parity, receive support in making appeals and submit complaints. Using these complaints, the Parity Registry advocates for better enforcement of parity law.

Recommendation: State insurance regulators should participate in the NAIC’s MHPAEA Working Group by sharing best practices from their state, using templates and other tools developed by the Working Group, and following best practices from other states.

NAIC MHPAEA (B) Working Group

- This [NAIC Working Group](#) is charged with:
 - Monitoring, reporting and analyzing developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and making recommendations regarding NAIC strategy and policy with respect to those developments.
 - Monitoring, facilitating and coordinating best practices with the states, the DOL, and HHS related to the MHPAEA.
 - Monitoring, facilitating, and coordinating with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to MHPAEA.
 - Providing supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
 - Coordinating with and providing input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

The NAIC Working Group maintains a growing list of resources submitted by individual states to provide ideas and models for other states regarding MHPAEA.

Additional Resources

LEGAL BRIEFINGS

- [Wit v. United Behavioral Health APA Amicus Brief \(filed May 19, 2021\) – Summary of Argument](#)
 - Managed care organizations (MCOs) often base coverage decisions on internally developed, overly restrictive level-of-care guidelines that lead patients to be denied or cut off from coverage for MH/SUD treatment.
 - Despite progress in parity with quantitative treatment limitations (QTLs), MCOs continue to apply discriminatory, internally developed criteria on NQTLs (e.g., medical necessity) for MH/SUD treatment.
 - MCOs' internally developed guidelines often cover continuing and comprehensive care insufficiently, particularly as patients transition out of inpatient environments, leading to high rates of rehospitalization, relapse, overdose and death, among other negative outcomes.
- [United Behavioral Health, United Healthcare Insurance Co. Plans to Pay \\$15.6 million, Take Corrective Actions After Federal, State Investigations](#)
 - Following investigations and litigation by the U.S. Department of Labor and the New York State Attorney General, United Behavioral Health and United Healthcare Insurance Co. will pay \$13.6 million to affected participants and beneficiaries for its parity violations and will cease the violations; will pay another \$2 million in penalties; and will take other corrective actions, including improving its disclosures to plan participants and committing to future compliance.

FEDERAL BRIEFINGS, REPORTS AND ADDITIONAL GUIDANCE

- [DOL 2020 Report to Congress](#)
 - This report describes the Employee Benefits Security Administration's (EBSA's) MHPAEA implementation and enforcement efforts as well as state and stakeholder partnership efforts.
- [FAQs: MH/SUD Parity Implementation](#)
 - DOL, HHS and the Treasury prepared these FAQs to aid understanding of MHPAEA, the 21st Century Cures Act, the SUPPORT Act, and the Employee Retirement Income Security Act (ERISA). The FAQs include examples to illustrate MHPAEA requirements and implementing regulations.

ADDITIONAL TOOLS

- For Policymakers
 - [ParityTrack](#). ParityTrack is a national leadership coalition that tracks parity-related legislation at the federal and state levels, develops model legislation and compliance tools, and offers resources for consumers to understand and exercise their rights. Its *Six Step Parity Compliance Guide for NQTL Requirements* is available [here](#).

IV. Improve access to multidisciplinary, multimodal care for patients with pain

Recommendation: States should ensure that patients with pain have access to evidence-based pharmacological and nonpharmacological alternatives to opioids.

Increase access to evidence-based pharmacological alternatives to opioids (ALTOs)

- [Colorado House Bill 21-1276](#) (Passed in June 2021)
 - Requires plans that provide prescription drug benefits to provide coverage for at least one atypical opioid that is FDA-approved for the treatment of acute or chronic pain, and specifies that the coverage must be at the lowest cost-sharing tier of the carrier’s formulary with no requirement for step therapy or prior authorization.
- [Texas Medical Board COVID-19 Temporary Emergency Waiver Permitting Telemedicine Refills of Certain Prescriptions for Established Pain Patients](#) (2020)
 - During the COVID-19 pandemic, the Texas Medical Board (TMB) once extended an emergency waiver temporarily permitting telemedicine refills of certain controlled substance prescriptions for pain patients.
- [“What does a sufficient pain care formulary look like?”](#) American Medical Association (2019)
 - The AMA believes it is essential for formularies to include a broad range of evidence-based pain care options.
 - In 2019, the AMA asked physicians from multiple medical specialty societies who are advising the AMA Pain Care Task Force to provide information about pain treatments they provide to their patients, and developed a resource to provide an overview for policymakers of the types of treatments practicing physicians use to treat pain. The provided list may be subject to formulary exclusion or administrative barriers such as prior authorization or step therapy, or subject to cost-prohibitive co-pays, cost sharing and adverse formulary tiering.

