Substance Use Disorder Treatment Policy Recommendations for the State of Louisiana

Final Report — March 2019

Submitted to the Louisiana Legislature and the Louisiana Advisory Council on Heroin and Opioid Prevention and Education

The Pew Charitable Trusts

Executive Summary

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization dedicated to serving the public. Our substance use prevention and treatment initiative works with states to expand access to evidence-based treatment, such as medication-assisted treatment (MAT), for opioid use disorder (OUD).

Technical assistance is provided to states that request Pew's expertise and support with a formal invitation. Pew's partnership with states is intended to assist in their efforts to achieve a treatment system that provides quality substance use disorder (SUD) treatment that is disease-focused, and supports improved disease management and patient outcomes. In response to the state's technical assistance invitation, Pew analyzes the state's treatment system using a set of comprehensive treatment principles and conducts an assessment based on stakeholder interviews, data analyses, and policy reviews. This process culminates in recommendations for the state's executive branch and legislative leadership.

In response to Louisiana's invitation for technical assistance, Pew conducted a full system assessment to inform recommendations for the state on timely, comprehensive, evidence-based, and sustainable treatment for OUD. To better understand the strengths and gaps in Louisiana's existing OUD treatment system and other stakeholder policy priorities, Pew had discussions with more than 100 stakeholders from across the state. In addition, Pew reviewed evidence-based and emerging practices found in the gray literature (e.g., reports, briefings, case studies, and presentations) to inform the development of these recommendations. Recommendations were also informed by engagement with national OUD leaders. Finally, Pew assessed existing state regulations relevant to OUD treatment.

This final report consists of eight policy recommendations grouped by four key components of an effective treatment system: treatment system transformation, substance use disorder workforce, coverage and reimbursement, and underserved populations.

Treatment System Transformation

Recommendation 1: The Louisiana State Legislature should consider a resolution encouraging the Louisiana Department of Health to issue regulations by December 31, 2020 to allow the establishment of new opioid treatment programs and methadone dosing sites.

Recommendation 2: Louisiana's Medicaid program, with funding support from the Louisiana State Legislature, should pay for care coordination for community-based medication-assisted treatment providers, and consider other reforms, such as increasing reimbursement rates, that will expand the availability of opioid use disorder treatment.

Recommendation 3: Louisiana's Medicaid program, with funding support from the Louisiana State Legislature, should pay for the care coordination to facilitate emergency department

initiation of medication-assisted treatment and transition to community-based care upon release.

Recommendation 4: The Louisiana Department of Health, through the state licensure regulations, should phase in service requirements that expand the use of medication-assisted treatment in residential facilities.

Substance Use Disorder Workforce

Recommendation 5: The Louisiana State Legislature should consider clarifying state statute to ensure that nurse practitioners and physician assistants can prescribe buprenorphine.

Coverage and Reimbursement

Recommendation 6: The Louisiana Department of Health, with funding support from the Louisiana State Legislature, should add Medicaid coverage of methadone for treatment of opioid use disorder; as a first step the Louisiana State Legislature should appropriate the necessary level of funding.

Recommendation 7: The Louisiana Department of Health, with funding support from the Louisiana State Legislature, should remove Medicaid prior authorization and address other drug utilization management barriers for buprenorphine and naltrexone.

Underserved Populations

Recommendation 8: The Louisiana State Legislature should consider funding for a pilot program to implement all three U.S. Food and Drug Administration-approved medications for opioid use disorder in select correctional institutions.

Introduction

In May 2018, Pew was invited to provide technical assistance on expanding access to evidence-based treatment for SUDs in Louisiana by Governor John Bel Edwards, Speaker of the House Taylor Barras, Senate President John Alario, Secretary of the Louisiana Department of Health Dr. Rebekah Gee, Co-Chairs of the Advisory Council on Heroin and Opioid Prevention and Education (HOPE) Dr. James Hussey and Matt Adams, and Drug Policy Board Director Dr. Chaunda Mitchell. Pew's technical assistance includes a treatment system needs assessment consisting of stakeholder engagement, quantitative research, and analysis of existing Louisiana policies.

Scope of the Opioid Crisis in Louisiana

Fatal and non-fatal opioid-related overdoses and opioid-related hospital visits continue to rise in Louisiana; opioid-related overdose deaths more than doubled between 2014 and 2017.[1] Southeastern parishes — Jefferson, St. Tammany, Orleans, Washington and East Baton Rouge — had the highest number of opioid-related deaths in 2017. However, northern parishes, such as Caddo and Ouachita, rank in the top ten. Overdose deaths affect all demographic groups. Between 2014 and 2017, opioid-involved overdose deaths among African American residents increased by 100 percent and 82 percent among White residents.[2]

The impact of opioids can be seen across the health care system. Between 2013 and 2015, emergency department visits due to suspected opioid overdose increased by 33 percent.[3] Opioid-related inpatient visits also increased to 1,271 in 2016; a 53 percent increase since 2013.[4] In 2018, opioid-related emergency department visits cost the state Medicaid program nearly $2 million dollars.[5]

Despite the marked rise in overdoses and opioid-related inpatient visits, treatment capacity has not kept pace with the need for services. Based on an analysis of federal data conducted by the Louisiana Department of Health (LDH) in 2017, only 5 percent of people needing treatment for SUDs in the state receive it.[6] Pew's system assessment found that low access is largely driven by the limited number of providers across the state.

For individuals who can access services, evidence-based treatment is often out of reach. MAT, which pairs behavioral therapy, such as counseling, with U.S. Food and Drug Administration (FDA)-approved medications, is the most effective way to treat OUD. Nationally, just 43.7 percent of treatment facilities offered at least one form of medication, and of those that offer MAT, 28.6 percent do not accept Medicaid, according to 2019 data.[7]

People with OUD have three options for where to get MAT. Behavioral health service providers, which include both residential and outpatient treatment, treat mental health and substance use disorders. Unfortunately, of the 81 behavioral health service providers in Louisiana for which there is federal SUD treatment data, fewer than half (35) provide some form of MAT and of those,

11 provide naltrexone only.[8*] Louisiana's ten opioid treatment programs (OTPs) treat patients with methadone and other forms of MAT while delivering counseling and other services. Finally, outpatient providers may prescribe buprenorphine and naltrexone. In 2017, 452 prescribers had completed federal requirements to prescribe buprenorphine.[9] According to fiscal year 2018 Medicaid data, 883 physicians prescribed forms of buprenorphine and naltrexone.[10]

Louisiana — like many states — lacks complete data demonstrating the size of the state's treatment gap. For example, there is no data source that pinpoints treatment capacity, need, or utilization across the state by the level of care provided (for example, intensive outpatient or inpatient). The Louisiana State Legislature recognized the need for better data and coordination. In 2017 the Legislature passed Act 88 (House Bill 490)[11] to establish The Advisory Council on HOPE within the Governor's Drug Policy Board.

The HOPE Council is responsible for organizing an interagency response from state government and producing data on the opioid crisis in Louisiana. The Council supports LDH's efforts to plan and manage the Louisiana State Opioid Response grant (LaSOR) — a federal grant aimed at increasing access to MAT. Further, the HOPE Council coordinated with the Office of Public Health, the Bureau of Health Informatics, and the CDC in launching the Louisiana Opioid and Data Surveillance System (LODSS) in October 2018.[12] The availability of such data, which can be delineated by population and geographic factors, improves the capacity of researchers and decisionmakers to produce, analyze, and evaluate policies aimed at addressing the opioid crisis in Louisiana. The Council meets regularly to provide updates on these efforts and Pew has used these forums to engage with stakeholders.

Stakeholder Engagement

Since July 2018, Pew met with more than 100 stakeholders across the state. These discussions strengthened Pew's understanding of state data, highlighted key barriers to evidence-based treatment, and helped to target recommendations toward areas of highest need for reform in Louisiana. Pew also built off the extensive efforts and expertise of many of these stakeholders, including the HOPE Council, local governing entities, the Louisiana Hospital Association, and the Louisiana Primary Care Association.

Pew engaged stakeholders with different perspectives and roles in the treatment system. Broadly these stakeholders included: state agency leaders and program administrators, state legislators, parish agency directors and staff, provider professional societies, individual providers across the continuum of care and across practitioner-type, associations representing various care settings, and public and private insurers, among others. The perspectives of these stakeholders are reflected in many of the recommendations in this report.

* Data on substance use treatment facilities was taken from the National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of all known public and private substance use disorder treatment facilities in the United States. The data represent a census on March 31st every year. The N-SSATS 2017 facility response rate was 89%.

This effort builds on previous initiatives. In 2018 the Louisiana Department of Health, with assistance from Johns Hopkins University, engaged an expert panel in developing recommendations for addressing the opioid crisis. The recommendations included expanding access to evidence-based treatment plus five corresponding action steps.[13]

Scope of the Report

OUD is a complex relapsing brain disease caused by the recurrent use of opioids, including prescription opioids, heroin, or other synthetic opioids like fentanyl.[14] Evidence-based treatment is one component of addressing the opioid crisis, but prevention, harm reduction, and recovery support services are also important and often complementary. Pew's work in Louisiana has focused on expanding access to treatment that is timely, comprehensive, evidence-based, and sustainable. Although there are some recommendations that touch on aspects of recovery support services, they are in the context of improving treatment initiation and retention. The exclusion of interventions from other domains does not reflect a lack of importance, but rather Pew's expertise and the need for access to evidence-based treatment to curb the current opioid crisis and prepare the treatment system for any future treatment needs.

