

Running Down a Pain Killer

As opioid addiction rages in all 50 states, the federal government is offering aid for states ready to do battle.

The Opioid Epidemic

Nationally, nearly 2 million people are struggling with it. Opioid addiction — a highly lethal substance use disorder (SUD) — is surging, claiming thousands of lives a year, devastating millions of families, and costing state and local governments billions of dollars.

In the past few years, drug overdose has become the leading cause of accidental death in the U.S.,¹ killing more people than automobile accidents.² This increase is largely driven by opioid use disorder. The death rate from opioid-based painkillers tops heroin's by nearly two to one.³

“Dependence on opioids, including heroin and prescription painkillers, is a medical disease that has become increasingly pervasive throughout our urban, suburban and rural areas and across all socioeconomic groups,” says Edward V. Nunes, a professor at the Columbia University Medical Center. The co-author of a major study on opioid addiction adds, “It is hard to overestimate how deadly and devastating this disease is. It is a top killer of young people.”

In the past year, the federal government has taken major steps to curtail the epidemic. Part of its focus has been on helping state and local governments contain the crisis and improve the treatment of those suffering from what is, in effect, a chronic disease.



Medicaid is a key part of the federal government's state thrust, and with good reason. Nearly 12 percent of Medicaid beneficiaries (and 15 percent of those who could be eligible for Medicaid under the Affordable Care Act Medicaid expansion) have an SUD.⁴ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that by 2020, the federal-state partners in Medicaid will be footing 28 percent of the \$42 billion spent nationally on SUDs.

In a July 2015 letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) laid out its basic approach. States would be given leeway and funding to initiate or expand evidence-based treatments within its Medicaid plan and through waivers. Treatments that weren't covered before might now be cost-shared with the federal government. The letter also spelled out a chief concern of CMS: that recovery programs emphasize medication-assisted treatment (MAT).

States that have taken some of these steps are achieving significant success. California, which has been using MAT for opioid-addicted Medicaid patients, cut its medical costs by one-third over three years, including hospital, emergency room and outpatient clinic expenditures.⁵

4 Steps to Combat the Problem

As the opioid epidemic rages and the federal government ramps up support and funding for states, there are four low- or no-cost steps state and local governments can take to work with the federal government and take advantage of its new incentives.

Step 1: Inform the Public and Improve Access to Resources

Connecticut launched a toll-free hotline for opioid addiction, which Gov. Dannel P. Malloy calls "a common sense step that we hope will support those who need it." While the federal government has several national 800 numbers, an in-state hotline with links to access local treatment is immediate and direct.

Connecticut's opioid hotline directs callers to a walk-in assessment center in their area and then follows up with those callers to make sure they were able to connect to necessary services. The state's 2-1-1 line and website also provide individuals with an SUD or their family or friends with information about local treatment resources.

To keep its Medicaid beneficiaries aware of available services, Tennessee provides information on the back of each member's TennCare insurance card. TennCare also uses its member newsletter to remind beneficiaries about access to care and sends postcards to spread

the word. Interstate 65, a main travel corridor in Tennessee, is home to billboards with access numbers and links to substance use services.

Step 2: Educate Stakeholders

Response strategies need to be in lock step with public education campaigns, which means policymakers (legislators, governors, county executives and their staffs) and drug court judges should be aware of the chronic nature of the disease and of what is and is not effective treatment.

What is not as effective, it turns out, is conventional, abstinence-based treatment: detoxification followed by counseling. In a study published in March 2016 in the *New England Journal of Medicine*, a clinical trial of 300 men and women found 64 percent of those treated post-detox with counseling and referrals only relapsed within 6 months; 5 of them overdosed. Those who were part of an alternative therapy plan (a MAT which continues crave-blocking drugs after detoxification) fared better. Only 43 percent relapsed; there were no overdoses. In other words, those who received MAT treatment had a lower relapse rate.

Legislators may be unaware that the laws they pass mandating a designated time for treatment — 2 weeks in some states, 30 days in others — are counterproductive for most individuals with SUD unless that time is paired with a follow-on regimen of MAT.

However, acceptance of MAT has been controversial, due in part to misunderstandings regarding the treatment, including the fear that treatment drugs themselves could be abused.

Despite this, a growing number of recent clinical trials demonstrate that MAT helps a majority of adults with an opioid addiction deal with the challenges of withdrawal and recovery.⁶ Maintenance on the medication has helped most of them return to a productive life.

Some states have begun to assess their capacities for MAT. In the work-up toward the writing of Massachusetts' landmark opioid legislation, which was signed into law in March 2016, the state's Health Policy Committee assessed the availability and success rate of MAT in the state.^{7,8} The positive news: Access to MAT reduced rates of addiction and in-patient hospital admissions. The negative finding: The rate of opioid-related hospital visits were up to 70 percent higher for individuals who had to travel more than 5 miles for treatment.

Given the disparities in the availability of the treatment, it is not surprising that Massachusetts is one of six New England states where governors are urging Congress to amend federal law and allow medical professionals to prescribe MAT drugs. Currently, nurse practitioners can prescribe addictive

In the past few years, **OPIOID overdoses have killed more people than automobile accidents.**





Two million people in the U.S. struggle with opioid addiction. Mark Brennick started abusing prescription drugs at age 16. At the time this picture was taken, he had been clean 9 months.

DAVID KIDD

narcotics for pain, but under the Drug Abuse Treatment Act of 2000, they are barred from prescribing medications designed to break addiction to those drugs.

Rhode Island is also putting in place additional means to expand the availability of MAT programs. As part of the state's multipronged attack on the opioid epidemic, Gov. Gina Raimondo has called for training of over 400 healthcare providers in administering MAT drugs.