Increase access to evidence-based nonpharmacological ALTOs

- [Colorado House Bill 21-1276](#) (Passed in June 2021)
 - Requires plans to provide a cost-sharing benefit for nonpharmacological treatment where an opioid might be prescribed. The required cost-sharing benefit must include a cost-sharing amount not to exceed the cost-sharing amount for a primary care visit for nonpreventive services.

Recommendation: States should ensure patients have access to multimodal pain care.

Promote access to evidence-based interdisciplinary pain management delivery models

- [The Swedish Hospital System's Structured Functional Restoration Program \(SFRP\)](#)
 - Provides a “pain boot camp” involving intensive coordination of care by a number of pain specialists and providers, including pain management specialists, pain psychologists, physical and/or occupational therapists, relaxation therapists, and pain nurse educators.

Advance medical education curriculum focused on evidence-based, compassionate care for patients with pain

- [International Association for the Study of Pain \(IASP\) Curriculum Outline on Pain for Medicine \(2018\)](#)
 - Outlines medical school curriculum to embed pain care and education into medical training.

Recommendation: States should protect provider discretion to develop individualized treatment plans for patients with pain.

State Resources

- [Georgia House Bill 952 \(Introduced in March 2020\)](#)
 - Would have prohibited pharmacies from implementing restrictions on controlled substances that would interfere in the patient-physician relationship.
- [Oklahoma Senate Bill 57 \(Signed by the Governor in June 2021\)](#)
 - Incorporates changes to the state’s Anti-Drug Diversion Act, adding, “Nothing in the Anti-Drug Diversion Act shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).”
- [New Hampshire House Bill 1639 \(Passed in August 2020\)](#)
 - Requires physicians and pharmacists to consider the “individualized needs” of pain patients, treat them with dignity and ensure that they are “not unduly denied the medications needed to treat their conditions.” The law additionally emphasizes that “for those patients who experience chronic illness or injury and resulting chronic pain who are on a managed and monitored regimen of opioid analgesic treatment and have increased functionality and quality of life as a result of said treatment, treatment shall be continued if there remains no indication of misuse or diversion.”
- [Alaska Board of Pharmacy Guidance \(Issued in January 2019\)](#)
 - Provides clear direction that the decision to dispense a controlled substance must be made pursuant to the health care professional’s professional judgment and based on the individual patient before the pharmacist. “Controlled substance prescriptions are not a ‘bartering’ mechanism. In other words, a pharmacist should not tell a patient that they have refused to fill a prescription and then explain that if they go to a pain specialist to get the same prescription then they will reconsider filling it.”

ADDITIONAL STATE RESOURCES

- [AMA Letter Urging States to Revisit Policies Based on the 2016 CDC Opioid Prescribing Guideline \(June 2020\)](#)
 - AMA letter urging the CDC to revisit the 2016 CDC Opioid Prescribing Guideline and support policies that promote individualized care for patients with pain.