A conclusive body of research has demonstrated that MAT is the most effective way to treat OUD. People who receive MAT are less likely to die of overdose, use illicit opioids, and contract infectious diseases such as HIV and hepatitis C.[15] Based on the strength of the evidence of effectiveness and clear lack of availability of MAT, Pew is focusing its efforts on policy changes that could expand access to all FDA-approved medications and behavioral health counseling. Although the recommendations are focused on OUD, many of the policy recommendations in this report are aimed at strengthening the treatment system to improve the ability to respond statewide to any future drug epidemics with effective evidence-based treatment.

This report is focused on policy recommendations to expand access to OUD treatment, which is only one form of SUD. OUD — which includes use of heroin, prescription opioids and synthetic substances, such as fentanyl — is a type of SUD. When OUD-specific evidence was not available, this report cites evidence specific to the broader category SUDs. However, these recommendations, once implemented, have the potential to transform Louisiana's treatment system for all SUDs.

There are many potential avenues to advance the policy changes outlined in these recommendations, which will primarily be achieved by legislative or regulatory change. Pew provides guidance on strategies for achieving policy change, based on the outcomes of the system assessment. However, state agency and legislative staff could pursue alternative strategies to achieve the intended outcomes.

Preventing stigma toward individuals with OUD informs our recommendations, though isn't directly addressed by any of them. Policy solutions, such as increasing access to MAT, integrating physical and mental health services, and improving provider education, could alter perceptions of OUD over time.

Goals of a comprehensive treatment system

The American Society of Addiction Medicine (ASAM),[16] the U.S. Surgeon General's Report on Alcohol, Drugs, and Health,[17] and the National Academies of Sciences, Engineering, and Medicine[18] support a SUD treatment system that ensures patients have access to evidence-based treatment that is matched with disease severity. Policy options intended to increase access to SUD treatment should include data-informed practices as well as some emerging and innovative models that incorporate the following characteristics:

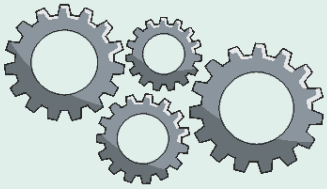
- **Timely:** Ensures that capacity exists to meet treatment demands through the availability of facilities, providers, and services. A timely system ensures that all services and levels of care recommended by the ASAM guidelines[19] are geographically distributed across the state according to need. To the extent possible, timely includes access to on-demand treatment, or at a minimum, timing of treatment that is consistent with disease severity.
- **Comprehensive:** Provides coverage of the full spectrum of treatment services — including screening, diagnosis, withdrawal management, maintenance, and recovery — by public (such as Medicaid) and private insurers. A comprehensive treatment system addresses population-specific needs, such as care for juvenile, pregnant, and justice-involved populations, and coordinates care for SUDs, mental health, and physical health.
- **Evidence-based:** Includes coverage and utilization of all FDA-approved medications for the treatment of SUD and behavioral health services recommended in evidence-based guidelines, as well as the screening and treatment of co-occurring mental health disorders and infectious disease complications. The state infrastructure, including surveillance systems, will be optimized to document the scope of SUDs, monitor progress, and guide evidence-based interventions.
- **Sustainable:** Uses funding efficiently, optimizes federal funding resources, and collaborates with community-based partners to augment treatment services. A sustainable treatment system retains relevance by adapting to emerging substances of misuse and effectively managing the disease burden in the state.

Comprehensive Treatment System Framework

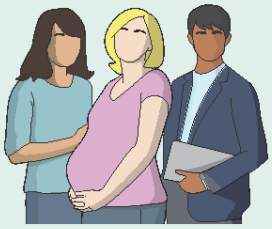
An effective and comprehensive treatment system requires several foundational elements to ensure access to high-quality and evidence-based care. Pew has categorized its recommendations into four areas: treatment system transformation, substance use disorder workforce, coverage and reimbursement, and underserved populations. These areas are based upon engagement with state stakeholders and extensive discussions with federal, state, and academic experts. This framework provides a lens to monitor and guide Louisiana's progress towards building a robust treatment system that can meet the need for SUD care across the state.

Substance use disorder workforce A robust pipeline of clinical and nonclinical providers who deliver prevention, treatment, and recovery services to people with SUD

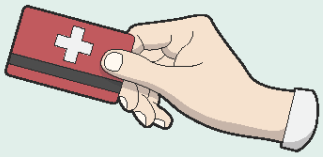
Treatment system transformation Models and approaches that affect the delivery of care in states



Timely
Comprehensive
Evidence-based
Sustainable



Underserved populations People and communities requiring specialized care or services that have access to treatment



Coverage and reimbursement Insurance policies, payments, and benefits provided by payers that ensure access to care

Recommendations

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Treatment System Transformation

Background

Nationwide, the treatment system falls short in meeting the needs of people with substance use disorders (SUDs). Only one in nine people with an SUD receives any treatment,[20] the quality of treatment varies significantly from site-to-site and many do not offer medication-assisted treatment (MAT), the gold standard for treatment.* When people with SUD seek treatment, they often face barriers related to access. According to federal survey data, 30.3 percent of respondents with an SUD reported a lack of health care coverage and not being able to afford the cost of treatment as a barrier, while 10.9 percent reported not knowing where to go for treatment.[21]

ASAM has established guidelines for effective SUD treatment based on disease severity.[22] These guidelines advise on location, intensity, and frequency of treatment according to patient need, resources, and psychosocial functions. Support of long-term recovery and access to the FDA-approved medications — methadone, buprenorphine, and naltrexone — are featured extensively in ASAM's continuum of services.

Patients should have access to multiple medications to ensure they receive the treatment that is appropriate for them. Opioid agonists, such as buprenorphine and methadone, and antagonists, such as naltrexone, have different mechanisms of action on the brain and varying methods of administration: daily dosing (methadone), take-home prescriptions (buprenorphine and oral naltrexone) and monthly injections (naltrexone). All of these factors affect whether patients are successful in recovery. Therefore, facilities and programs should offer more than one option for treatment. An added layer of complexity is that these medications have different regulatory requirements — methadone is only available at opioid treatment programs (OTPs) and buprenorphine is only available from prescribers who complete federally mandated training requirements and receive a waiver.

An additional shortcoming of treatment systems nationwide is that physical and mental health conditions are often treated by siloed systems of care — a separate set of providers and facilities in different locations. More than 8.5 million adults have co-occurring mental illness and SUD, but only 8.3 percent of this population received both mental health care and specialty substance use treatment (hospital inpatient, drug or alcohol rehabilitation, or mental health centers).[23] Access to affordable care that is integrated across primary, acute, and behavioral health settings is critical to meet the complex needs of patients with SUD.

Federally qualified health centers (FQHCs), OTPs, existing OUD providers, and health systems are prime opportunities to build services and integrate care. Based on a 2018 national survey of

* This data was taken from the National Survey of Drug Use and Health (NSDUH), a nationally representative annual household survey of non-institutionalized populations 12 years and older in the U.S.

community health centers, which qualify as FQHCs, only half of the centers provided any OUD medications and, of those, only 11 percent provided all three medications.[24] Integrating behavioral health into primary care can provide patients access to a wide range of physical health, mental health, and substance use disorder treatment services and ensures that providers are aware of one another's treatment approaches.[25]

Hub-and-spoke is an evidence-based treatment model that other states, such as Vermont, have pursued to build services and care integration systemwide in facilities such as OTPs and FQHCs. In general, patients receive withdrawal management, stabilization, and initial MAT services at specialized hubs and maintenance therapy from community-based providers, or spokes.[26] Three years after Vermont's implementation, most individuals with OUD (73 percent) were on MAT, reducing the state's treatment gap.[27] After five years, the number of buprenorphine-waivered physicians increased by 64 percent.[28]

The Louisiana Office of Behavioral Health (OBH) within LDH is adopting this model using State Opioid Response grant (SOR) funds –$23.1 million in grant funding for two years from the Substance Abuse and Mental Health Services Administration (SAMHSA).[29] Under OBH's plan, the state's ten OTPs will act as the system hubs and community-based providers will act as spokes. Spoke Care Teams will ensure sufficient case management and coordination between each hub and its respective spokes.[30]

While federal grant funding is providing the initial investment to implement delivery system reforms, Medicaid funding for the services that underpin hub-and-spoke would ensure long-term sustainability. Pew provides four recommendations aimed at transforming Louisiana's treatment system and assisting the state's efforts to adopt hub-and-spoke. This includes two complementary Medicaid changes aimed at first increasing the number of community based-providers offering OUD treatment in integrated settings and subsequently enhancing inductions and referrals to treatment from emergency departments. Additional recommended regulatory changes would allow for the establishment of new OTPs and require MAT availability in residential programs. Residential treatment is one component of any state's treatment system and appropriate for patients needing higher levels of care.

Pew's system assessment revealed provider concerns about Medicaid prior authorization processes and the length of stay permitted in residential facilities. However, there is limited evidence regarding an optimal length of stay in residential facilities due to the lack of research between program duration and therapeutic benefit. Further, state approaches regarding day limits vary considerably.[31]

Recommendations

Recommendation 1: The Louisiana State Legislature should consider a resolution encouraging the Louisiana Department of Health to issue regulations by December 31, 2020 to allow the establishment of new opioid treatment programs and methadone dosing sites.

Problem

Louisiana does not have a sufficient number of OTPs to treat people with OUD; additionally, current OTPs are not integrated with physical health settings and do not provide Medicaid-reimbursed services.

Background

OTPs are state- and federally-regulated facilities that provide medication, counseling, and other services for individuals with opioid use disorder (OUD). An OTP is the only facility where patients can receive methadone, one of the three FDA-approved medications for the treatment of OUD.

