

# **Substance Use Disorder Treatment Policy Recommendations for the State of Delaware**

Final Report — March 2019

Submitted to the Delaware Behavioral Health Consortium  
The Pew Charitable Trusts

## Executive Summary

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization dedicated to serving the public. Pew's 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).

Pew provides technical assistance to states that request Pew's expertise and support through a formal invitation. Pew's partnership with states is intended to assist in their efforts to achieve a treatment system that provides quality OUD 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. Pew's process culminates in recommendations for the state's executive branch and legislative leadership.

In response to Delaware'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 Delaware's existing OUD treatment system Pew had discussions with more than 150 stakeholders from across the state. In addition, Pew reviewed previous reports including the Behavioral Health Consortium (BHC) Three Year Action Plan and a report by Johns Hopkins University, as well as evidence-based and emerging practices from other states, to inform the development of these recommendations. National experts on OUD policy also informed these recommendations. Finally, Pew assessed existing state laws and regulations in Delaware 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 General Assembly should consider directing the Division of Medicaid and Medical Assistance and the Division of Substance Abuse and Mental Health to fund reimbursement for care coordination for SUD treatment with a rate comparable to surrounding states and informed by evidence of the full cost of such services.

**Recommendation 2:** The General Assembly should consider directing the Division of Substance Abuse and Mental Health to issue regulations to allow for medication units, dosing sites associated with opioid treatment programs, to expand the capacity of existing treatment facilities and integrate methadone into other types of healthcare settings.

**Recommendation 3:** The Division of Medicaid and Medical Assistance—in collaboration with the Division of Substance Abuse and Mental Health—should amend its Medicaid managed care contracts to mandate a common assessment tool based on the current American Society of Addiction Medicine criteria for substance use disorder diagnoses and patient placement.

### Substance Use Disorder Workforce

**Recommendation 4:** The General Assembly should consider amending the Medical Practice Act to ensure that all waived physician assistants can prescribe buprenorphine regardless of the waiver status of their supervising physicians.

**Recommendation 5:** The Board of Medical Licensure and Discipline should remove the requirement for providers to obtain a waiver to prescribe buprenorphine via telemedicine. If this requirement is not removed, the Division of Substance Abuse and Mental Health should publish guidance and offer technical assistance to providers on how to obtain such a waiver.

### Coverage and Reimbursement

**Recommendation 6:** During calendar year 2019, the Behavioral Health Consortium should form a task force of private insurers, employers, and other stakeholders to provide to the Consortium an agreed upon set of policies that private payers will adopt with the goal of increasing access to SUD treatment for privately-insured Delawareans. This agreement should be provided to the Consortium by September 1, 2019.

### Underserved Populations

**Recommendation 7:** The General Assembly should consider appropriating sufficient funding for the Delaware Department of Correction to expand its provision of all three forms of FDA-approved medication-assisted treatment to all persons with opioid use disorder in any Delaware correctional facility.

**Recommendation 8:** The Division of Medicaid and Medical Assistance, with input from the Department of Corrections, should amend its contracts with managed care organizations to require care management for people with high care needs returning to the community, including individuals with OUD.

## Introduction

In July 2018, Governor John Carney, Lieutenant Governor Bethany Hall-Long, Speaker of the House Peter Schwartzkopf, and Senate President Pro Tempore David McBride invited The Pew Charitable Trusts to provide technical assistance to Delaware that would detail ways for the state to expand access to evidence-based treatment for opioid use disorder (OUD).

Pew's technical assistance begins with a treatment system needs assessment based on stakeholder engagement, quantitative and qualitative research, and analyses of existing Delaware policies and plans. Based on the results of this assessment, Pew provides tailored policy recommendations for expanding access to evidence-based treatment for OUD, as well as guidance on how these policies could be implemented.

To conduct this technical assistance, Pew worked closely with the Behavioral Health Consortium, which is led by Lt. Governor Hall-Long and charged with developing strategies to address substance use and mental health challenges in the state.<sup>1</sup>

### Scope of the Opioid Crisis in Delaware

Overdose deaths continue to climb in Delaware. Between 2014 and 2017, the rate of deaths per 100,000 residents increased from 20.9 to 37. The state's overdose death rate is now tied for fifth-highest in the country.<sup>2</sup> While 2018 data are not yet finalized, preliminary estimates from the Delaware Division of Forensic Science (DFS) indicate that over 400 people in the state died of a drug overdose last year.<sup>3</sup>

In 2017, DFS reported 345 overdose deaths, a twelve percent increase over the previous year; most of these deaths were related to opioids. Toxicology reports found fentanyl in 210 deaths, heroin in 135, and other opioids in 99, including prescription medications. (These numbers exceed the total 345 number of fatal overdoses since each death can involve more than one drug type).<sup>4</sup> While both heroin and fentanyl-related deaths have increased since 2013, fentanyl has played an increasing role in fatal overdoses—in 2013 fentanyl was present in just 18 drug overdose deaths compared to 210 in 2017.

These deaths have affected the entire state. Each county contains zip codes that had more than 32 overdose deaths per 100,000 in 2017, and zip codes with overdose death rates exceeding 55 per 100,000 could be found from north to south—in Wilmington and near Bethany Beach.<sup>5</sup>

Despite the marked rise in overdoses, treatment capacity has not kept pace with the need for services. A treatment needs assessment conducted for the Delaware Department of Justice found that less than half of people in Delaware needing treatment for OUD received it in 2014.<sup>6</sup>

While this shows that treatment rates in Delaware are higher than in other states,<sup>7</sup> the state's high overdose rate indicates that more treatment capacity is still needed.\*

For people who do access services, evidence-based treatment is often out of reach. The most effective therapy, medication-assisted treatment (MAT), combines counseling or other behavioral interventions such as cognitive behavioral therapy with one of three medications approved by the Food and Drug Administration (FDA)—buprenorphine, methadone, or naltrexone. The medications work to relieve the symptoms of opioid withdrawal or block the effects of opioids while behavioral therapies help patients improve coping skills and reduce the likelihood of relapse.<sup>8</sup> Compared to placebo or treatment without medications, people who use medications to treat their OUD are less likely to use illicit opioids.<sup>9</sup> Increased use of MAT is associated with reductions in fatal overdoses<sup>10</sup> and improves other health outcomes, such as reducing the transmission of infectious diseases including HIV and hepatitis C.<sup>11</sup>

Nationally, just 43.6 percent of treatment facilities offered at least one medication for OUD, and of those that offer MAT, 28.6 percent do not accept Medicaid, according to 2019 data.<sup>12</sup> As a result, evidence-based care may be unavailable for low-income people. In Delaware in 2016, fewer than half of people admitted to outpatient specialty treatment facilities for opioid use disorder received MAT. The numbers were even worse for inpatient and detox facilities. In these settings, less than one percent<sup>†</sup> of people who were admitted received MAT.<sup>13</sup>

Delaware—like many states—lacks complete data demonstrating the size of this treatment gap. For example, no comprehensive data source pinpoints treatment capacity, need, or utilization across the state by the level of care provided (e.g., intensive outpatient or inpatient). The Data and Policy Committee of the Behavioral Health Consortium should address this problem in collaboration with the Delaware Open Data Council, which was established to promote data sharing among state agencies.<sup>14</sup> Once these data are available, the state can track its progress towards developing a treatment system that meets the needs of people in the state.