Additional Resources

- [Pain Management Best Practices Interagency Task Force Report: Updates, Gaps, Inconsistencies and Recommendations, HHS \(2019\)](#)
 - A 29-member Interagency Task Force, including federal agency representatives, nonfederal experts and representatives from a broad group of stakeholders, was convened by HHS to identify gaps, inconsistencies, and updates and to make recommendations for best practices for managing acute and chronic pain. The report emphasizes the importance of individualized patient-centered care in the diagnosis and treatment of acute and chronic pain, and is organized in sections that are relevant to different groups of stakeholders regarding best practices.
- [Stakeholders' Challenges and Red Flag Warning Signs Related to Prescribing and Dispensing Controlled Substances \(2015\)](#)
 - A consensus document developed by a coalition of 16 stakeholder organizations that outlines the challenges faced by all stakeholders in the prescribing and dispensing of controlled substances; highlights red flag warning signs for health care practitioners to detect diversion, misuse and abuse of controlled substance medications; and identify aberrant behavior indicators. The report specifically notes that “appropriate pain management typically is tailored to the individual needs of the patient in collaboration with the prescriber, pharmacist and patient.”
- [No Shortcuts to Safer Opioid Prescribing, New England Journal of Medicine \(NEJM\) Perspective \(2019\)](#)
 - Dr. Deborah Dowell, chief clinical research officer for the CDC's Division of Overdose Prevention at CDC's Injury Center, articulates concerns about the mis-implementation and misapplication of the CDC's opioid-prescribing guideline, noting, “Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations... Such actions are likely to result in harm to patients.”
- [When Someone on Your Team Has Chronic Pain, Harvard Business Review \(2021\)](#)
 - Up to 40 percent of American workers experience chronic pain, or pain that persists for more than three months, which can lead to increased absence, decrements in job performance, concentration problems, physical limits and more. Drawing from its survey of 500 American business leaders, HBR outlines five key steps employers can take to support employees dealing with chronic pain in the workplace.

- [Chronic Noncancer Pain Management and Systemic Racism: Time to Move Toward Equal Care Standards](#), Journal of Pain Management (2020)
 - A literature review examining the history of racism in medicine and its implications for the medical system today in the inequitable treatment of Black, Indigenous, people of color (BIPOC) patients suffering from pain. The study concludes that to address gaps in access and treatment, it is imperative to incorporate BIPOC voices in policy decisions, increase the number of BIPOC professionals in leadership and health equity roles, and provide more opportunities for BIPOC individuals to enter health and medical professions—in particular, Black, Indigenous and Latinx individuals focused on pain management practices.
- [Third Annual Survey of Pain Medicine Specialists Highlights Continued Plight of Patients With Pain, and Barriers to Providing Multidisciplinary, Non-Opioid Care](#), The American Board of Pain Medicine (ABPM) (2021)
 - In a survey of 100 practicing pain medicine specialists in the U.S., more than 80 percent said they were required to reduce the quantity and/or dose of medication prescribed to a patient with pain. The survey also found that 88 percent of pain medicine physicians said they have been required to submit a prior authorization for non-opioid pain care—with the physicians and their staff spending hours per day on such requests. These figures are similar to the findings of previous ABPM surveys, in 2018 and 2019.
 - The AMA encourages states to implement similar surveys to measure the impact of prior authorization and other policies on physicians who treat patients with pain.
- [The Underestimated Cost of the Opioid Crisis](#), The Council of Economic Advisers (2017)
- The costs of the opioid epidemic are substantial; in a November 2017 report, the CEA estimated the economic cost of the opioid crisis to be \$504 billion in 2015, or 2.8 percent of GDP that year.

V. Expand harm reduction efforts to reduce death and disease

Recommendation: States should increase access to naloxone by removing cost-sharing and administrative barriers for individuals seeking a prescription for naloxone for themselves or a family member or loved one; by promoting and encouraging health care professionals to prescribe naloxone to patients who may be at risk of overdose (or their family members or friends); and by supporting community-based harm reduction organizations in distributing no-cost naloxone in the community.

Reduce pricing and increase access for local entities to purchase and distribute naloxone

BULK PURCHASING OF NALOXONE

- [Massachusetts – Bulk Purchasing of Naloxone Program Through the State Office of Pharmacy Services](#)
 - The state negotiates with a wholesaler, allowing eligible entities to purchase naloxone at the negotiated rate as long as they have an active Massachusetts Controlled Substance Registration.
- [Massachusetts Municipal Naloxone Bulk Purchase Trust Fund](#)
 - The AG partnered with the Massachusetts Department of Public Health and the legislature to use settlement money from a naloxone manufacturer to create a Narcan fund for cities and towns—the Municipal Naloxone Bulk Purchase Trust Fund. The state has since appropriated additional money to the fund and also uses revenue from municipalities.
 - Amended in 2018 to allow nonprofit organizations to participate in the program.

COMMUNITY-BASED NALOXONE DISTRIBUTION EFFORTS

Most states allow pharmacies to “dispense” naloxone pursuant to a standing order. States also may authorize harm reduction programs to dispense naloxone. The AMA encourages a broader view—to add the authority to “distribute” naloxone to broaden the entities providing the lifesaving opioid-overdose reversal agent.