OTPs are a critical part of any state's treatment system and a key provider of MAT. Like other chronic diseases, the right medication to treat OUD may vary from patient to patient. OTPs offer a highly structured environment that may be the appropriate care setting for some individuals, depending on their treatment needs. Patients typically come daily to receive their medication and engage in frequent counseling sessions. Patients can also receive buprenorphine and naltrexone at OTPs; of the 10 Louisiana facilities, nine provide buprenorphine or naltrexone in addition to methadone.[32]

Methadone is the most rigorously studied medication available for the treatment of OUD, with a large body of research demonstrating its effectiveness[33] and safety when used to treat OUD. Methadone-related overdoses are primarily associated with its use for the treatment of pain, not for its use in treatment of OUD.[34]

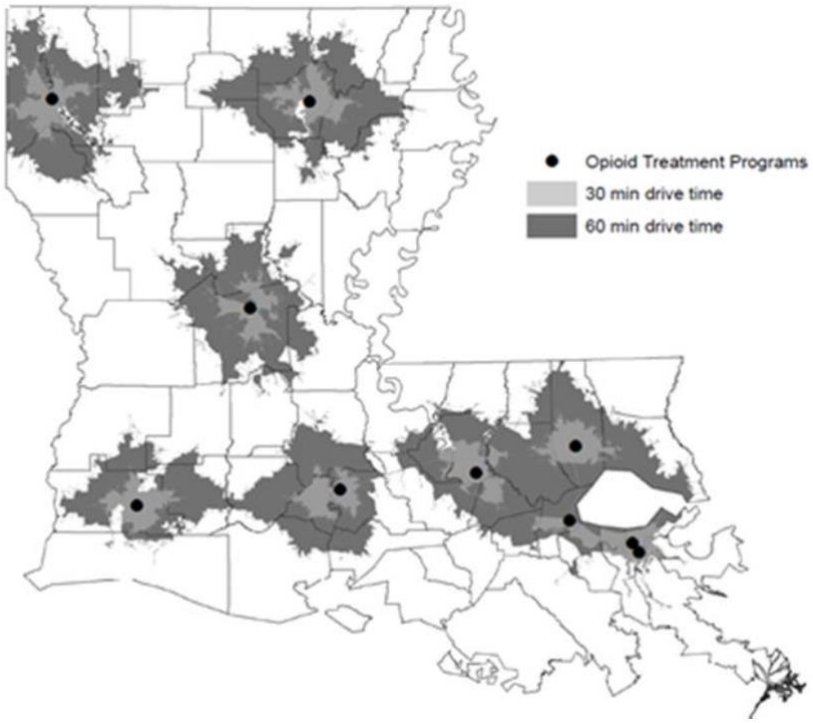
OTPs are also an important part of the care during pregnancy, as MAT with buprenorphine or methadone is the standard of care for pregnant women with OUD because of improved maternal and neonatal outcomes when combined with comprehensive prenatal care.[35]

Stigma and misconceptions about individuals with OUD often restrict the establishment of OTPs around the country. However, studies have shown that drug treatment centers, including OTPs, are not associated with increases in crime.[36] MAT is associated with reductions in criminal activity.[37] Further, the federal Americans with Disabilities Act prohibits the enactment of local laws, including zoning restrictions, that treat OTPs differently from other health-care facilities.[38]

Louisiana has one of the lowest numbers of OTPs per capita in the country — 46th compared to all states and the District of Columbia. Among other Gulf states, Alabama, Florida and Texas all have more OTPs per capita.[39] Accessing OTPs can be a particular challenge for people in rural areas; nationwide, patients in low- or moderately-populated areas must travel farther to access OTPs.[40] In Louisiana, most rural parishes are more than an hour away from OTPs.[41] Figure 1 provides a visual display of the distribution of the state's OTPs. In the 10 parishes with the highest number of drug overdose deaths in 2016, only half had a methadone provider.[42]

Urban and suburban areas may be underserved as well. Although Jefferson, St. Tammany and Orleans parishes, which include and are located near New Orleans, had the highest number of opioid overdose deaths in 2016, just two OTPs serve those three parishes.

Figure 1: Driving distance to OTPs in Louisiana, 2017



Source: Louisiana Commission on Preventing Opioid Abuse, "The Opioid Epidemic: Evidence Based Strategies Legislative Report," 28 (2017), http://ldh.la.gov/assets/docs/BehavioralHealth/Opioids/LCPOAFinalReportPkg20170331.pdf

Increasing the number of OTPs will expand patient access to this evidence-based treatment, but providers face challenges in opening new sites, and coordinating with other parts of the health care system.

First, to open additional facilities, LDH must conduct an assessment, called a need review, to determine whether new OTPs are needed in a certain geographic location. Once LDH determines the need exists, it must issue a request for applications (RFA) to be reviewed by a committee appointed by the Secretary.[43] However, this process has not been completed since it was created in 2010. Louisiana's assessment process acts, in effect, as a *de facto* moratorium on new OTPs since expansion of these facilities has ceased in the past decade.

Second, current Medicaid policy in Louisiana hinders patient access to effective treatment offered by OTPs since Medicaid does not cover methadone. As a result, patients receiving care at OTPs rely on out-of-pocket payments, state and federal grants, and private insurance. Recommendation 6 addresses Medicaid coverage of methadone and other services available at OTPs.

Third, OTPs are siloed from the rest of the health care system. Creating incentives for facilities such as health systems and FQHCs to operate OTPs would improve the availability of methadone

maintenance therapy by increasing the number of providers offering those services. It would allow OUD treatment to be offered where patients may already be seeking care for other medical conditions. Finally, an effort to build relationships between OTPs and primary care could lead to reduced stigma against patients with OUD.[44]

Ohio and Indiana are two states that have successfully expanded OTP capacity. A 2017 Ohio law allowed more OTPs to open by permitting for-profit entities to enter the market and removing a requirement that licensed facilities operate for two years before becoming an OTP.[45] More than 60 entities expressed interest in opening OTPs in the state, according to the 2017 annual report released by the Ohio Department of Mental Health and Addiction Services.[46] In January 2017, the state had 26 OTPs;[47] by December 2018, the number of OTPs increased to 43, according to SAMHSA.[48]

Ohio also is one of several states pursuing medication units, which are sites affiliated with OTPs that provide methadone dosing. Medication units can provide daily dosing at a location that may be more convenient for patients, who could continue to receive other less frequently administered services, such as counseling, at the affiliated OTP. Locating medication units at other health care sites can facilitate integration with other providers; medication units also offer promise in expanding services to rural areas. Ohio finalized regulations in November 2018 that allow medication units in locations that include jails, prisons, local boards of public health, FQHCs, residential treatment centers and rural counties.[49]

Indiana — a previous Pew partner state — is in the process of doubling the number of OTPs in the state. The state went from 14 OTPs in 2014,[50] when a moratorium was in place, to 19 in 2018.[51] This expansion occurred through legislative change that focused on opening facilities in hospitals and community mental health centers.[52] Locations of the five new OTPs were strategically chosen to reduce the time it takes individuals to access daily treatment, and improve access to care in counties with high usage of the overdose reversal medication naloxone.[53,54] In 2018, the Indiana General Assembly passed another law enabling the establishment of nine additional OTPs.[55] When these OTPs begin serving people with OUD, nearly every person in Indiana should be less than an hour's drive to treatment.[56]

Proposed Solution

The Legislature should pass, and the governor should sign, a resolution that encourages the OBH within LDH to issue regulations that establish application processes for new OTPs and medication units. These regulations should be issued by Dec. 31, 2020. The Legislature should consider annual reporting to monitor the progress of this OTP expansion, including the number of Medicaid patients served at OTPs and other measures of success.

The application process for new OTPs should prioritize the expansion of organizations already operating OTPs in the state and in good standing with OBH, and the integration of new sites with FQHCs and health systems. Existing providers are well positioned to expand services in the state because of their knowledge of the communities, health care system and state Medicaid policies. New OTPs should:

1) Offer all three FDA-approved medications for OUD;
2) Obtain certification as a Medicaid provider and deliver services to patients covered under the Medicaid program;
3) Enter into partnerships with providers offering physical health services, such as FQHCs or health systems, either by direct integration with these facilities, co-location or providing physical health services within the OTP. These partnerships should prioritize the screening and treatment of comorbid conditions, such as hepatitis C and HIV.

Other regulatory requirements could be included in the application process as determined by OBH staff during a public rulemaking process. For example, the state could consider OTP application requirements demonstrating that representatives from the applying OTP conducted community outreach. Outreach to community leaders is an important step in building out a comprehensive treatment system and combatting the stigma associated with individuals with SUD, but state and local laws and regulations should not restrict the establishment of OTPs beyond those that apply to all health care facilities. The existing need review and RFA process could also remain in place for facilities not meeting these three criteria. These changes would add demands on OBH staff to ensure effective oversight of the OTP system. The governor's office should work with LDH to ensure there is an adequate level of staff available for this work.

LDH should also create an application process and needed regulations for the establishment of medication units to expand the availability of methadone. Throughout the public rulemaking process, LDH should engage with local governing entities, OTPs, FQHCs, and health systems to establish these dosing sites. Rural parishes with higher rates of overdose deaths could be logical location for these dosing sites. Washington Parish, for example, had the highest overdose death rate in the state in 2016, but had no methadone services located within the parish. Other state regulatory approaches have specified the distance a medication unit should be in relation to the OTP and the types of locations where medication units can be opened.

Federal funds may be available to help organizations expand access to MAT. The U.S. Department of Agriculture (USDA) is one source of funding that should be considered by providers interested in locating services in rural areas. USDA's community facilities direct loan and grant program is available to construct or refurbish existing buildings, including health care facilities. The Health Resources and Services Administration, which oversees FQHCs, also provides grant funding to advance access to SUD services in these facilities.