## Development of Delaware-specific Recommendations

Since July 2018, Pew has met with more than 150 stakeholders across the state to understand the challenges that Delaware patients and providers encounter in accessing treatment and delivering evidence-based care. These stakeholders included state agency leaders and program administrators, state legislators, provider professional societies, individual providers across the

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\*Data on national treatment rates can be found in 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. See Substance Abuse and Mental Health Services Administration, "National Survey on Drug Use and Health (NSDUH)," <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.

<sup>†</sup> These data are from the Treatment Episode Data Set (TEDS). This data set annually compiles admission and discharge-level data (not unique individuals) for substance use disorder treatment of persons 12 years and older. The data represent only admissions and discharges reported in state agency data systems. See Substance Abuse and Mental Health Services Administration, "Treatment Episode Data Set (TEDS)," <https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set>.

continuum of care and practitioner-type, public and private insurers, and national experts. These discussions strengthened Pew's understanding of state data, highlighted key barriers to evidence-based treatment, and helped target recommendations toward areas of highest need for reform.

Pew's Delaware engagement effort builds on other statewide initiatives. Starting in 2017, Delaware's Behavioral Health Consortium has developed a three-year action plan for improving the state's behavioral health system based on input from over 600 community members.<sup>15</sup> In 2018, Johns Hopkins University worked with the BHC on recommendations to address the opioid crisis in Delaware.<sup>16</sup> Many of the steps detailed in the action plan and in the Hopkins report are underway:

- **The Overdose System of Care** was established by House Bill 440 in September 2018. The legislation authorizes the Division of Substance Abuse and Mental Health (DSAMH) to designate stabilization centers that can provide treatment for people experiencing a non-life-threatening overdose. Acute health care facilities, hospitals, freestanding emergency departments, and emergency medical service providers are all eligible to apply for this designation, provided they can care for patients experiencing an overdose, initiate MAT, and refer stabilized patients to other services.<sup>17</sup>
- **The Delaware Treatment and Referral Network** was launched by DSAMH in October 2018.<sup>18</sup> This cloud-based tool allows referring providers at participating facilities to see in real time the services, available treatment slots, and current waiting times at substance use and mental health treatment centers in the state.<sup>19</sup> According to DSAMH Director Elizabeth Romero, 72 people were accepted into treatment based on referrals made using the tool in its first week of operation.<sup>20</sup>
- **The Substance Use Treatment and Recovery Transformation (START) Initiative**, also launched in October 2018, uses funding from the federal State Targeted Response to the Opioid Crisis grant, as well as Medicaid and other state funds, to pay for the creation of "hubs," specialty substance use treatment providers that can treat patients with the most severe OUD until they are ready to transfer to a less intensive level of care. The Initiative also places certified recovery peers in a variety of settings including emergency departments, primary care, and urgent care. These peers help people with OUD identify and engage in care and address other challenges that may affect their recovery, such as housing and employment. The state estimates that the START Initiative will serve 900 new clients in its first year.<sup>21</sup>

Pew developed a set of recommendations that complements these programs as well as other steps described in the action plan and the Hopkins report in two ways. First, when implemented, these recommendations would increase the treatment capacity in the state, particularly in outpatient and primary care settings, and would help people with OUD to access coordinated care that meets their individual needs. Second, they provide additional detail on how some policies outlined in these previous reports could be implemented.

## Scope of the Report

This report focuses on policy recommendations to expand access to treatment for OUD, one type of substance use disorder (SUD). OUD is a chronic relapsing brain disease caused by the recurrent use of opioids, including prescription opioids, heroin, or other synthetic opioids like fentanyl.<sup>22</sup>

A conclusive body of research has demonstrated that MAT is the most effective way to treat this disorder. Based on the strength of the evidence and clear barriers to accessing MAT, Pew focuses its efforts on policy change that could expand access to all three U.S. Food and Drug Administration (FDA)-approved medications and behavioral health counseling. The exclusion of prevention, harm reduction, and recovery support interventions does not reflect their lack of importance. Rather, the focus on treatment access reflects the scope of the state's invitation to Pew and the pathway that responds most directly to the pressing need to curb opioid overdose deaths.

Stigma towards individuals with OUD is another important issue not directly addressed in this report. Many of the recommendations could help address stigma by improving the integration of OUD treatment with physical and mental health care; however, stigma is not the direct target of any single recommendation.

Finally, although the recommendations are focused on OUD, several of the policy recommendations in this report are aimed at strengthening Delaware's treatment infrastructure to improve the ability to respond statewide to any future drug epidemics with effective evidence-based treatment. These recommendations can be extended to build out a more robust mental health care delivery system.

## Goals of a comprehensive treatment system

The American Society of Addiction Medicine (ASAM),<sup>23</sup> the U. S. Surgeon General's Report on Alcohol, Drugs, and Health,<sup>24</sup> and the National Academies of Sciences, Engineering, and Medicine<sup>25</sup> 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<sup>26</sup> 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, 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 Delaware's progress towards building a robust treatment system that can meet the need for SUD care across the state.



# How States Can Strengthen Access to Treatment

Components of an effective substance use disorder treatment system



## Recommendations

### Treatment System Transformation

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## Underserved populations

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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 aged 12 or older with SUD receives any treatment.<sup>27</sup> Among those receiving treatment, the quality of care varies significantly, with medication-assisted treatment (MAT), the gold standard for treating opioid use disorder (OUD), often not offered. When people with SUD seek treatment, they often face barriers related to access, including lack of health care coverage and the inability to afford the cost of treatment (30.3 percent), health coverage that does not cover treatment or does not cover the full cost of treatment (10.5 percent), and not knowing where to go for treatment (10.9 percent).<sup>28</sup>

Another challenge is that treatment for SUD, like other behavioral health conditions, is rarely integrated with medical care, leaving patients responsible for navigating a fragmented treatment system. More than 8.5 million adults have co-occurring mental illness with SUD, but only 8.3 percent of this population receives mental health care and specialty substance use treatment (defined as hospital inpatient, drug or alcohol rehabilitation, or mental health centers).<sup>29</sup> Access to affordable care integrated across primary, acute, and behavioral health settings is critical to meet the complex needs of patients with SUD.

Federally Qualified Health Centers (FQHCs), which are community-based providers that receive federal funds and provide services in underserved areas, are one type of primary care setting well-positioned to deliver integrated SUD treatment. Based on a 2018 national survey of FQHCs, 73 percent experienced an increase in the number of patients with OUD.<sup>30</sup> However, both nationally and in Delaware, not all health centers provide MAT or have enough capacity to meet patient need. In conversations with two of Delaware's largest community health centers, Pew learned that these organizations are increasing the number of clinicians who can prescribe OUD medications, but they have concerns about their ability to address these patients' psychosocial needs.

Recommendation 1 outlines policy changes that would increase the number of integrated OUD treatment settings in Delaware by helping primary care providers coordinate care for patients with OUD and address the psychosocial needs of these patients. These primary care providers will be able to serve as spokes to the START Initiative's specialty treatment provider hubs, receiving patients who are ready to step down to less intensive treatment.

Another opportunity to integrate care is the co-location of opioid treatment programs (OTPs) within primary care settings. These state- and federally-regulated facilities are the only ones that can provide methadone for the treatment of OUD, making them the only locations where all three FDA-approved medications could be available. By co-locating these services in other settings, like FQHCs, patients can have all their health needs addressed at one location. These locations will also serve as spokes in the START Initiative. Recommendation 2 discusses more fully one mechanism to achieve co-location of OUD treatment with other types of medical care.