- [The Naloxone Buyers Club](#)
 - The Buyers Club is a community-level naloxone purchasing and distribution effort that purchased and helped distribute more than 3.7 million vials of naloxone between 2017 and 2020. Community-based efforts such as the Buyers Club are responsible for saving tens of thousands of lives every year.
- [The California Department of Health Care Services Naloxone Distribution Project](#)
 - A local initiative that has distributed over 600,000 units of naloxone, and recorded over 30,000 overdose reversals since 2018.

ADVOCACY TO IMPROVE NALOXONE ACCESS

- [AMA Letter Urging That Naloxone Be Made Available Over the Counter \(OTC\)](#) (November 2021)
 - The AMA has called for the removal of prescription drug status for naloxone and for [all naloxone manufacturers](#) to submit applications to the Food and Drug Administration (FDA) to make their products available and affordable over the counter.

Issue a standing order for naloxone

Standing orders authorize pharmacies or other entities permitted by law to dispense naloxone under the prescribing authority of a state-level medical profession. They can also include language allowing for dispensation and distribution in nonpharmacy settings.

According to a [September 2020 survey](#) conducted by the Legislative Analysis and Public Policy Association (LAPPA), 33 states have a statewide standing order for naloxone. Examples include:

- [Illinois Standing Order/Naloxone Standardized Procedure \(2017\)](#), which permits pharmacies or overdose education and prevention programs to use a standing order to distribute naloxone.
- [Pennsylvania State Physician General Naloxone Standing Order \(2021\)](#).
- [Georgia Statewide Standing Order for Prescription of Naloxone \(2019\)](#).

Remove prior authorization for naloxone

- [Missouri Annotated Statutes § 191.1165](#)
 - Requires naloxone to be placed on the lowest cost-sharing tier of an insurer's or PBM's formulary, including the Missouri HealthNet program; prohibits any annual or lifetime dollar limitations.

Institute Good Samaritan laws for naloxone administration

Good Samaritan laws are policies/statutes that specify the person who calls for help, the person who administers naloxone, and the person to whom it is being administered are not subject to arrest, civil or criminal charges, or other penalties.

- [18 Vermont Statutes Annotated § 4254 \(2017\)](#)
 - Cited as one of the most comprehensive in the country, Vermont's law 18 V.S.A. § 4254 includes limited immunity for any crime under the Controlled Substances Act, which applies to any bystander at the scene or within close proximity to the scene of an overdose.
- [Tennessee Public Chapter 623 \(2014\)](#)
 - Grants immunity from civil suit to providers who prescribe naloxone to a patient, family member, friend or other person in a position to assist in giving naloxone, and grants a Good Samaritan civil immunity for administering the medicine to someone they reasonably believe is overdosing on an opioid.

Disallow evidence of naloxone prescription for life insurance underwriting

- [Colorado Division of Insurance Bulletin \(January 2020\)](#)
 - Bulletin clarifying the DOI's expectation that insurers will not adversely evaluate any application for insurance due to the applicant obtaining prescription medications unrelated to the applicant's health.
 - The bulletin encourages anyone who believes they may have been denied insurance, had their coverage rescinded or been charged a higher premium due to obtaining naloxone to submit a complaint to the DOI.
- [Massachusetts Division of Insurance Bulletin 2019-01](#)
 - Massachusetts instructs insurance carriers not to use prescriptions intended for public health prevention efforts unrelated to an individual's medical condition for underwriting purposes (e.g., naloxone prescription to a family member).
 - The bulletin includes this language: "prior to making an underwriting decision, carriers will obtain information sufficient to determine if an applicant has obtained a prescription that is not relevant to the applicant's health or is designed to prevent disease."

Recommendation: States should adopt laws and other policies to remove barriers to sterile needle and syringe exchange programs, including decriminalization of syringe services program (SSP) supplies, and to ensure continuity of syringe services programs, including by expanding PPE priority to include harm reduction organizations and other community-based organizations that provide services to people who inject drugs, to help protect against the spread of blood-borne infectious disease.