Recommendation 2: Louisiana's Medicaid program, with funding support from the Louisiana State Legislature, should pay for care coordination for community-based MAT providers, and consider other reforms, such as increasing reimbursement rates, that will expand the availability of opioid use disorder treatment.

Problem

Individuals with an OUD seeking treatment are often unable to access MAT, in large part due to the shortage of community-based providers that offer MAT.

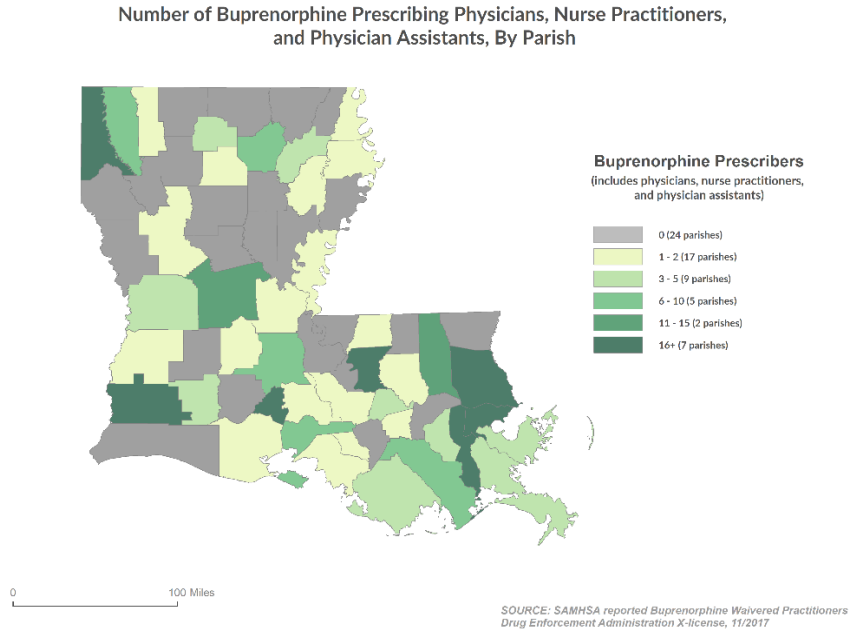
Background

Not enough providers in Louisiana offer MAT to people seeking treatment for their substance use. In fact, the fiscal year 2018-2019 Louisiana Combined Behavioral Health and Assessment Plan found that only about 5 percent of individuals that need treatment in the state receive it,[57] compared with 11 percent of individuals nationally.[58] MAT is most effective method of treatment for OUD.[59]

Community-based providers, such as primary care physicians, are a core element of a comprehensive treatment system for people with OUD. In addition to screening patients for OUD or the risk for developing one, community-based providers can prescribe treatment medications and connect patients with counseling or other services. Receiving these services from community-based providers can increase a patient's comfort with initiating therapy and reduce other barriers, such as the distance patients need to travel to receive care. In a hub-and-spoke system, which Louisiana is in the process of adopting, community-based providers could function as the spokes.

Community-based providers can prescribe buprenorphine and naltrexone to treat patients with OUD. Buprenorphine is a medication that can be taken by patients at home while naltrexone is a long-acting injectable that lasts for 30 days between administrations. There are federal training requirements and patient limits associated with buprenorphine prescribers. Louisiana faces a significant shortage of providers who are authorized to prescribe buprenorphine and are actively prescribing the medication.[60] For instance, 0.11 percent of physician assistants are waivered in Louisiana.[61] Figure 2 shows the distribution of waivered physicians in the state as of July 2017. Twenty-four parishes do not have any physician or other health-care provider who can prescribe buprenorphine.[62]

Figure 2:



Source: Pew contracted analysis of Substance Abuse and Mental Health Services Administration Buprenorphine Waiver Notification System, June 23, 2017.

Effective models of community-based care have four key components: medication delivery; counseling; integration of care, including coordinated services; and provider and community education.[63] States such as Virginia have used their Medicaid programs to build out those components and the number of community-based providers. Virginia substantially redesigned its Medicaid SUD benefit as part of a Centers for Medicare and Medicaid Services (CMS) section 1115 waiver. Virginia added multiple services to its Medicaid benefit to offer the full ASAM continuum of care with an emphasis on strengthening state-wide capacity in outpatient and residential settings.

As part of Virginia's 2016 budget,[*] the legislature gave the Medicaid program funds to, among other goals, improve the state's community-based SUD services. This included evaluating service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates. Virginia Medicaid subsequently established a workgroup[†] tasked with redesigning the

[*] In 2016, the Virginia General Assembly appropriated $11 million over two years ($2.6 million for fiscal year 2017 and $8.4 million for fiscal year 2018) to cover the state's share of the cost. See 2016 Virginia Acts of Assembly, Chapter 780, May 20, 2016, p. 286.

[†] The Virginia ARTS Core Workgroup was made of representatives from:

- State health agencies, including Department of Behavioral Health and Developmental Services, Department of Health, Department of Health Professions
- Chief Medical Officers from all Medicaid Managed Care Organizations and Magellan
- Addiction medicine experts
- Public and private behavioral health providers
- FQHCs (continued)

Medicaid benefit to accomplish this and other goals outlined in the budget. In less than six months, the workgroup developed, and Virginia Medicaid worked with CMS to create, the Addiction and Recovery Treatment Services (ARTS) benefit. The benefit, which was based on feedback from the workgroup on how to best increase the number of community-based providers in the state, was implemented one year after creation of the workgroup.

Virginia's new benefits increased the number of community-based providers and expanded MAT statewide. Community-based providers who committed to prescribe buprenorphine and deliver on-site behavioral health therapy received the following incentives:

- Enhanced reimbursement rates for buprenorphine induction and maintenance (the enhanced rates match what is available from commercial insurance plans in Virginia);
- A monthly per member payment for care coordination to patients with moderate to severe OUD that receive MAT. Care coordinators are required to be licensed as behavioral health therapists with clinical experience in direct service to individuals with SUDs. Care coordinators are expected to make referrals for medical, behavioral health, or social service needs outside of the practice and subsequently track and support the patient;
- Elimination of the prior authorization requirement for buprenorphine.[64]

In partnership with provider associations, Virginia Medicaid provided education and training across the state on the details of the new benefits, how to provide assessment, screening, and monitoring for at-risk patients, how to integrate MAT into outpatient clinical practice, and how to develop a business model that includes OUD treatment in primary care. Additionally, Virginia Medicaid offered buprenorphine waiver training and billing support. These trainings were available in all parts of the state, held at 28 separate events, and open to physicians and appropriate support staff.

Increased provider capacity driven by these reforms lowered the treatment gap. In the first year following implementation of the new Medicaid benefits, the number of Virginia Medicaid providers offering MAT and the number of residents with Medicaid receiving MAT increased rapidly: 40 percent of individuals with Medicaid needing treatment for SUD received it, up from only 24 percent the year before implementation. Additionally, the number of outpatient providers billing for the new services increased by 173 percent, which includes 848 providers that prescribe buprenorphine for OUD. The number of physicians offering outpatient treatment for OUD to patients with Medicaid increased by 358 percent, from 128 to 586.

Access to MAT for underserved populations also increased due to these reforms. For example, treatment rates for pregnant patients with OUD with Medicaid increased from 4 percent (42 patients received treatment) to 25 percent (262 patients received treatment) following ARTS implementation.[65] People of color with OUD also experienced increased access to treatment. Treatment for African Americans increased the most — by 64 percent — though treatment rates

- Hospitals
- Peer recovery organizations, and
- Consumers

are still lower than other demographic groups. This increase is noteworthy for Louisiana, given the state's high percentage of African-American Medicaid enrollees.

In addition to increased use of MAT, the new program contributed to decreases in unnecessary acute services among individuals with Medicaid. For instance, the number of emergency department visits related to OUD decreased by 25 percent, which supported a 9 percent overall decrease in emergency department visits — over 70,000 fewer visits — by all Virginia residents with Medicaid. The number of individuals with Medicaid and an acute inpatient hospital stay related to OUD also decreased by 6 percent. The effects of these reforms on other areas affected by the opioid crisis, such as the criminal justice and child welfare systems, have not been evaluated yet.[66]

Proposed Solution

The Legislature should pass a resolution that directs LDH to develop and implement a plan to increase the number of community-based providers based on the recommendations of an implementation workgroup. The resolution should specify:

- The creation of an implementation workgroup that should be consulted to determine the scope of necessary Medicaid changes to increase access to outpatient SUD treatment.
- By Dec. 31, 2019: LDH workgroup should submit plan with a fiscal year 2021 budget request to the Legislature.
- By July 1, 2020: Concurrent with the Legislature considering the fiscal year 2021 budget request, LDH should submit a state plan amendment to CMS and amend the state's managed care contract.
- By Dec. 31, 2020: Changes are fully implemented and take effect.

Without legislative direction, LDH should pursue these changes through regulation on a similar timeframe.

These changes will support and strengthen the hub-and-spoke treatment system that LDH is developing through the federal grant funding. That funding is scheduled to expire in the fall of 2020, which would be close to the date the Medicaid reforms recommended here should go into effect. These reforms would make the system supported by grant funding more comprehensive and sustainable by creating incentives for community-based providers to serve as spokes in this model.

The plan should include the following four components and other reforms considered at the discretion of LDH:

- *Preferred Provider Designation*: Establish a designation of high-quality care for outpatient SUD services. This designation should include practices that, at a minimum, include a buprenorphine-waivered physician who can prescribe buprenorphine and naltrexone in a variety of office-based practice settings (such as primary care clinics, outpatient health system clinics, psychiatry clinics, FQHCs, local governing entities, and physician offices),

and OTPs, with on-site or partnerships with behavioral health practitioners who provide counseling to patients receiving MAT.