Comprehensive, effective treatment systems also ensure that patients are receiving appropriate treatment based on clinical criteria and their individual circumstances. Not all patients with SUD need the same level of care. While many can enter the treatment system at the outpatient level, others will need more intensive inpatient services and treatment needs can change over time. To facilitate this movement, patients should be regularly reassessed and offered care coordination services to help them seamlessly transition to the right level of care.<sup>31</sup> Recommendation 3 outlines an approach to ensuring that patients with Medicaid receive these assessment and placement services in a consistent way regardless of who conducts an initial assessment or which managed care organization is administering their benefits.

## Recommendations

**Recommendation 1:** The General Assembly should consider directing the Division of Medicaid and Medical Assistance and the Division of Substance Abuse and Mental Health to fund reimbursement for care coordination for SUD treatment with a rate comparable to surrounding states and informed by evidence of the full cost of such services.

### *Problem*

Delaware does not have enough providers to deliver medication-assisted treatment (MAT), in part because of inadequate payment mechanisms for services such as care coordination. Care coordination can support Delaware's ongoing treatment infrastructure changes (the START Initiative and the Overdose System of Care) and increase community-based SUD treatment provider participation.

### *Background*

Delaware has taken several steps to improve access to MAT, including the following:

- Developing stabilization units in the Overdose System of Care, sites equipped to acutely treat patients with non-life-threatening overdoses,
- Treatment hubs and peer recovery support through the START Initiative, and
- The Treatment and Referral Network, an electronic tool that helps providers see the immediate availability of services.

This new system will require transition points, such as transferring patients from the emergency room to a stabilization center or stepping patients down from a START specialty treatment provider to a community-based provider. Effective care coordination will be an important core element in helping patients navigate the new system and receive needed supports alongside treatment, as well as giving providers the financial and care management resources they need to support their practice.

According to the Agency for Healthcare Research and Quality's (AHRQ) definition, "(c)are coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care." It requires providers to ask about

patients' needs and preferences ahead of time and communicate this knowledge to the right people in a timely fashion.<sup>32</sup> The Centers for Medicare and Medicaid Services (CMS) includes the following care coordination services in describing its billing codes for behavioral health integration:

- Outreach to and engagement in treatment of patients
- Development of individualized treatment plans
- Tracking patient follow-up and progress
- Monitoring of patient outcomes using validated rating scales
- Relapse prevention planning as patients achieve remission of symptoms
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, and counseling.<sup>33</sup>

Pilot programs in Pennsylvania designed for Medicaid beneficiaries with high needs incorporated enhanced care coordination as a core element. These interventions led to lower mental health-related hospitalizations, lower readmission rates, and fewer ED visits.<sup>34</sup> The use of care coordination and integration is one of four components identified in effective models of OUD treatment in primary care.<sup>35</sup> States that have implemented these models have seen increased provider capacity and improved access to MAT.

### *State Examples*

#### Massachusetts

Massachusetts developed a Nurse Care Manager Model, in which nurses at FQHCs work in care teams that include a primary care provider and a medical assistant to manage up to 125 patients with OUD. While the primary care provider prescribes buprenorphine, the nurse care manager leads care coordination activities:

- Conducts patient screening and intake,
- Provides patient education,
- Refers patients to other services such as counseling, and
- Monitors patient adherence to treatment.<sup>36</sup>

Over three years, the implementation of this model increased the number of waived physicians working in FQHCs in Massachusetts by 375 percent.<sup>37</sup>

### Vermont

To support the primary care settings in its “hub and spoke” model, Vermont used Medicaid funds to develop MAT teams consisting of one registered nurse and one master’s level behavioral health practitioner per 100 patients. These teams support multiple spokes depending on the number of patients at each spoke. The nurse and the behavioral health practitioner share care coordination duties. The nurse meets with new patients and monitors treatment, while the behavioral health practitioner provides brief counseling services, coordinates additional counseling, and helps patients address needs such as housing and transportation. The model increased the number of waived physicians in the state by 64 percent between 2012 and 2016.<sup>38</sup>

Community-based providers, such as primary care physicians and community health centers, are essential to a comprehensive treatment system for people with OUD. In addition to screening patients to identify people with an OUD or at risk for developing one, community-based providers can prescribe medications and connect patients with psychosocial counseling or other services. Receiving services from community-based providers can increase patients’ comfort with starting therapy and reduce other barriers, such as the distance patients might need to travel to receive care.

To meet the treatment need, Delaware officials in the Department of Health and Social Services (DHSS) should create incentives to increase the number of treatment providers beyond addiction medicine specialists to include community-based providers who can prescribe buprenorphine and naltrexone, two of the three FDA-approved medications to treat OUD. Buprenorphine is a medication that can be taken by patients at home while naltrexone is a long-acting injectable medication lasts for 30 days between administrations. To prescribe buprenorphine, physicians must take an eight-hour Drug Enforcement Agency (DEA)-mandated course and register with the agency.

Unfortunately, there is a shortage of providers nationwide who have taken the course and are actively prescribing buprenorphine.<sup>39</sup> Delaware has 1.36 prescribers per 10,000 residents—Maryland and Pennsylvania exceed that figure by 49 and 29 percent, respectively.<sup>40</sup> As shown in Figure 2 on page 25, several areas in Kent and Sussex counties have significant rates of fatal opioid overdose, but lack buprenorphine prescribers.

One method to increase the number of community-based providers is to increase the reimbursement rates for SUD treatment providers. Recognizing need to establish competitive payment rates, the Division of Substance Abuse and Mental Health (DSAMH) has started the process to re-evaluate the current rates for SUD services. This payment review could augment the other positive steps Delaware has taken to build up its treatment infrastructure. When implemented, higher reimbursement rates have been shown to increase provider participation, as sign in programs carried out in other states.

### *State Example*

#### Virginia

In evaluating strategies for increasing community-based providers, Virginia is a promising example that Delaware could use as a model. Virginia substantially redesigned its SUD benefit to engage community-based providers in delivering outpatient treatment with MAT using a Centers for Medicare and Medicaid Services (CMS) section 1115 waiver. Virginia added multiple services to its Medicaid benefit to offer the full American Society of Addiction Medicine (ASAM) continuum of care with an emphasis on strengthening Commonwealth-wide capacity.

With the funding appropriated in the Commonwealth's 2016 budget,<sup>41</sup> the Department of Medical Assistance Services (DMAS) established a workgroup\* tasked with redesigning the Medicaid benefit to accomplish goals outlined in the budget. The workgroup included a cross-section of Commonwealth stakeholders. In less than six months, the workgroup developed and submitted a Medicaid waiver to CMS to create the Addiction and Recovery Treatment Services (ARTS) benefit. The benefit was implemented one year after creation of the workgroup.

Virginia's new investment for treatment services 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 benefits:

- 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 SUD. 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; and
- Elimination of the prior authorization requirement for buprenorphine.<sup>42</sup>

In partnership with provider associations, Virginia's Medicaid program also provided education and training across the Commonwealth on the details of the ARTS program, how to provide assessment, screening, and monitoring for at-risk patients, integrating MAT into outpatient

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\* 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, hospitals, peer recovery organizations, and consumers.



clinical practice, and how to develop a business model that includes OUD treatment in primary care. Additionally, Medicaid offered buprenorphine waiver training and billing support. These trainings were available in all parts of the Commonwealth, including twenty-eight separate events, and open to physicians and appropriate support staff.