Decriminalize Syringe Services Program supplies

REMOVE INJECTION EQUIPMENT FROM THE DEFINITION OF DRUG PARAPHERNALIA UNDER STATE LAW

- [Oregon Revised Statutes § 475.525](#)
 - “(3) For purposes of this section, ‘drug paraphernalia’ does not include hypodermic syringes or needles.”
- [Nevada Revised Statutes § 439.985](#)
 - “The provisions of NRS 439.985 to 439.994, inclusive, are intended to:
 - Ensure the availability and accessibility of sterile hypodermic devices by encouraging distribution of such devices by various means.
 - Provide for the effective operation of sterile hypodermic device programs that protect the human rights of people who use such programs.
 - Guarantee that sterile hypodermic devices and other sterile injection supplies are not deemed illegal.
 - Ensure that sterile hypodermic device programs operate in harmony with law enforcement activities.”
- [Wisconsin Statutes § 961.571](#)
 - “(b) ‘Drug paraphernalia’ excludes: 1. Hypodermic syringes, needles and other objects used or intended for use in parenterally injecting substances into the human body.”

Authorize harm reduction centers

- [Rhode Island HB-5245 Substitute A](#)
 - Authorizes a two-year pilot of safe consumption programs in the state of Rhode Island.
- [New York City Supervised Injection Sites](#)
 - In November 2021, New York City authorized two supervised injection sites in Manhattan that began providing sterile supplies, administering naloxone if necessary and providing people who use drugs with options for addiction treatment.
- [Safehouse Philadelphia](#)
 - Model for harm reduction center developed in Philadelphia, Pennsylvania. Includes full spectrum of harm reduction services including health evaluation; provision of sterile supplies; testing; supervision; naloxone distribution; connection to social, legal and medical services; and connection to MOUD.

Expand PPE priority to include harm reduction organizations

- [CDC Interim Guidance for Syringe Services Programs \(2020\)](#)
 - CDC guidance that clarifies “SSPs” should be considered by the state, local, territorial and tribal jurisdictions as essential public health infrastructure that should continue to operate during the COVID-19 pandemic.

Decriminalize fentanyl test strips and other drug-checking supplies

- [Arizona SB 1486 \(2021\)](#)
 - Added “Other than narcotic drug testing products that are used to determine whether a controlled substance contains fentanyl or a fentanyl analog” to definition of drug paraphernalia.
- [Vermont H. 225 \(2021\)](#)
 - Removes criminal penalties for possession of 224 milligrams or less of buprenorphine. Persons under 21 years of age in possession of 224 milligrams or less of buprenorphine shall be referred to the Court Diversion Program for the purpose of enrollment in the Youth Substance Awareness Safety Program. Persons under 16 years of age in possession of 224 milligrams or less of buprenorphine shall be subject to delinquency proceedings in the Family Division of the Superior Court.
- [Colorado SB19-277 \(2019\)](#) (codified in [Colorado Revised Statutes § 18-18-426](#))
 - Removes from the definition of “drug paraphernalia” equipment, products, and materials used in testing or analyzing a controlled substance.

Additional Resources

LEGAL RESOURCES

- [SAMHSA Guidance on Fentanyl Test Strips \(2021\)](#)
 - SAMHSA announced on April 7, 2021, that federal funding may now be used to purchase rapid fentanyl test strips (FTS). This change applies to all federal grant programs as long as the purchase of FTS is consistent with the purpose of the program.
 - Example programs:
 - CDC Overdose Data to Action Cooperative agreement—funds health departments for drug overdose surveillance and prevention.
 - SAMHSA State Opioid Response (SOR) Grant—aims to increase access to MOUD, reduce unmet treatment need, and reduce opioid overdose-related deaths through support of prevention, treatment and recovery activities. Meant to supplement current state and territory activities.
 - State laws may need to be changed in order to take advantage of this federal guidance.
- [The Policy Surveillance Program \(a Project of LawAtlas\)](#)
 - Tracks syringe service program laws across the country and has a tool that allows for filtering by different provisions.
- [The Network for Public Health Law's Harm Reduction Legal Project](#)
 - The Harm Reduction Legal Project works to address the legal and policy barriers that impede the establishment and expansion of evidence-based harm reduction measures such as naloxone distribution, syringe access programs, and access to evidence-based substance use disorder treatment.