- *Payment for Care Coordination Services*: Offer Medicaid reimbursement for care coordination to preferred outpatient providers that provide buprenorphine induction and maintenance and on-site, or partnerships to provide, behavioral health therapy. Care coordinators should be expected to establish referral networks with providers of all ASAM levels of care, physical health providers, OB-GYNs, and support patients in accessing needed recovery supports.

- *Evaluate Reimbursement Rates*: Reimbursement rates for services associated with delivering MAT should be competitive with commercial rates. At a minimum, rates for assessment, induction, maintenance, and behavioral health counseling should be competitive to encourage provider uptake.

- *Statewide Provider Education and Outreach*: To provide education about changes made to engage providers in the treatment of OUD, the plan should include funding for trainings in partnership with local governing entities and statewide provider associations that include MAT-specific courses, buprenorphine waiver training, integration of the ASAM criteria, and setting up Medicaid billing practices. These trainings should be open to all interested providers at no cost and available to all parts of the state through collaboration between LDH, local governing entities, and state-wide provider associations.

The workgroup should reflect a geographically diverse cross-section of stakeholders that could be affected by reforms across the state. At a minimum, the workgroup should include designees from:

- LDH;
    - Medicaid;
    - OBH;
- A representative from the Louisiana chapter of the ASAM;
- Louisiana Hospital Association;
- Representatives from the local governing entities covering the parishes with the highest rates of drug overdose deaths;
- Representatives from OTPs;
- Louisiana Primary Care Association;
- Louisiana Medicaid Managed Care organizations;
- Louisiana Psychiatric Medical Association; and
- Chairs of the House and Senate Health and Welfare Committees or their appointees.

The budget request should include funding for an evaluation that assesses the effect of implemented reforms on Medicaid spending, including opioid-related emergency department visits, inpatient admissions, and other admissions for acute services. The evaluation should also

measure the uptake in providers offering MAT to individuals with Medicaid and the increase in individuals with Medicaid accessing MAT.

Other recommendations address additional barriers to the provision of community-based care. Recommendation 7 recommends removing prior authorization requirements in the state's Medicaid program.

While this recommendation focuses on building up the community-based provider workforce, it is only an initial step toward ensuring there is adequate capacity for receiving treatment referrals. Emergency departments are a critical setting for starting MAT and connecting patients with the appropriate treatment. Many individuals who suffer non-fatal overdoses are not initiated on MAT or connected to care in the community. As a second step, recommendation 3 addresses policy changes that will ensure emergency departments are equipped to initiate and coordinate care for OUD.

Recommendation 3: Louisiana's Medicaid program, with funding support from the Louisiana State Legislature, should pay for the care coordination to facilitate emergency department initiation of medication-assisted treatment and transition to community-based care upon release.

Problem

People presenting in emergency rooms with an opioid overdose are not started on treatment and connected with community-based care.

Background

The national rate of overdose-related visits to emergency departments nearly doubled between 2005 and 2014.[67] According to Louisiana state data, opioid-related emergency department visits increased by 25 percent between 2013 and 2015.[68] Hospital-based care represents a critical opportunity to initiate treatment and connect people with OUD to care.[69] Patients are also more receptive to SUD treatment following an overdose.[70]

Recognizing the potential to initiate care in emergency rooms, federal regulations allow the administration of methadone and buprenorphine in emergency situations to treat withdrawal symptoms and arrange for treatment.[71] In these cases, methadone can be administered outside of an OTP and physicians do not need the waiver required to prescribe buprenorphine, but treatment can last no longer than three days.

Initiating MAT with buprenorphine in the emergency department produces better health outcomes and is cost-effective compared to other approaches.[72] A randomized clinical trial showed that more patients were engaged in treatment 30 days after buprenorphine was initiated in the emergency department and coupled with a referral, compared to interventions that did not include buprenorphine.[73] Another study found that emergency department induction of buprenorphine was more cost-effective than either brief intervention or referral upon discharge.[74]

Recommendation 2 includes Medicaid incentives for the uptake of care coordination in outpatient settings; continuation of care is similarly an important component of ensuring overdose patients receive continued treatment following emergency care.[75] Rhode Island, New Jersey, Ohio, and Pennsylvania offer examples of state programs that have been implemented to encourage treatment initiation and connection to care from the emergency department to community-based providers:

- Rhode Island's AnchorED program connects patients with a certified peer recovery specialist prior to discharge from the emergency department. Peer recovery specialists maintain follow-up with the patient for 10 days following release from the emergency department to aid in navigating the treatment system and support their recovery. More than 1,400 individuals met with a peer recovery coach in the emergency department through AnchorED during the first 29 months of the program and 80 percent of those individuals engaged in recovery support services upon discharge.[76]
- In 2015, New Jersey implemented the Opioid Overdose Recovery Program, a care coordination program modeled after AnchorED, to facilitate the entry of individuals who receive naloxone into SUD treatment.[77] Of the 293 overdose patients admitted to emergency departments in five counties from January 2016 to June 2016, roughly 37 percent (109 patients) entered treatment.[78]
- In Ohio, the Department of Mental Health and Addiction Services used a federal grant to provide funding to emergency departments on the condition they implement one of four models of care encouraging the transition of patients from the hospital to intermediary primary care while they await specialized care at OTPs or office-based opioid treatment (OBOT).[79] This redesign has allowed hospitals to use additional funding to hire primary care providers as case managers to help transition patients.[80]
- Similarly, Pennsylvania's Department of Human Services is granting $193,000 to hospitals that adopt up to four induction and referral models encouraging care coordination between emergency departments and community providers.[81] These models all require a 24-hour case management team and include practices such as emergency department induction of buprenorphine and immediate referral to office-based treatment and adopting evidence-based treatment for pregnant persons with OUD.[82]

Based on stakeholder interviews, many emergency department physicians are willing to start patients on buprenorphine but expressed reservations regarding challenges in properly referring patients to their next stage of treatment. As the state implements other policies to increase community-based providers to treat OUD (see recommendations 2, 5, and 7), changes to Medicaid policy will provide hospitals with resources to successfully induct patients with OUD on MAT and refer them to treatment.

Proposed Solution

To facilitate successful hospital-based buprenorphine induction and referral, Medicaid should provide financial resources to hospitals for the case management services required to transition OUD patients from the emergency rooms to community-based providers. There are multiple avenues that LDH could pursue for this recommendation that include:

1) Inclusion in the plan and FY 2021 budget request to the Legislature around care coordination described in recommendation 2. This would include the creation of a unique outpatient SUD case management code that hospitals could bill in emergency department settings.

2) Implementation of value-based purchasing agreements in managed care organization (MCO) contracts to provide funding to hospitals that employ case management teams or other measures to reduce SUD-related hospital readmissions. Value-based purchasing refers to the use financing strategies that link provider performance to reimbursement. Payers in these systems provide incentives to providers to perform low-cost preventive services, while discouraging the use of clinically unnecessary or non-effective interventions. LDH has expressed interest in employing value-based purchasing models in Medicaid managed care contracting.[83]

Recommendation 4: The Louisiana Department of Health, through the state licensure regulations, should phase in service requirements that expand the use of medication-assisted treatment in residential facilities.

Problem

The majority of residential treatment facilities in Louisiana do not provide access to any MAT.

Background

Although many patients can be appropriately treated in outpatient settings, the share of patients with OUD that received treatment in an inpatient setting, which includes residential or hospital treatment, increased from 37.5 percent in 2004-2008 to 51.9 percent in 2009-2013 nationally.[84] In Louisiana, 58 percent of individuals enrolled in Medicaid seeking OUD care received treatment at inpatient and residential facilities.[85] This treatment cost the state Medicaid program approximately $34 million in 2018. By comparison, the 42 percent of Medicaid OUD patients treated in outpatient settings cost the state approximately $6 million.[86]

Conversations with stakeholders in Louisiana revealed that residential treatment is often perceived as the default form of treatment for OUD, regardless of patient circumstance or clinical guidelines. The high utilization of residential facilities provides an opportunity to introduce evidence-based treatment in these spaces at a higher rate.

Unfortunately, many residential treatment facilities nationwide rely upon abstinence-based treatment protocols, which have higher rates of relapse in patients upon release.[87] More than half of the 35 residential treatment facilities in Louisiana* do not use MAT in treatment [88] and only six offer both buprenorphine and naltrexone.[89] As discussed previously, the right medication

* The Louisiana Administrative code defines residential treatment programs as a coordinated protocol of 24-hour professionally-directed evaluation, observation, monitoring, and treatment with varying degrees of clinical service.

to use during treatment will vary from patient to patient. Both agonist (buprenorphine and methadone) and antagonist (naltrexone) treatment should be offered in residential settings.

In 2018, LDH submitted a waiver to CMS to provide additional coverage for residential treatment for Medicaid patients.[90] This waiver allows Medicaid to use federal funding to pay for OUD treatment at residential facilities containing more than 16 beds. As part of the federal requirements for the waiver, residential providers must offer MAT onsite or "facilitate access to MAT off-site" to be eligible for reimbursement.[91] LDH implemented the waiver with the latter approach, which does not create an incentive for residential facilities to actually deliver MAT onsite. Pew's recommendation would take the implementation of the waiver a step further by ensuring MAT will be offered in these facilities.

Proposed Solution

LDH should amend the administrative code for behavioral health service providers to require onsite access to at least one form of agonist treatment as a condition of licensure for residential facilities. Antagonist treatment should either be offered onsite or be made available through referral to another provider. This requirement could be satisfied by facilities administering or dispensing the medication itself. LDH should complete this regulatory update by January 1, 2020. Existing licensed facilities should have a period of three years to implement the new requirements. By January 2021, residential providers should give LDH a progress report with updates regarding new staff and the implementation of new treatment protocols. LDH should use this window to develop a monitoring mechanism to communicate which facilities are observing new regulations by offering MAT.