In the first year following implementation of ARTS in Virginia, the number of Medicaid providers offering MAT and the number of Virginians receiving MAT increased rapidly and dramatically:

- The number of outpatient providers billing for ARTS services increased by 173 percent, which includes 848 providers who prescribe buprenorphine for OUD.
- The number of physicians offering outpatient treatment for OUD to patients with Medicaid increased by 358 percent.
- 34 percent more enrolled individuals received pharmacotherapy for OUD.

Access to MAT for underserved populations, such as pregnant persons, also increased due to these reforms. For example, treatment rates for pregnant patients with SUD increased from 2 percent to 18 percent following ARTS implementation.<sup>43</sup> Increased provider capacity driven by these reforms narrowed the treatment gap. Prior to ARTS implementation, only 24 percent of Medicaid-covered individuals needing treatment for SUD in Virginia received it; a year following ARTS implementation, this figure increased to 40 percent.

In addition to increased access to MAT, ARTS contributed to decreases in preventable acute service use among Medicaid recipients. For instance, the number of ED visits related to OUD decreased by 25 percent, which contributed to a 9 percent overall decrease in ED visits by all individuals with Virginia Medicaid. The number of individuals with Medicaid who had an acute inpatient hospital stay related to OUD also decreased by 6 percent. Such reductions can lead to significant cost savings. In only the first five months of implementation, total spending on SUD-related ED visits declined by \$3 million (14 percent).<sup>44</sup> The effect of these reforms on other areas impacted by the opioid crisis, such as the criminal justice and child welfare systems, have not been evaluated, but represent other potential areas of cost savings.<sup>45</sup>

### *Solution*

The General Assembly should appropriate funds for care coordination for people in Delaware diagnosed with an SUD. The reimbursement rate for care coordination should be informed by SUD treatment providers and should be competitive with those of nearby states. The rate should be linked to quality standards established by DSAMH and reported by providers on an ongoing basis. The funding may be time-limited with an option to renew and should be sufficient to conduct an evaluation of associated cost-savings, such as reductions in SUD-related ED visits and inpatient hospital stays.

To better engage providers in the treatment of SUD, the General Assembly should direct DSAMH, the Division of Medicaid and Medical Assistance, and the Division of Public Health to collaborate with provider associations including the Medical Society of Delaware and the Delaware chapter

of the American College of Obstetricians and Gynecologists to develop and disseminate state-wide provider outreach and education. Providers should be offered free trainings on the following topics:

- Buprenorphine waiver training
- Application of ASAM criteria in practice
- Best practices for treating pregnant patients with OUD
- Best practices for addressing co-occurring conditions, including screening and referral to appropriate services, and
- Setting up Medicaid billing practices.

Once these providers are established, they should be included in the Delaware Treatment and Referral Network so that other providers can easily refer their patients to them.

**Recommendation 2:** The Delaware General Assembly should consider directing the Division of Substance Abuse and Mental Health to issue regulations to allow for medication units, dosing sites associated with opioid treatment programs, in order to expand the capacity of existing treatment facilities and integrate methadone into other types of healthcare settings.

### *Problem*

Although Delaware has many opioid treatment programs (OTPs) per capita, patients cannot easily access methadone in integrated care settings that can address their co-occurring needs such as other chronic health conditions and mental health disorders.

### *Background*

OTPs, which provide medication, counseling, and other services for individuals with OUD, are a critical part of any state's treatment system. Like other chronic diseases, the right medication to treat OUD varies 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 visit OTPs daily to receive their medication and engage in regular counseling sessions.

OTPs are an important part of the treatment system in Delaware. Over 90% of people on MAT in Delaware who receive care at specialty substance use treatment facilities (which include residential and inpatient facilities as well as OTPs and other outpatient settings) get their care at OTPs.<sup>\*46</sup>

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\* These data are 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%. See Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS)," <https://www.samhsa.gov/data/data-we-collect/nssats-national-survey-substance-abuse-treatment-services>.

Methadone, which can only be prescribed at OTPs, is the most rigorously studied medication available for the treatment of OUD, with a large body of research demonstrating its effectiveness.<sup>47</sup> The safety of methadone maintenance therapy as a treatment for OUD is also well-established. Methadone-related overdoses are primarily associated with its use for the treatment of pain, not for its use in treatment of OUD.<sup>48</sup>

Delaware has a robust OTP delivery system that facilitates access to all forms of MAT. The state ranks third in the country in OTPs per capita.<sup>49</sup> Of the 17 OTPs in the state, nearly all provide buprenorphine and naltrexone, in addition to methadone. Further, the majority accept Medicaid, a major insurer for individuals with a substance use disorder.<sup>50</sup> OTPs are also an important part of the care of pregnant women with OUD. MAT with buprenorphine or methadone is the standard of care for pregnant persons with OUD because of improved maternal and neonatal outcomes when combined with comprehensive prenatal care.<sup>51</sup>

However, because methadone is most often administered daily, the time it takes patients to access OTPs affects treatment retention. A study in Spokane County Washington found that a distance of just a few miles can make a difference; patients who lived more than 10 miles from an OTP were approximately 30 percent more likely to miss a dose than patients living within 5 miles of their provider.<sup>52</sup> And patients in low or moderately populated areas must travel farther to access OTPs.<sup>53</sup>

To increase the availability of MAT, the Substance Abuse and Mental Health Services Administration (SAMHSA), which oversees OTPs at the federal level, permits the establishment of medication units to dispense methadone. OTPs establish these facilities to provide daily dosing at a location that may be more convenient to patients; the facilities can also conduct drug urine screens. Patients seen at medication units can still receive other required services, such as counseling, at the affiliated OTP.<sup>54</sup> Like OTPs, medication units must register with the federal Drug Enforcement Administration and comply with requirements related to the security and storage of methadone.<sup>55</sup>

States are responsible for creating specific regulations regarding the operation of medication units, such as distance requirements from the original OTP and sites where medication units can be located. These regulations can also promote the integration of methadone treatment into other types of settings and healthcare systems. In California's adoption of a hub and spoke delivery system, medication units can serve as a hub and coordinate with other providers.<sup>56</sup> In Ohio, eligible locations include homeless shelters, jails, prisons, county or local boards of public health, federally qualified health centers, providers certified to provide ASAM level three residential services, and Appalachian counties, which are located in the southern and eastern parts of the state.<sup>57</sup> Integrating substance use treatment into other systems helps people with OUD address the multiple challenges they often face, such as other chronic health conditions and mental health disorders,<sup>58</sup> involvement with the criminal justice system,<sup>59</sup> and homelessness.<sup>60</sup>

### *Solution*

With direction from the General Assembly, the Division of Substance Abuse and Mental Health should issue final regulations to allow for medication units by September 1, 2019. These regulations should include provisions for integrating MAT into more care settings, expanding the reach of existing OTPs, and incorporating medication units into the delivery system being developed by the START Initiative.

These regulations would detail the information OTPs would need to submit as part of an application to open a medication unit, and include distance, location types and/or other requirements for operating these facilities as determined by DSAMH. Non-metropolitan areas with low treatment availability could be appropriate sites for medication units.

Throughout the public rulemaking process, DSAMH should engage with OTPs, FQHCs, and health systems to establish these dosing sites.