EXAMPLES OF SUCCESSFUL COMMUNITY INTERVENTIONS, PROGRAMS AND BEST PRACTICES

- [New York City Methadone Delivery Program](#)
 - The New York City Department of Health and the New York State Office of Addiction Services and Supports launched a program to deliver methadone to patients with COVID-19-like illness or at high risk of contracting COVID-19. Deliveries include naloxone to decrease chances of overdose. The department estimates that teams have the capacity to make 1,300 deliveries per month to enrolled individuals.
- [Rhode Island Governor's Task Force – Prevent Overdose Rhode Island](#)
 - The task force is a coalition of professionals and community members working toward prevention, treatment, rescue and recovery.
 - Task force includes data tracking of naloxone distribution, links to direct delivery programs, and a map of pharmacies and other locations with naloxone.

- [New York City Emergency Overdose Rescue Kit Program](#)
 - The NYC Department of Health has partnered with select chain pharmacies across the city to make free Overdose Rescue Kits available to any individual who requests one, and provides a list of participating pharmacy locations organized by borough and ZIP code. Anyone is eligible to get a kit, and no ID or insurance is required.
- [New York State Overdose Education and Naloxone Distribution Program](#)
 - Corrections-based program for those recently incarcerated in state prisons. The program trains people who were incarcerated, their family members, and corrections staff to recognize and respond to the signs of opioid overdose, and provides naloxone kits to incarcerated individuals upon release.
- [Wisconsin Department of Health Services “Wisconsin Voices for Recovery”](#)
 - Initiative working with Milwaukee-based pharmacy to install naloxone boxes containing naloxone, instructions on use, and resources for treatment and recovery support.
- [Colorado Naloxone Project](#)
 - Private initiative with the goal of having all Colorado hospitals and EDs distribute naloxone to at-risk patients prior to their departure from the hospital.
- [Maine’s Overdose Prevention Through Intensive Outreach Naloxone and Safety \(OPTIONS\) Initiative](#)
 - A coordinated effort of the [Maine Office of Behavioral Health \(OBH\)](#) and other state agencies. It has a co-responder initiative that includes licensed behavioral health clinicians within local emergency medical services (EMS) and law enforcement agencies in every county across Maine.

TECHNICAL RESOURCES

- [CDC Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design and Implementation](#)
 - Guidance from the CDC for health departments, community-based organizations, and other stakeholders, including sections on planning, design and implementation as well as data collection and evaluation.
 - **See also:** [General CDC information and resources regarding syringe services programs.](#)
- [CDC Harm Reduction TA Center](#)
 - The National Harm Reduction Technical Assistance Center is designed to strengthen the capacity and improve the performance of SSPs throughout the United States by supporting enhanced technical assistance (TA) to ensure the provision of high-quality, comprehensive harm reduction services.
 - In serving as the coordinating entity, the CDC receives the request and assigns it to one of three TA providers: National Alliance of State and Territorial AIDS Directors (NASTAD), University of Washington or National Harm Reduction Coalition (NHRC).

ADVOCACY AND CONSUMER RESOURCES

- [National Harm Reduction Coalition](#)
 - The NHRC works to build evidence-based strategies with and for people who use drugs.

VI. Monitor and evaluate programs

Recommendation: States should fund and implement standardized systems to accurately monitor and evaluate overdose and mortality trends in order to provide equitable public health interventions that include comprehensive, disaggregated racial and ethnic data collection related to testing, hospitalization, and mortality associated with opioids and other substances.

Current data on substance use and substance use disorder is incomplete, not standardized for comparison, delayed, and widely variable from location to location. There is no national data on nonfatal overdoses, a key indicator that is not widely collected or standardized across states and communities. These data gaps greatly hinder understanding of local situations and the ability to advance prevention, treatment and harm reduction efforts.

Surveillance case definitions—the uniform criteria used to define a condition for public health surveillance—enable public health officials to classify and count cases consistently across jurisdictions. Standardized case definitions aid in monitoring the health of the nation consistently and help facilitate interactions between stakeholders. These case definitions are developed by the Council on State and Territorial Epidemiologists (CSTE) in coordination with the CDC. CSTE has developed two case definitions for overdose outcomes:

- [Nonfatal opioid overdose standardized surveillance case definition](#)
- [Neonatal Abstinence Syndrome \(NAS\) standardized case definition](#)

Regular, frequent, timely information on individual cases is considered necessary to monitor trends, identify populations or geographic areas at high risk, formulate and assess prevention and control strategies, and formulate public health policies.