The state should also offer technical assistance to these facilities that includes buprenorphine waiver training, administrative support, and other guidance as requested by participating providers. This timeline and approach complements other Pew recommendations. Recommendations 2 and 5 in this report are focused on increasing the providers available to treat OUD, therefore creating a sufficient workforce to implement MAT availability in residential facilities.

Substance Use Disorder Workforce

Background

An effective treatment system must have enough providers to meet the need for services across the state. In order to prescribe buprenorphine, providers are required to obtain a waiver through the Drug Enforcement Administration and SAMHSA.[92] The waiver requires providers to receive additional education for treating OUD: eight hours for physicians and 24 hours for nurse practitioners and physician assistants.[93]

Nationwide, 44 percent of all counties do not have a physician that is authorized to prescribe buprenorphine.[94] Similarly, 74 percent of all counties lack a waivered nurse practitioner and 88 percent have no waivered physician assistants.[95] This shortage is more pronounced in rural areas: 60 percent of all rural counties lack any type of waivered provider.[96] Louisiana experiences a dual problem of overall provider shortages and poor distribution of existing providers.[97] More than 60 percent of Louisiana's rural or mostly rural parishes do not have a waivered provider, compared to just 10 percent of urban parishes.[98] The actual problem may be more acute, since one study found that nearly half of rural physicians nationwide who obtained a waiver were not accepting new patients.[99]

Nurse practitioners and physician assistants play an important role in increasing access to MAT, as recent federal laws enable them to prescribe buprenorphine. In 2016, Congress passed legislation temporarily allowing nurse practitioners and physician assistants to prescribe buprenorphine after completing specified training, and in 2018 additional legislation passed making this allowance permanent.[100] However, there are only 42 buprenorphine-waivered nurse practitioners and one buprenorphine-waivered physician assistant in Louisiana.[101] These numbers represent a fraction of Louisiana's available nurse practitioner and physician assistant workforce – 1.74 percent and 0.11 percent, respectively.[102] These figures suggest that more can be done to encourage these kinds of providers to become active members of the OUD treatment workforce.

Pew provides one recommendation using clarifications in state law to ensure a greater proportion of nurse practitioners and physician assistants can prescribe buprenorphine.

Recommendations

Recommendation 5: The Louisiana State Legislature should consider clarifying state statute to ensure that nurse practitioners and physician assistants can prescribe buprenorphine.

Problem

Patients in rural areas have difficulty accessing evidence-based treatment for OUD. Nurse practitioners and physician assistants are providers that can bolster the workforce in rural

underserved areas. However, state law and regulatory policies prevent them from prescribing buprenorphine.

Background

Approximately one quarter of Louisianans live in rural parishes.[103] However, more than 95 percent of the state's 452 waivered prescribers practice in urban parishes.[104] The state's sole waivered physician assistant also practices in an urban parish, as do 93 percent of waivered nurse practitioners.[105] In total, only 22 providers with this waiver practice in parishes that are rural or mostly rural.[106]

Nurse practitioners and physician assistants have the potential to improve access to buprenorphine in rural areas.[107] The number of waivered providers—including physicians, nurse practitioners, and physician assistants—per 100,000 population doubled in rural areas nationwide from 2012 to 2017, due in part to the federal policy changes allowing them to prescribe buprenorphine.[108] Each additional nurse practitioner or physician assistant can treat up to 30 patients for OUD in their first year of practice upon receiving the waiver; they can apply to treat up to 100 patients in their second year.[109]

Under federal law, nurse practitioners and physician assistants who have obtained the necessary waiver to prescribe buprenorphine do not need their qualifying physician to also have a waiver.[110] However, many states do require this. The Louisiana State Board of Nursing (LSBN) issued a declaratory statement in 2017 that requires nurse practitioners to have a collaborating physician who has received that waiver, while the Louisiana State Board of Medical Examiners (LSBME) has not provided any statements for guidance on this issue as it relates to PAs as of February 2019.[111]

Pew's system assessment revealed that nurse practitioners and physician assistants were often unsure or hesitant to prescribe buprenorphine. This additional state requirement for nurse practitioners (and the lack of clarity for physician assistants) is not in line with the federal definition of a qualifying physician and may disproportionately affect nurse practitioners and physician assistants in rural areas that have a limited number of waivered physicians.

LSBN policy also conflicts with evidence-based OUD treatment guidelines such as those developed by ASAM. Policy statements from the LSBN dictate uniform practices such as weaning from agonist treatment and encourage a transition to antagonist treatment; this approach is not supported by evidence.[112] This statement has also not sufficiently clarified the guidelines for evidence-based OUD treatment of pregnant women, which should include buprenorphine and methadone.[113]

Proposed Solution

The Legislature should pass a bill which the governor should sign to allow nurse practitioners and physician assistants to obtain and use a waiver to prescribe buprenorphine within the scope of their license, regardless of whether their collaborating or supervising physician holds a similar waiver and regardless of medical specialty. This statutory clarification will give the LSBN an

opportunity to amend prior policy statements that require a collaborating physician also have a waiver. The LSBME should also use this opportunity to issue a similar policy statement that clarifies physician assistants' ability to prescribe buprenorphine with respect to the status of their qualifying physician. Both boards should revise existing policy statements regarding the use of MAT (or creating new ones) to be in line with evidence-based treatment guidelines.

None of these changes would affect the scope of practice for nurse practitioners or physician assistants or alter requirements to enter collaborative practice or physician supervision agreements. However, removing these barriers to providing treatment could increase access, particularly in rural areas of the state that already face significant shortages of providers with waivers to prescribe buprenorphine.

Coverage and Reimbursement

Background

Public and private payers play a critical role in ensuring access to evidence-based treatment through benefit design, coverage policies, utilization managements strategies, adequacy of provider networks, member education and other strategies.

Medicaid plays an important role in OUD treatment. In 2017, Medicaid covered nearly 40 percent of nonelderly adults with OUD and 54 percent of low-income individuals (those with income at less than 200 percent of the federal poverty level) with OUD nationwide.[114] Moreover, the prevalence of co-morbid physical and mental health disorders is higher among Medicaid enrollees. For example, the rates of behavioral health disorders are estimated to be 50 to more than 100 percent higher in Medicaid than in the general population.[115] The treatment and outcomes for individuals with OUDs enrolled in Medicaid are therefore critically important aspects of the public health response to the OUD crisis.

In Louisiana, Medicaid covers 1.46 million individuals,[116] representing 31 percent of the state's population. The program also has one of the highest percentages of African-American enrollees in the country, behind only the District of Columbia and Mississippi; in 2017, 52 percent of Louisiana enrollees were African American.[117]

Although Pew's recommendations in this section highlight Medicaid-related policy changes, all payers, including commercial plans, have a role in encouraging the use of MAT for OUD treatment. In Louisiana, 44 percent of the state population had employer-based insurance in 2017.[118] According to an analysis of MarketScan,[*] a database of employer-based insurance claims, just 19 percent of commercially-insured patients receiving OUD treatment received buprenorphine[119] and less than 1 percent were treated with naltrexone.[120] Private payers should consider implementing similar policy changes to streamline utilization management and ensure sufficient provider networks are available for the provision of OUD treatment.

All payers should ensure comprehensive coverage that includes the full spectrum of services, including screening, diagnosis, withdrawal management, maintenance, and recovery. These services should include all three FDA-approved medications (methadone, buprenorphine, and naltrexone) and evidence-based behavioral therapies, as well as all levels of care recommended by ASAM guidelines.[121] Although it does not cover methadone, Louisiana's Medicaid program covers buprenorphine, naltrexone, and services within all ASAM levels of care.[122]

[*] The MarketScan® Commercial Claims and Encounters (MarketScan) Database from IBM MarketScan Research contains reimbursed health care claims for persons enrolled in medium and large employer-sponsored health plans nationwide, not Medicaid or Medicare. These national data represent approximately 56 million enrollees per year, an estimated one third of people covered by employee-sponsored health insurance plans. The number of Louisiana enrollees represented in MarketScan were relatively stable from 2011-2016.

Payers also are a critical driver in ensuring provider networks are available to deliver care where and when it is needed. This can be done by ensuring sustainable funding for treatment models, such as hub-and-spoke, and adequately reimbursing providers for the cost of administering evidence-based treatment. Inadequate reimbursement for MAT has been frequently cited by providers as a reason why they are hesitant to offer these services.[123]

Pew recommends two policy changes to improve Medicaid coverage and reimbursement policies in Louisiana to support increased access to evidence-based treatment for individuals with OUD.

Recommendations

Recommendation 6: The Louisiana Department of Health, with funding support from the Louisiana State Legislature, should add Medicaid coverage of methadone for treatment of opioid use disorder; as a first step, the Louisiana State Legislature should appropriate the necessary level of funding.

Problem

Methadone is a well-studied and effective treatment for OUD, yet Louisiana is among a minority of states that do not cover this treatment. Without coverage, many residents do not have access to evidence-based care.

Background

Methadone for OUD can only be distributed at OTPs; many OTPs also offer treatment with buprenorphine and naltrexone. Additionally, all OTPs provide counseling services to people with OUD. FDA approved methadone for the treatment of OUD in 1972, decades before buprenorphine and naltrexone; numerous studies have demonstrated its efficacy.[124] Recommendation 1 discusses the importance of methadone, other regulatory barriers that hinder access to OTPs, and strategies the state can use to expand the number of OTP providers in the state. This recommendation focuses on making it easier for people with Medicaid to receive care at OTPs.