**Recommendation 3:** The Division of Medicaid and Medical Assistance—in collaboration with the Division of Substance Abuse and Mental Health—should amend its Medicaid managed care contracts to mandate a common assessment tool based on the current American Society of Addiction Medicine Criteria for substance use disorder diagnoses and patient placement.

### *Problem*

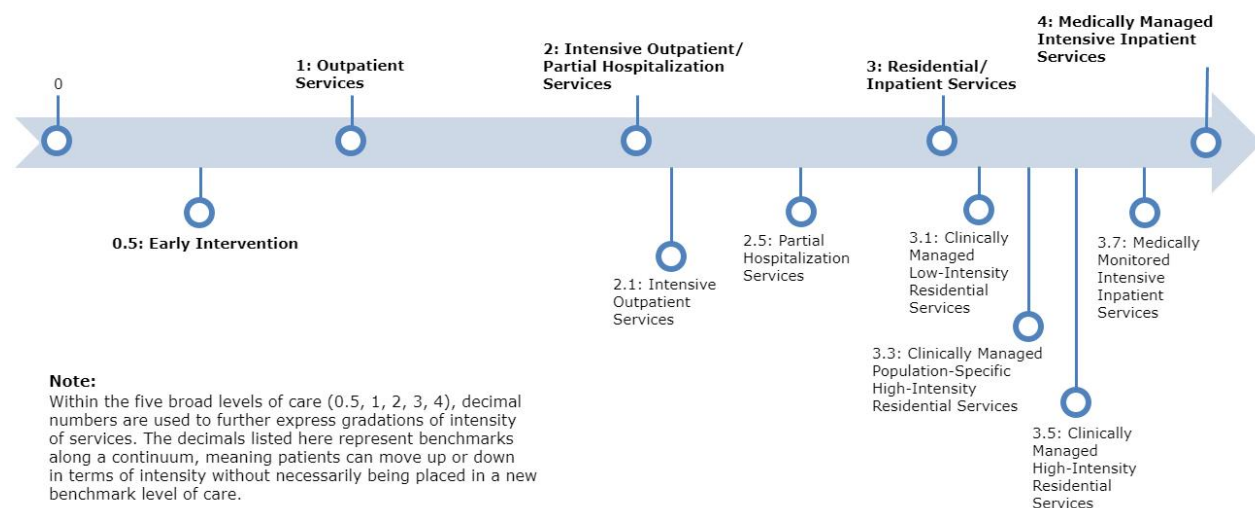
Because providers and payers in Delaware do not use the same approach to assess patients with substance use disorder, patients can be placed in inappropriate levels of care which hinders recovery.

### *Background*

Recommendation 1 supports funding for care coordination as a necessary element for treatment system transformation, as well as a vehicle to support and sustain the participation of treatment providers. As Delaware builds its START Initiative and Overdose System of Care, proper patient assessment is another important element for achieving the best outcomes for patients who need SUD services. The American Society of Addiction Medicine (ASAM) has produced widely accepted guidelines for this purpose, and research supports the value of the consistent use of evidence-based assessment tools to match patients to the level of care tailored to their needs.

The appropriate level of treatment is based on a holistic assessment of patients in areas that include their other health conditions, readiness for change, living environment, and other factors.<sup>61</sup> Once patients' needs are understood through assessment, they can be assigned to a level of care that will serve them best, as shown in the figure below.

Figure 1: The ASAM levels of care



Source: *The American Society of Addiction Medicine*

Research on the ASAM Criteria and patient placement suggests that matching patients to the appropriate treatment setting improves outcomes. A 2014 study using the ASAM criteria in Norway found that appropriately matched patients were more likely to be ready to step down to a lower level of care than patients placed in a higher or lower level of intensity than necessary, indicating better treatment progression.<sup>62</sup> The study also found that the criteria were able to appropriately match patients to care for co-occurring psychiatric disorders.<sup>63</sup> Another study conducted in Massachusetts in 2007 found that placing patients in a level of care higher or lower than they needed resulted in more treatment no-shows. This effect was especially strong for patients with co-occurring psychiatric disorders who received a higher than necessary level of care.<sup>64</sup> In addition, a study of 95 veterans at a Veterans Administration hospital in Massachusetts found that patients with OUD who received a lower level of care than needed had twice as many hospital bed days over the following year than patients who were matched to the right treatment setting or could have been treated in a lower level.<sup>65</sup> These studies suggest that the consistent use of evidence-based assessment tools delivers better outcomes for patients at lower costs.

The use of these criteria and the importance of providing the appropriate level of treatment are well accepted within the state of Delaware by state agencies, private insurers, and treatment providers. The Division of Substance Use and Mental Health (DSAMH) requires an assessment of patients according to these criteria to determine eligibility and placement for long-term substance use treatment.<sup>66</sup> In compliance with federal requirements, the Division of Medicaid and Medical Assistance (Medicaid) cites the utilization of appropriate SUD treatment based on the ASAM criteria as one of the goals of the draft 1115 substance use disorder amendment waiver application.<sup>67</sup> Two of the largest insurers in the state, Aetna and Highmark Blue Cross Blue Shield,<sup>68</sup> both incorporate ASAM criteria in making their coverage decisions.<sup>69</sup> Several different

providers have informed Pew that they use ASAM criteria with patient intake and clinical decision-making.

Despite the broad acceptance of the ASAM Criteria, its use varies among payers and providers. At present, the major SUD treatment providers and payers in Delaware use different assessment tools. Applying different tools can lead to conflicting expectations on the proper clinical placement of patients. For example, providers and payers could disagree on the appropriate course of treatment for a patient if they use different tools to evaluate that individual's co-occurring mental health conditions. These disagreements on clinical placement and medical necessity have led to uncompensated service delivery to patients. An informal roundtable discussion of treatment providers held by the Ability Network of Delaware in September 2018 revealed that the total cost of unpaid claims for the members present was \$15 million.<sup>70</sup> While payers and providers must communicate to resolve payment challenges, the lack of a uniform assessment tool used throughout the state prevents consistency in clinical decision-making.

### *State Examples*

#### Oregon

To address both patient placement and payment challenges, states such as Oregon and Minnesota have reformed the ways in which patients are assessed and placed in the appropriate level of care. In Oregon, as part of a shift to managed care for Medicaid substance use treatment in the 1990s, the state implemented standardized patient placement criteria. A study comparing treatment placement in Oregon to a neighboring state found that after implementing the standardized criteria, patients in Oregon were more likely to be placed in the appropriate level of care.<sup>71</sup>

#### Minnesota

In 2013, the Minnesota Department of Human Services (MDHS) submitted a comprehensive report to its legislature with an analysis of the barriers in the state's treatment system. The report noted payment barriers and convoluted patient placement processes, which include a multiplicity of assessment tools and prior authorization requirements, that ultimately prevented patients from obtaining care seamlessly. In response to the report, the state passed legislation establishing pilot projects to implement its recommendations, including a streamlined assessment process.<sup>72</sup> In 2017, Minnesota's legislature passed a law to expand the pilots statewide, directing the Medicaid agency to add comprehensive assessments to Medicaid benefits and identify vendors eligible to perform assessments.<sup>73</sup>

### *Solution*

The Division of Medicaid and Medical Assistance, in collaboration with The Division of Substance Abuse and Mental Health, should choose a single assessment tool based on the ASAM criteria and, through contract amendments, mandate its use by the MCOs and contracted SUD treatment providers when initiating or reassessing care for a person with an SUD diagnosis. A common tool would help payers and providers across the state be more consistent in their medical necessity and patient placement determinations. It would also ensure that Medicaid patients are placed in the level of care that meets their individual needs.