Data is currently being collected and maintained by different agencies—public health, health care providers, behavioral health, law enforcement, etc.—and developing data use agreements is difficult. The aim of the case definitions developed by CSTE is to assist stakeholders, including health care professionals, hospitals (especially emergency departments), emergency medical services (EMS), poison control centers, laboratories, harm reduction and syringe services programs, and law enforcement, in identifying survivors of opioid overdose and linking them to care and other interventions.

Building capacity and supporting needs of state and local epidemiologists is also critical. Reliance on a federal funding source makes it difficult to leverage funding during allotted time frames to comprehensively support drug overdose surveillance. For states to adequately collect and maintain data sources, evaluate information, and advance public health interventions, adequate funding should be allocated for infrastructure and full-time staff.

While data is critical to improving outcomes, current data is:

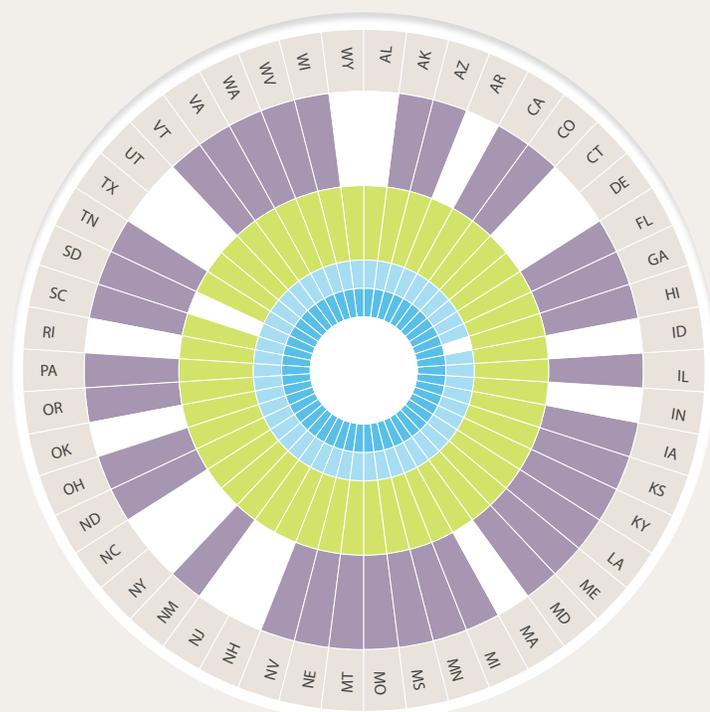
- ...incomplete**
- ...not standardized for comparison**
- ...not timely**
- ...widely variable from location to location**

Difficulties remain in accessing high quality, timely, comprehensive and standardized data. While metrics are generally available for drug-related overdoses, data for non-fatal overdoses and other key indicators are not widely collected or standardized across states and communities. These data gaps greatly hinder understanding of local situations and advancing prevention, treatment and harm reduction efforts.

Inadequate data collection prevents effective public health interventions to reduce overdose and death.

Data categories

- Prescriptions
- Fatal overdoses
- PDMP
- Non-fatal overdoses
- No data



Standardize data reporting

- [Recommended CSTE Surveillance Indicators for Substance Abuse and Mental Health \(Version 3\)](#)
 - A set of substance use and mental health surveillance indicators for use by state and local public health departments was developed. Regular collection of these indicators will provide an opportunity to routinely analyze and disseminate results.
- [CDC National Notifiable Diseases Surveillance System \(NNDSS\)](#)
 - Provides additional resources for data reporting, including standardized case definitions to classify and count cases consistently across reporting jurisdictions.
- [Creating an Action Plan for Opioid Surveillance](#)
 - In CSTE’s interactive online learning course, participants are guided through five recorded modules on identifying the public health burden of opioid misuse through key data sources and relevant data indicators found in ICD-10 codes.
- [CSTE Webinar Series](#)
 - Data linkages of State Unintentional Drug Overdose Reporting System (SUDORS), emergency medical services (EMS) and public safety data sources are highlighted.