Thirteen states, including Louisiana, do not cover methadone for the treatment of OUD in their Medicaid program; among the five Gulf states, Florida and Mississippi both cover this treatment.[125] Accordingly, Medicaid patients in Louisiana typically must pay out-of-pocket to receive methadone treatment. Although the state allocated a portion of a $16 million federal grant distributed over two years to provide methadone to uninsured and underinsured patients, relying on federal grant funds to expand access to methadone is not a sustainable strategy.[126]

In addition to improving outcomes, treatment with methadone has the potential to save dollars over time. One analysis of individuals with OUD in a commercial health plan found that per member health care costs were 50 percent lower for individuals on methadone, compared to individuals receiving two or more outpatient treatment visits without methadone. Additionally, costs were 62 percent lower for individuals on methadone than for individuals not receiving methadone with zero or one outpatient treatment visits.[127] A simulation study of publicly-funded

treatment administered in California found that if individuals had received immediate access to methadone, the health care sector would have saved $1.23 billion over 10 years. This immediate access option was compared to standard state practices, in which medically managed withdrawal was limited to 21 days and two or more failed treatments were required before starting methadone treatment—guidelines that are more stringent than federal regulations.[128]

Congress recognized the importance of Medicaid and Medicare coverage of OTPs in two key provisions of the SUPPORT for Patients and Communities Act, which was enacted in 2018.[129] One provision mandates that state Medicaid programs cover all FDA-approved medications for OUD, including methadone. Another provision requires Medicare coverage of services provided at OTPs. Additionally, LDH officials, OTPs, and other stakeholders reiterated the importance of methadone coverage during conversations with Pew.

Proposed Solution

With the appropriate level of funding from the Legislature, Louisiana Medicaid should submit a state plan amendment to CMS to provide coverage of OTP services. The state cost of Medicaid coverage is influenced by many factors, including the federal government's contribution, which varies by state. In Louisiana, the federal government provides 67 percent[130] of the costs incurred for the traditional Medicaid population (primarily low-income families, qualified pregnant persons, and children) and 90 percent of the costs incurred for the expansion population (adults earning 138 percent of the federal poverty line or less). Therefore, the state's investment in methadone coverage will be highly matched by the federal government and result in an evidence-based system of care that will better serve the residents of Louisiana.

Recommendation 7: The Louisiana Department of Health, with funding support from the Louisiana State Legislature, should remove Medicaid prior authorization and address other drug utilization management barriers for buprenorphine and naltrexone.

Problem

Treatment initiation for individuals with OUD is delayed by administrative barriers, such as prior authorization, that inhibit timely, effective care.

Background

Louisiana stakeholders identified public and private payer administrative processes, such as prior authorization requirements and quantity limits for buprenorphine and naltrexone, as barriers to treatment. These policies mean that providers must receive approval from the payer before beginning treatment and limit the amount of medication the patient can receive.

Insurers typically use utilization management techniques to ensure the appropriateness of care, control cost, and prevent diversion. However, one 2016 survey of adults with SUD found that diversion of buprenorphine in fact reflected the difficulty many people have in accessing treatment. A majority (58 percent) of participants reported a history of using diverted buprenorphine; most (81 percent) of these respondents indicated they would prefer using prescribed buprenorphine if it were available.[131]

Prior authorization procedures are a significant cost to physicians in terms of regulatory burden and time.[132] These requirements also decrease utilization of affected medications,[133] and delay the initiation or continuation of necessary treatments, often resulting in negative health outcomes.[134] Given the potential negative outcomes of delayed treatment for individuals with OUD, payers should eliminate unnecessary administrative barriers that delay initiation of treatment.

A review of the five managed care plans in Louisiana's Medicaid program found that several have utilization management techniques that could negatively affect patient access to effective treatment. Currently:

- Each of the five MCOs have different Preferred Drug Lists (PDLs) that include a different array of formulations for OUD medications
- Most of these plans require prior authorization on preferred medications. For example, three of the five MCOs have prior authorization requirements for Suboxone, a branded formulation of buprenorphine, and naloxone. The other two MCOs do not list this formulation on the PDL.
- All plans have quantity limits on some formulations.[135]

LDH is in the process of establishing a single PDL, with the goal of simplifying and creating uniform pharmacy policies across MCOs.[136] OUD medications are being considered as part of this process, including eliminating prior authorization and quantity limits. Finalizing this change will improve access to treatment for Medicaid beneficiaries with OUD.

Proposed Solution

To ensure that barriers to providing timely access to evidence-based treatment are removed, LDH should continue efforts to streamline pharmacy benefits. This should include eliminating prior authorization requirements in all Medicaid managed care plans for buprenorphine-naloxone, buprenorphine mono-product—the formulation that is used to treat pregnant patients—and naltrexone products for OUD treatment.

Additionally, LDH should ensure any quantity limits placed on medications to treat OUD by Medicaid managed care plans are aligned with the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.[137] Removing these restrictions will ease the administrative burden on prescribers and improve access for patients. Medicaid also should explore payment strategies that create incentives for providers and drug makers to keep OUD patients in care.

Underserved Populations

Background

Many in Louisiana face population-specific barriers in accessing evidence-based treatment. In conversations with patients and providers across the state, four populations were identified as being particularly underserved: pregnant women, individuals with criminal justice system involvement, rural residents, and African Americans.

Pregnant Women

Pregnant women with OUD who receive evidence-based treatment (i.e., MAT with buprenorphine mono-product or methadone) have improved adherence to prenatal care[138] and improved neonatal outcomes, including higher birthweight infants.[139] On the other hand, medication-assisted withdrawal during pregnancy is associated with high relapse rates.[140]

Less than four percent of all women in need of treatment receive it in Louisiana.[141] Pregnant women often face additional challenges to accessing MAT due to a shortage of providers that serve their specific need. In 2017, the State of Louisiana Commission on Preventing Opioid Abuse identified improved access to effective OUD treatment and prenatal care for pregnant women with OUD as a priority.[142] Integrated prenatal care and MAT can increase maternal motivation for OUD treatment and ongoing MAT in the postpartum period.[143]

Although Pew does not have recommendations specifically targeting the pregnant population, expanding OUD treatment capacity in OTPs (recommendation 1), community-based providers (recommendation 2), residential facilities (recommendation 4), and providing Medicaid coverage of methadone (recommendation 6) will help create an effective health system for all patients, including those who are pregnant.

Rural Communities

An additional underserved population is Louisiana's rural communities, where there are high overdose rates, but limited access to MAT. Based on 2017 Louisiana opioid-involved death data, roughly half of these deaths occur outside of the three most highly populated parishes—Orleans, Jefferson, and East Baton Rouge.[144] Despite the effect of the opioid crisis in rural areas, the treatment system is largely inaccessible for residents. For instance, more than a quarter of Louisiana residents live more than an hour away from an OTP and 24 parishes lack a single buprenorphine-waivered provider.[145] Recommendations in this report could improve access in rural parishes by expanding community-based providers that offer MAT and lowering existing barriers for mid-level practitioners to prescribe buprenorphine.

African Americans

Finally, limited access to evidence-based treatment for OUD in Medicaid disproportionately affects the African-American community in Louisiana. Although African Americans make up only 33 percent of the state population,[146] they account for 52 percent of the non-elderly Medicaid

population.[147] Moreover, they make up more than 66 percent of the state adult correctional population.[148]

Between 2015 and 2016, opioid overdose death rates increased more rapidly among African Americans than any other racial group, with an increase of 56 percent.[149] Increasing community-based providers, ensuring care is coordinated between physical, behavioral, and social supports, improving treatment availability in state and parish correctional facilities, and effectively transitioning individuals reentering the community who had criminal justice system involvement into treatment are important steps to reduce opioid-related overdose deaths among African American and other underserved populations.

Individuals with Criminal Justice System Involvement

Individuals with criminal justice system involvement in Louisiana face significant barriers to care. During incarceration, most are unable to access MAT regardless of whether they were in such treatment upon entry into prison or jail. Terminating access to effective treatment upon entrance into the correctional system can put individuals reentering the community at a high risk for relapse, overdose, or death. In fact, within one week of release, overdose deaths are responsible for more than twice as many deaths as any other cause.[150]

The Louisiana Department of Corrections[151] estimates that 80 percent of inmates in state prisons have substance use concerns that contribute to their criminality. As such, there is great opportunity to use the criminal justice system as a setting to provide care that may address criminal-related outcomes and reduce overdose deaths. Although Louisiana has used a portion of its federal State Targeted Response (STR) funding to provide naltrexone to some of its prison inmates, the program does not offer all FDA-approved medications and does not reach all individuals in need across Louisiana state and parish correctional facilities.

Other states have integrated evidence-based treatment in their correctional system. For example, in 2016, the Rhode Island Department of Corrections (RIDOC) launched a treatment program that provided the option for anyone who screened positive for OUD to receive any of the three FDA-approved medications.[152] A partnership between RIDOC and Rhode Island's treatment hubs, known as Centers of Excellence, has established a seamless care continuity process that has helped inmates in SUD treatment transition into community treatment upon release. Rhode Island saw a 61 percent decrease in overdose deaths among individuals returning to the community after implementing this program; a more comprehensive approach to MAT availability in Louisiana's jails and prisons could also make significant progress in reducing the overdose rate.

Pew recommends one policy change targeted at improving access to evidence-based SUD treatment for underserved populations in Louisiana.

Recommendations

Recommendation 8: The Louisiana State Legislature should consider funding for a pilot program to implement all three U.S. Food and Drug Administration-approved medications for opioid use disorder in select correctional institutions.

Problem

People with OUD in state and parish correctional facilities, with few exceptions, cannot access MAT.