# Substance Use Disorder Workforce

## Background

Delaware, like many other states, does not have enough providers able to prescribe buprenorphine, one of three FDA-approved medications to treat opioid use disorder (OUD). The state has only 1.36 waived prescribers per 10,000 residents. This figure lags neighboring states Maryland and Pennsylvania, which have prescriber rates that are 49 percent and 29 percent higher, respectively.<sup>74</sup>

This dearth of providers is one reason that fewer than half of the people in the state who need treatment for OUD receive it, according to a needs assessment commissioned by the state Department of Justice in 2017.<sup>75</sup> Another analysis\* reveals that only 15.7 percent of Delawareans with commercial insurance and an opioid-related problem in the study sample received buprenorphine, compared to an average of 25.3 percent in seven nearby states.<sup>76</sup>

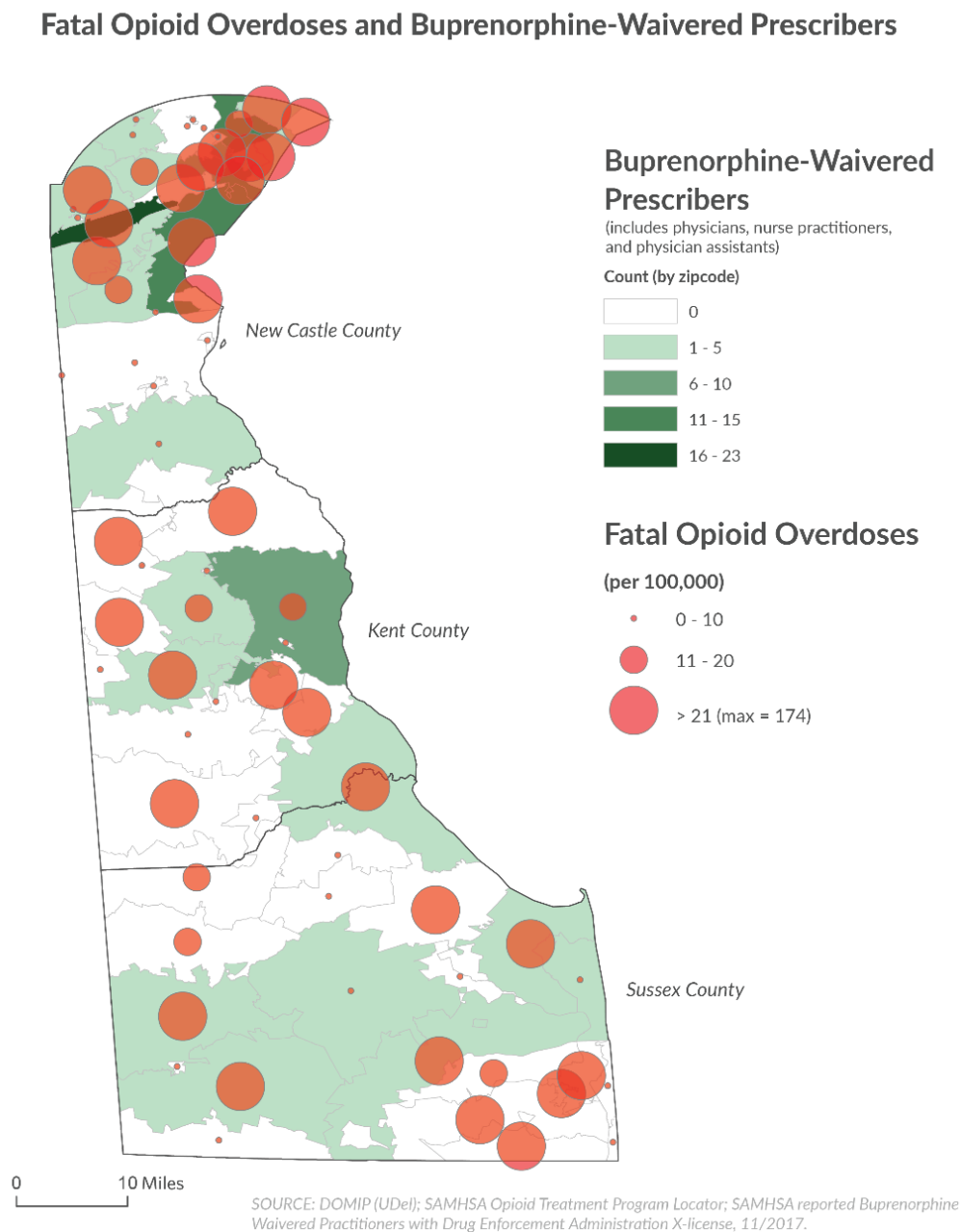
Providers are also unevenly distributed across the state. As shown in the maps below, many zip codes in Delaware do not have a single waived buprenorphine prescriber, and several of these underserved zip codes have high overdose rates. In particular, providers with a buprenorphine waiver are concentrated in the northern part of New Castle County, though many areas of Kent and Sussex County also have high opioid overdose rates.

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\*The source of these data is an analysis of the MarketScan® Commercial Claims and Encounters (MarketScan) Database from IBM. These data show the percentage of individuals in the MarketScan commercial data with opioid-related problems receiving opioid related treatment. This data set contains reimbursed healthcare claims for persons enrolled in more than 250 medium and large employer-sponsored health plans. These data represent approximately 56 million enrollees per year, an estimated one third of people covered by employee-sponsored health insurance plans. The number of Delaware and enrollees represented in MarketScan were relatively stable from 2011-2016. Because the MarketScan data only includes data on the commercially insured from a select group of employers, the actual treatment access rates in the commercial population may differ. See The Penn State Hershey Public Health Sciences Center for Applied Studies in Health Economics, "MarketScan" (accessed February 11, 2019), <http://cashe.psu.edu/resources/marketscan/> and the Henry J. Kaiser Family Foundation State Health Facts, "Health Insurance Coverage of the Total Population" (2017), <https://www.kff.org/other/state-indicator/total-population>.



Figure 2: Some zip codes without buprenorphine-waivered prescribers have high overdose rates (2017)



Sources: Substance Abuse and Mental Health Services Administration reported buprenorphine-waivered practitioners with Drug Enforcement Administration X-license (November 2017) and the University of Delaware Center for Drug and Health Studies, "Delaware Opioid Metric Intelligence Project" (accessed January 23, 2019), <http://udel.maps.arcgis.com/apps/MapSeries/index.html?appid=f6bfa2985e3747d9bae1d70a9326ff0b#>.