Create publicly available data dashboards

- [New Jersey Drug Overdose Dashboard](#)
 - New Jersey’s dashboard includes a comprehensive list of metrics, including drug-related deaths; drug-related emergency department visits; drug-related inpatient hospitalizations; prescription data (benzodiazepine, opioid, stimulant); naloxone incidents; drug abuse violations (possession/use, sale/manufacture); treatment data; hepatitis cases; and neonatal abstinence syndrome (NAS) cases.
 - In addition, the state’s dashboard aggregates data from multiple agencies.
- [Georgia Department of Public Health Drug Surveillance Unit](#)
 - Georgia’s Drug Surveillance Unit uses syndromic surveillance to detail opioid-related harms throughout the state.
- [Vermont Department of Health Opioids Scorecard](#)
 - Vermont uses a “scorecard” approach to report on SUD-related statistics from several different state agencies, including emergency medical services (EMS), the state’s Division of Alcohol and Drug Abuse Programs, and the Department of Public Safety.

Capture data with comprehensive information

- [Indiana Drug Data](#)
 - On a county-by-county basis, Indiana's dashboard reports on overdose deaths (with an option to select drug type), ED visits and hospital discharges (with an option to select drug type), and naloxone distribution (including a heat map).
- [Pennsylvania Opioid Data Dashboard](#)
 - Pennsylvania established a state-level dashboard that provides information at the state and county levels on newborns who are on Medicaid and are born with neonatal abstinence syndrome, the number of successful naloxone reversals, individuals covered by Medicaid expansion who have OUD, individuals covered by Medicaid who receive MOUD, and individuals covered by Medicaid who have OUD.
- [Colorado Consortium for Prescription Drug Abuse Prevention](#)
 - The Colorado Consortium for Prescription Drug Abuse Prevention has developed one of the nation's most comprehensive dashboards, which provides data on mortality, ED visits, hospital discharges, opioid prescriptions, treatment admissions and nonmedical use of pain relievers.
- [New Mexico List of Notifiable Diseases or Conditions](#) (New Mexico Administrative Code 7.4.3.13)
 - Since 2003, New Mexico has required that overdoses be reported using the same mechanism as other reportable conditions.

Stand up a State Unintentional Drug Overdose Reporting Surveillance (SUDORS) system

- [North Carolina Opioid Action Plan Data Dashboard](#)
 - In the third publication, North Carolina's Opioid Action Plan and corresponding surveillance measures impact through metrics and local actions. The state provides resources for metrics and local actions, which enables community involvement and customization.
- [Georgia Department of Public Health](#) (GDPH)
 - Created a system to electronically match prescription drug monitoring program (PDMP) data with de-identified SUDORS cases, which will enhance rapid abstraction since this will no longer be done manually.
- [Ohio Department of Health](#) (ODH)
 - Included language in the Ohio Revised Code for the Ohio Violent Death Reporting System indicating that a partner state agency or political subdivision may share data with ODH, facilitating cross-agency data-linking projects.
 - For example, ODH worked with the Ohio Department of Medicaid Data to match Medicaid claims to overdoses.

Recommendation: States should use federal and state data to assess the results of their SUD, pain, and harm-reduction policies to identify and expand successful programs and to make appropriate midcourse corrections where needed.

Conduct evaluations at set intervals using state and federal data

- [Medicaid Outcomes Distributed Research Network \(MODRN\)](#)
 - This initiative, launched by AcademyHealth’s Evidence-Informed State Health Policy Institute in collaboration with a data coordinating center at the University of Pittsburgh, is a group of state Medicaid agencies and partner universities that adopt a common data model, contribute to a common analytic plan, and conduct analysis locally on their own Medicaid data using standardized code developed by a data coordinating center.
 - The first project assessed OUD treatment quality and outcomes in Medicaid, working with nine states (Kentucky, Maryland, Michigan, North Carolina, Ohio, Pennsylvania, Virginia, West Virginia and Wisconsin) to inform policy decisions on coverage of OUD treatments in Medicaid.
- [West Virginia State Opioid Response Grant Program Evaluation](#)
 - As part of West Virginia’s State Opioid Response grant, West Virginia University statistics and data are helping to track the impact of policy changes adopted using this grant funding.

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