Background

The criminal justice system has an important role to play in engaging people with SUDs.[153,154] A 2017 report from the Bureau of Justice Statistics, using data from 2007-2009 (the most recent data available), showed high rates of regular opioid use (defined as using opioids once a week or more for at least a month) among state prisoners and sentenced jail inmates (state prisoners 16.6 percent; sentenced jail inmates 18.9 percent); rates of opioid use have likely increased since then.[155] However, most persons with OUD in correctional settings do not receive MAT,[156] the gold standard of treatment.[157]

Research demonstrates the benefits of providing SUD treatment for those with criminal justice system involvement.[158] The Legal Action Center, a non-profit law and policy organization that advocates and advances public policies on behalf of people with SUDs, HIV/AIDS, or criminal records, suggests that prisons and jails should provide MAT to those in need.[159] ASAM and the American Correctional Association recommend inmates with OUD be evaluated for consideration to continue MAT if they entered the correctional facility already taking the medication.[160] Continuity of MAT for individuals with OUD in jails was highlighted in November 2018 when a federal judge ruled that a Massachusetts jail was required to provide ongoing methadone maintenance to a specific individual.[161] While this ruling applied to one person in one jail, similar lawsuits have been filed in Maine and Washington state.[162]

The lack of access to all three FDA-approved medications for OUD in correctional settings is a missed opportunity, given the known effectiveness of MAT.[163] Existing programs include:

- In 2016, the Rhode Island Department of Corrections (RIDOC),* launched a treatment program that screened all incoming inmates for SUD and provided all FDA-approved medications for those who screened positive. Within six months of implementation, evaluation results showed a 61 percent decrease in post-incarceration overdose deaths, accounting for much of the state's overall 12 percent reduction in overdose deaths during that time. Participants used methadone and buprenorphine more often than naltrexone

* Rhode Island is one of six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) which runs a "unified public safety system," meaning that both the jails and prisons within the state fall under state administration. This contrasts with the majority of states, including Louisiana, in which prisons run by the state are responsible for individuals serving sentences over one year, while jails are run by counties, parishes, or cities and usually house those detained for sentences of one year or less as well as pre-trial individuals. While Louisiana does not control its parish jails, the state does house over half of state inmates in those jails.

for treatment within the correctional facility.[164] From October 2016 to September 2017, the program treated 896 inmates.[165]

- A study in Maryland prisons found that people who received buprenorphine while incarcerated were more likely to continue treatment upon release than those who received counseling only.[166]

Of the correctional institutions offering MAT, many limit medications to naltrexone for non-pregnant inmates.[167] As is the case in community treatment settings, the optimal OUD medication is the one that is clinically appropriate and the patient will follow. Naltrexone-only programs remove clinical and patient decision-making in the selection of the medication. For some patients, opioid-agonists (methadone and buprenorphine) may be more appropriate. Although RIDOC offers all three FDA-approved medications for OUD disorder, only 1.3 percent of inmates participating in its MAT program selected naltrexone.[168] Unlike methadone and buprenorphine, patients must be opioid-free for six to ten days prior to naltrexone induction,[169] which may be challenging for some patients. Therefore, programs in prison and jails that cover all three medications help ensure that treatment meets individual needs.

In Louisiana, a small number of parish jails have naltrexone programs, including Lafayette parish. However, most parish facilities do not provide methadone or buprenorphine to non-pregnant inmates, and many correctional institutions lack the resources to scale up naltrexone programs. Injectable naltrexone is available at two DOC facilities—the Louisiana Correctional Center for Women and Louisiana State Penitentiary at Angola—as well as one parish jail that utilizes DOC staff—the Steve Hoyle Intensive Substance Abuse Program, a 500-bed inpatient SUD treatment facility at the Bossier Parish Correctional Center.[*] Of the 500 beds, 175 are for inmates with OUD. Opioid-specific programming started in November 2017, while the injectable naltrexone program started in January 2018 with 33 injections provided as of January 2019. The DOC was scheduled to start offering injectable naltrexone at Dixon Correctional Institute and the Louisiana Transitional Care Institute beginning in January 2019.

As of December 2018, the DOC had no plans to offer methadone or buprenorphine to non-pregnant inmates. Although DOC officials have expressed a desire to expand the department's naltrexone program, it lacks the funding for scaling up at additional facilities.[170] For those who do start naltrexone in prison, ensuring access to care in the community following induction at a DOC facility remains a concern, given the lack of treatment providers in the community. Other recommendations in this report address increased access to community-based treatment.

Proposed Solution

To promote increased access to evidence-based treatment, in the 2019 legislative session the legislature should task the DOC, in partnership with other groups—including but not limited to the LDH, local governmental entities, and the Louisiana Commission on Law Enforcement and Administration of Criminal Justice (LCLE)—to determine an appropriate fiscal year 2021 budget

[*] The facility holds 600 inmates. However, 500 beds are specifically for SUD treatment services.

to pilot the availability of all three FDA-approved medications for OUD treatment in at least one state prison and up to three parish jails.

The legislature should then appropriate in the fiscal year 2021 budget the determined budget amount for the pilot. The legislature should task the DOC, LDH, and other stakeholders to also seek federal funding for this pilot. The Bureau of Justice Assistance previously awarded more than $10.8 million to assist 162 state, tribal, and local government agencies to improve evidence-based SUD treatment programs for inmates through their Residential Substance Abuse Treatment for State Prisoners Program.[171]

The amount of funding needed for a pilot varies by state and patient need. For example:

- RIDOC receives a $2 million[172] annual legislative appropriation for the MAT program at all correctional institutions. The MAT program offers all three FDA-approved medications to treat OUD. From October 2016 to September 2017, the program treated 896 inmates.[173]
- The Medication Assisted Treatment and Directed Opioid Recovery (MATADOR) naltrexone-only program at the Middlesex County, MA jail is funded by a two-year $139,000 annual grant from the Edward Byrne Memorial Justice Assistance Grants Program, and a $97,000 award from the Massachusetts Department of Public Health from the state's 21st Century Cures Act allocation. It also includes manufacturer-donated initial doses of injectable naltrexone. From October 2015 to April 2018, 383 inmates participated in the program.
- In 2014, the Vermont Department of Corrections, which is a unified jail and prison system, launched a two-facility pilot of MAT continuation for those entering the correctional system with a verified prescription for buprenorphine or methadone. The initial pilot was to continue medication for 90 days so that those facing relatively short stays would not have to withdraw and be inducted again upon release into the community. Of those who participated in the pilot, 71 individuals were maintained on buprenorphine and 49 on methadone. Vermont reported that the pilot cost $1600 per month in medical services to administer the medications. Security costs associated with the pilot program were an additional cost.[174]
- Denver Health, a public safety net health care system in Colorado, provides all health care services within the city and county jails in Denver. Denver Health received a $425,000 grant, financial support from marijuana taxes, and local funding to provide buprenorphine tablets and film, naltrexone tablets and injections, and salaries of two physician assistants and two counselors for its MAT program within the two Denver jails. The dollars covered the costs of MAT for 1,900 inmates for 11 months.[175]

A request for proposals (RFP) should determine which facilities are appropriate to receive the funding to pilot all three FDA-approved medications for OUD. The legislature should charge the DOC and other stakeholders such as the LCLE, the Louisiana Sheriffs' Association, LDH, Baptist Community Ministries, the Foundation for Louisiana, the Baton Rouge Area Foundation, and the Huey and Angelina Wilson Foundation to aid in the development of a RFP for the pilot and review submitted proposals.

The RFP should specify the correctional facility eligibility criteria which should, at a minimum, include a joint application between the local governing entity and parish sheriff, a partnership with an OTP, and a buprenorphine-waivered prescriber to provide care post-incarceration. The DOC should receive the funding from the legislative appropriation for the pilot, award funding to the selected facilities, and report to the legislature on the progress of each pilot program annually. The pilot programs should have the potential for scalability and other facilities seeking to implement MAT programs should adopt best practices resulting from the pilot programs.

Data Source Table

Data source & Sponsor	Sample	Strengths	Limitations	Technical Notes
MarketScan® Commercial Claims and Encounters (MarketScan) Database Sponsor: IBM MarketScan Research	Reimbursed health care claims for persons enrolled in medium and large employer-sponsored U.S. health plans	• Provides an assessment of the care received by a commercially-insured population	• Excludes Medicaid and Medicare claims. • The number of employers and enrollees represented in the database fluctuates annually.	• Please contact IBM MarketScan Research*
National Survey on Drug Use and Health (NSDUH) Sponsor: Substance Abuse and Mental Health Services Administration (SAMHSA)	Persons 12 years and older residing in U.S. households, noninstitutionalized group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases	• Representative sample of the 50 states and the District of Columbia	• May not capture the heaviest opioid users – those who may be unstably housed. • Respondent may be less forthcoming with heroin use.	• For details on limitations, question changes, and methodology see *National Survey on Drug Use and Health: Methodological summary and definitions* and Introduction section of the *National Survey on Drug Use and Health: Detailed Tables.*†
National Survey of Substance Abuse Treatment Services (N-SSATS) Sponsor: SAMHSA	Yearly cross-sectional survey of U.S. public and private substance use disorder treatment facilities	• Documents substance use disorder treatment facility characteristics, including the provision of medication-assisted treatment (MAT)	• Annual response rates may differ. • Does not include all office-based prescribing of buprenorphine and naltrexone.	• Data represent annual census on March 31st. • For details on methodology, see the *Description of the N-SSATS, N-SSATS Background,* and *Item Response and Imputation* sections in annual reports.‡

* MarketScan® Commercial Claims and Encounters, International Business Machines Corporation, https://www.ibm.com/us-en/marketplace/marketscan-research-databases

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‡ National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/data/data-we-collect/nssats-national-survey-substance-abuse-treatment-services

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