Even when waived providers are present, they may not be actively treating patients with OUD. Nationally, providers with a waiver to prescribe buprenorphine treat few patients. An analysis of three states (California, Maine, and Ohio) found that physicians waived to prescribe to a maximum of 30 patients had a monthly average of just 14 patients, and physicians who could prescribe buprenorphine to a maximum of 100 patients had a monthly average of 43 patients.<sup>77</sup> Further, an estimated one-third to one-half of providers nationwide who have received the waiver do not prescribe any buprenorphine to treat OUD.<sup>78</sup> In a survey of rural physicians, providers most frequently cite concerns over drug diversion, lack of mental health and psychosocial supports, and time constraints as barriers to prescribing buprenorphine.<sup>79</sup>

Delaware is not alone in needing to grow its SUD workforce. The number of people with OUD far exceeds the treatment capacity across the country.<sup>80</sup> In 2017, an estimated 2.1 million people aged 12 or older had OUD,<sup>81</sup> yet almost half (44 percent) of U.S. counties did not have a physician who had obtained the necessary credential to prescribe buprenorphine.<sup>82</sup> The treatment gap is likely even larger than this data suggests: a national survey of rural physicians approved to prescribe buprenorphine found that nearly a third (28.5 percent) of them either never prescribed or no longer prescribed buprenorphine.<sup>83</sup>

Patients in Delaware may also face challenges in traveling to appointments with the limited number of prescribers in the state. According to a survey conducted for the Delaware Division of Public Health, in 2015, nine percent of adults in Delaware did not see a doctor in the previous year because of transportation problems.<sup>84</sup>

Pew recommends two policy changes to increase the provider workforce through professional regulation changes and the expansion of telemedicine for MAT in Delaware.

## Recommendations

**Recommendation 4:** The General Assembly should consider amending the Medical Practice Act to ensure that all waived physician assistants can prescribe buprenorphine regardless of the waiver status of their supervising physicians.

### Problem

Many people in Delaware cannot readily access buprenorphine prescribers.

### Background

The 2016 federal Comprehensive Addiction and Recovery Act (CARA) gave nurse practitioners and physician assistants the ability to prescribe buprenorphine for OUD.<sup>85</sup> To obtain a waiver to prescribe buprenorphine, the Drug Enforcement Administration (DEA) requires physicians take an eight-hour course and register with the agency.<sup>86</sup> Physician assistants and nurse practitioners must also take an additional 16-hour course after the initial course, equaling 24 hours of training to prescribe buprenorphine.<sup>87</sup>

This change has contributed to an increase in the number of waived providers; between 2012 and 2017, the number of waived providers—including physicians, nurse practitioners, and physician assistants—per 100,000 population doubled in rural areas and nearly doubled in urban areas.<sup>88</sup> The 2018 federal SUPPORT for Patients and Communities Act made this authorization permanent for nurse practitioners and physician assistants and temporarily authorized other providers, such as clinical nurse specialists, to become waived prescribers.<sup>89</sup> As discussed previously, however, the total number of waived prescribers is still inadequate to meet the treatment needs of Delaware residents.

In states such as Delaware that require physician assistants to work in collaboration with or under the supervision of a physician, federal law does not require the qualifying physician to also obtain a waiver to prescribe buprenorphine. However, Delaware law does require this, stating that a “supervising physician may not delegate medical acts to a physician assistant that exceed the physician’s scope of practice.”<sup>90</sup> In November 2017, only 115 physicians had a waiver to prescribe buprenorphine in Delaware, limiting the potential entry of physician assistants who may wish to treat people with OUD.<sup>91</sup>

According to conversations with stakeholders, the statute as currently written contributes in part to the small number of physician assistants obtaining the federal waiver to prescribe buprenorphine. In Delaware, only five<sup>92</sup> of the 258 physician assistants<sup>93</sup> in the state have obtained waivers to prescribe buprenorphine, in part because they are only permitted to use such waiver authority if their supervising physician has also obtained a waiver. Given the small number of buprenorphine-waivered physicians in the state, even a small increase in the number of physician assistants with the capacity to prescribe buprenorphine would significantly increase treatment capacity.

Five states have already removed such a restriction: California, Maine (for physician assistants licensed by its osteopathic board), Montana, New Mexico (for physician assistants licensed by the state’s medical board), and Wisconsin.<sup>94</sup>

### *Solution*

The General Assembly should pass legislation to amend Subchapter VI of the Medical Practice Act (§ 1771 Physician’s duties in supervision of a physician assistant) to explicitly permit physician assistants to obtain and use a waiver to prescribe buprenorphine, regardless of their supervising physicians’ waiver status.

These changes would not affect the current scope of practice for physician assistants or alter requirements to enter collaborative practice or physician supervision agreements. However, removing these waiver barriers could increase access to treatment, particularly in areas of the state that face significant shortages of buprenorphine-waivered physicians. This statutory change would also place SUD treatment provider regulations in Delaware in line with the intent of recent federal policy.

**Recommendation 5:** The Board of Medical Licensure and Discipline should remove the requirement for providers to obtain a waiver to prescribe buprenorphine via telemedicine. If this requirement is not removed, the Division of Substance Abuse and Mental Health should publish guidance and offer technical assistance to providers on how to obtain such a waiver.

### *Problem*

There are few waived buprenorphine prescribers in Kent and Sussex Counties.

### *Background*

While there are 1.36 waived buprenorphine prescribers per 10,000 residents across Delaware, they are not evenly distributed across the state. New Castle county has 1.86 providers per 10,000 residents, while Kent and Sussex have just .79 and .80, respectively.<sup>95</sup> The concentration of providers in the southern counties is below the 50-state median of .99 per 10,000 residents.<sup>96</sup>

Telemedicine has shown promise in helping people access medication-assisted treatment (MAT) when providers are not available in their area. Multiple studies have demonstrated that behavioral health care can be effectively delivered via telemedicine. A Cochrane systematic review of the effectiveness of telemedicine for a variety of conditions included seven studies on the delivery of therapy for mental health or SUD. The review found that telemedicine was just as effective as face-to-face services on multiple outcomes, including reductions in condition severity, increased treatment adherence, and patient satisfaction.<sup>97</sup>

Several studies have shown the effectiveness of delivering MAT via telemedicine:

- West Virginia's Comprehensive Opioid Addiction Treatment (COAT) program uses videoconferencing for buprenorphine prescribing and medication management.<sup>98</sup> Patients living hundreds of miles from the treatment center participate in virtual group-based medication management followed by group therapy in the same visit. Retrospective analysis of the COAT program found comparable rates of treatment retention and abstinence from drug use when treatment was delivered via telemedicine or provided in-person.
- The University of Maryland, Baltimore (UMB) partnered with a drug treatment center in rural Western Maryland offering intensive outpatient treatment and transitional housing after the center's single waived provider retired, leaving the program's patients without access to buprenorphine.<sup>99</sup> Patients at the treatment center had a videoconference with a waived psychiatrist from UMB who conducted an evaluation, created a treatment plan, and followed up with each patient. The drug treatment center provided additional services and was responsible for conducting urine drug screens. A retrospective chart review found that treatment retention rates were comparable to those observed in urban office-based outpatient treatment.
- In Ontario, Canada, patients on MAT (either buprenorphine or methadone) can see their physician through in-person appointments, telemedicine, or a combination of the two.<sup>100</sup> For telemedicine encounters, the patient goes to a nearby clinic to have a secure teleconference with the physician. A retrospective analysis found that patients treated

via telemedicine—either primarily or in conjunction with some in-person visits—had better treatment retention rates than those primarily seen in-person. All three groups had similar rates of negative urine screens after one year.