Tennessee has assembled an advisory group to define an episode of care for substance use disease. It is also considering what the post-detox treatment should be in terms of access to medications.

Step 3: Review Medicaid Plans

A 15-page letter signed by Vikki Wachino, director of CMS, arrived on state Medicaid directors' desks in the middle of summer 2015. Its intent was stated clearly: "The purpose of this letter is to inform states of opportunities to design service delivery systems for individuals with substance use disorder (SUD)." The letter went on to spell out the numerous federal authorities that were offering states the flexibility to implement system reforms that could improve care, enhance treatment and offer recovery supports for SUD.

Part of what CMS suggests is for state Medicaid directors to review their Medicaid plan and see what it includes or excludes for SUD in general and opioid addiction in particular. Opioid treatment for children is already mandated but the federal government is now offering matching funds if states add adults to their Medicaid plan's opioid treatment coverage. There are also bonuses — monetary and regulatory — for states that use Medicaid waivers and amendments to adapt evidence-based approaches such as MAT for treating opioid addiction.

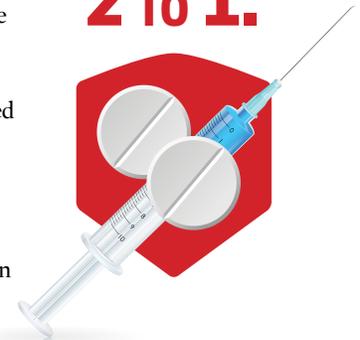
Several states are providing long-term, MAT-style opioid treatment within their Medicaid programs. Maryland, for example, offers coverage for outpatient substance use treatment that includes MAT with buprenorphine. As the patient stabilizes over the course of two to four months, a social worker helps him or her transfer to a primary care physician who can continue the buprenorphine treatment. Additional counseling is also available as is three more months of case management from the social worker.

Step 4: Work with Practitioners

One measure of the opioid epidemic is the increase in the number of opioid pain relievers — such as Vicodin, Percocet and Oxycontin — prescribed by physicians and practitioners. Where there were a mere 76 million prescriptions issued in 1991, today that number has leaped beyond 250 million a year. That's enough to give every American adult their own bottle of pills, according to the Centers for Disease Control and Prevention (CDC).⁹

This quantum leap is, in part, an unintended consequence from a medical decision made 15 years ago. At the time, there was a perception that pain was undertreated. As a result, the Joint Commission's 2001 Pain Management Standards began labeling pain as a "fifth vital sign." In addition to checking blood pressure, temperature,

The death rate from opioids-based painkillers tops heroin's by nearly 2 to 1.



The Rise in Painkiller Prescriptions



pulse and respiration, healthcare providers were now required by the Joint Commission to ask patients about their pain. This led to a surge in opioid prescriptions written outside of a hospital setting and an increase in overdoses and deaths tied to painkillers.

In March 2016, the CDC published guidelines and suggested limits for prescribing opioids in a primary care setting. The CDC directive noted that the guidelines are “intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain.”

Several states are improving communication with their physicians and practitioners by writing into legislation controls on opioid prescriptions. Massachusetts’ law, for example, is the first to limit an opioid prescription to a seven-day supply for a first-time prescription. Other provisions in that law require doctors to check the prescription monitoring program (PMP) database before writing a prescription for certain opioids. The law also requires prescribers to complete continuing education courses on effective pain

management and the risks of abuse and addiction associated with opioid medications, among others.

Whether or not they are the prescribing physician, many primary care physicians don’t screen for or recognize signs of opioid addiction. States can train physicians to use screening, brief intervention and referral to treatment (SBIRT). SBIRT – which is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs – can be included in a Medicaid plan or a state can open up billing codes to allow for it.

For example, the state of Washington has integrated SBIRT into its Medicaid program. So far, the state reports a savings of \$250 per Medicaid member per month, much of it coming from a decrease in inpatient hospitalization from emergency department admissions.¹⁰

This piece was developed and written by the Governing custom media division, with information and input from Optum.

Endnotes

1. <http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf>
2. <http://www.nber.org/papers/w22504>
3. <https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse>
4. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>
5. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>
6. <http://www.npr.org/sections/health-shots/2016/05/17/478387232/treating-opioid-addiction-with-a-drug-raises-hope-and-controversy>
7. http://www.asam.org/docs/advocacy/2012-9-25_nj-opiate-document.pdf?sfvrsn=2#search=%22opioid%20prescriptions%20increase%22
8. http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final
9. <http://www.cdc.gov/vitalsigns/opioid-prescribing/>
10. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

Produced by: **GOVERNING**

Governing covers politics, policy and management for state and local government leaders. Recognized as the most credible and authoritative voice in its field, *Governing* provides non-partisan news, insight and analysis on budget and finance; transportation and infrastructure; workforce and economic development; health and human services and more.

Governing is a division of e.Republic, the nation’s only media and research company focused exclusively on state and local government and education.

For:  **OPTUM**[®]

Optum is a leading information and technology-enabled health services business that is helping to make the health system work better for everyone. Our impact is broad and growing. Today we serve 115 million consumers, 300 health plans, hundreds of life science companies, 67,000 pharmacies, four out of five U.S. hospitals, half of the Fortune 500 employers, health departments, 18 federal agencies, and HHS agencies in 35 states and D.C. Today, we provide behavioral health services – including substance use disorder services – to 35 million Americans and 4.7 million Medicaid members in 24 states.

To find out more, visit optum.com/government or call 1-866-223-4603.