Additionally, research has found that for the purposes of treating SUD, most telemedicine visits are used to complement—not totally replace—in-person care and are most often used by individuals with severe SUD.<sup>101</sup>

Multiple federal and state safeguards limit the risk of telemedicine being used to inappropriately prescribe buprenorphine:

- The federal Drug Enforcement Administration (DEA) requires training to prescribe buprenorphine for OUD in any setting. This training covers the appropriate clinical use of the medication, patient assessment, relapse prevention, and other best practices, equipping providers with the information they need to prescribe buprenorphine safely.<sup>102</sup>
- The DEA has also established that practitioners can use telemedicine to prescribe buprenorphine without having previously examined the patient in person only under two scenarios: 1) if the site where the patient is (the originating site) is a DEA-registered hospital or clinic, or 2) if the patient is in the physical presence of a provider with a DEA registration.<sup>103</sup>
- State law requires providers to have an active Delaware license to provide any treatment via telemedicine.<sup>104</sup> If necessary, the Board of Medical Licensure and Discipline and the Board of Nursing could discipline any provider who is prescribing inappropriately.
- Except for those originating from a substance use treatment program, all buprenorphine prescriptions must be reported to the Delaware Prescription Monitoring Program (PMP) when they are filled at pharmacies in the state.<sup>105</sup> This allows the Office of Controlled Substances to monitor buprenorphine prescribing practices, regardless of whether they are prescribed following an in-person or telemedicine encounter.

Treating MAT via telemedicine could also reduce geographic barriers to treatment by reducing the amount of time patients need to travel to a provider and expand the workforce by allowing prescribers who practice in other states but also have a Delaware license to treat residents.

Delaware has recognized the potential for telemedicine to increase access to behavioral health services. Expansion of these services was identified as a priority in both its 2014-2016 and 2017-2020 strategic telehealth action plans.<sup>106</sup> Generally, the state also has coverage and reimbursement policies that support the use of telemedicine across the health care system. Medicaid reimburses for telemedicine visits at the same rate as for in-person visits and private payers must do the same.<sup>107</sup> Yet challenges to implementing telemedicine for treating OUD remain.

In June 2018, the Board of Medical Licensure and Discipline promulgated rules which prohibit the prescribing of opioids via telemedicine except by substance use treatment programs which receive a waiver from DSAMH.<sup>108</sup> However, as of December 2018, no provider has received such

a waiver. Conversations with stakeholders indicate confusion regarding the process for obtaining one, as well as the types of providers who would be eligible for a waiver, such as a licensed substance use facility or community-based provider.

In a preliminary scan of state practices, Pew found that at least six states (Delaware, Connecticut, Indiana, Michigan, New Hampshire, and Ohio) allow the prescribing of opioids or other controlled substances via telemedicine in at least some circumstances.<sup>109</sup> Of these, Delaware is the only one to require the provider to obtain a waiver such as this from the state.

### *Solution*

Given the other state and federal precautions in place to ensure that buprenorphine is not prescribed inappropriately, as well as the shortage of buprenorphine prescribes in rural parts of the state, the Board of Medical Licensure and Discipline should remove the requirement that providers obtain a waiver from DSAMH in order to prescribe buprenorphine via telemedicine.

If the Board elects not to remove the requirement, DSAMH should publish guidance for providers regarding the process for obtaining a telemedicine waiver no later than June 2019. This guidance should clarify the process for obtaining a telemedicine waiver, the types of providers who are eligible, and any privacy or cybersecurity requirements that must be met before a waiver is approved. DSAMH should collaborate with the director of telehealth planning and development in Delaware Health and Social Services to develop these requirements, conduct outreach to make providers aware of the waiver process, and offer support to providers who are interested in receiving a telemedicine waiver.

For five years, beginning in December 2019, DSAMH should report annually to the Behavioral Health Consortium the number of providers who have received the waiver and an estimate of the amount by which telemedicine has increased treatment capacity in the state. The number of providers with a waiver in December 2018 should be used as a baseline to assess the impact of the published guidance and technical assistance.

Clarifying these rules and providing technical assistance around the waiver process would increase provider use of telemedicine for treating OUD and increase access to evidence-based treatment across the state.

# Coverage and Reimbursement

## Background

Public and private payer policies are an important component of a comprehensive treatment system. Even among the insured, payer policies can serve as a barrier to accessing care. One study found that between 2008 and 2013, 11 percent of people with private insurance who felt a need for but did not receive SUD treatment reported financial factors, such as treatment not being covered, as a barrier.<sup>110</sup>

The role of payers in an effective SUD treatment system goes beyond covering the services and various levels of care outlined in the American Society of Addiction Medicine's (ASAM) guidelines; it includes building an adequate treatment network, ensuring that screenings for SUD are part of routine care, educating patients about the disorder and helping them rapidly access high-quality, coordinated care that treats SUD as a chronic condition, and adapts to meet patients' individual circumstances.

Delaware has taken multiple steps to create such a system, including covering a range of services in Medicaid, which covers 20 percent of the non-elderly population in Delaware.<sup>111</sup> For instance, Medicaid pays for all three medications for OUD (methadone, buprenorphine, and naltrexone),<sup>112</sup> and all ASAM levels of care ranging from outpatient services to inpatient care.<sup>113</sup> The state is also currently reviewing Medicaid reimbursement rates for substance use treatment to ensure that they are set appropriately.

Delaware has also improved access to care for people with private insurance, which in 2017, covered 69 percent of people under 65 in the state:<sup>114</sup>

- In 2017, Delaware passed legislation prohibiting carriers from imposing “precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including in-patient treatment, of drug and alcohol dependencies.”<sup>115</sup> Similar laws have been passed in New Jersey<sup>116</sup> and New York.<sup>117</sup>
- Delaware also created the Substance Abuse Treatment Insurance Coverage Assistance Program within the Department of Justice (DOJ) in 2017.<sup>118</sup> This program provides legal assistance in obtaining coverage for substance use treatment to people in Delaware with private or public health insurance.<sup>119</sup> According to interviews with DOJ staff, through November 2018, the program had helped approximately 30 people in Delaware obtain medically necessary treatment.
- In August 2018, Delaware passed Senate Bill (SB) 230, which builds on the federal Mental Health Parity and Addiction Equity Act of 2008. SB 230 requires insurers to report annually, starting in July 2019, on how they determine medical necessity for substance use treatment and any treatment limitations in place. This report must also include an analysis showing that these criteria and treatment limitations are comparable to those for other conditions.<sup>120</sup>

Pew offers a recommendation to build off the work Delaware has done to improve coverage and reimbursement for people with private insurance.

## Recommendation

**Recommendation 6:** During calendar year 2019, the Behavioral Health Consortium should form a task force of private insurers, employers, and other stakeholders to provide to the Consortium an agreed upon set of policies that private payers will adopt with the goal of increasing access to SUD treatment for privately-insured Delawareans. This agreement should be provided to the Consortium by September 1, 2019.

## Problem

Delaware residents with OUD and private health insurance access MAT at lower rates than in neighboring states.<sup>121</sup>

## Background

Private insurance plays a significant role in addressing the opioid epidemic. Nationally, nearly 40 percent of non-elderly adults with OUD had private insurance in 2016. That year, private payers spent \$2.6 billion on treatment and overdose services for people with large employer coverage, which may underestimate the total spending for this population since some people choose to pay for addiction-related treatment without billing their insurance company. This amount was a dramatic increase from 2004, when private payers spent just \$0.3 billion.<sup>122</sup>

As described above, Delaware has already taken several steps to help individuals with private insurance access substance use treatment. However, people with private coverage still face barriers to accessing care. Multiple providers and provider groups who spoke with Pew indicated that coverage for treatment is often denied. According to analysis of the MarketScan commercial data, in 2016 only about one-fifth (19.8 percent) of commercially insured Delawareans diagnosed with opioid-related problems received any treatment.<sup>123</sup> As shown in the following table, this is the lowest rate in the region that includes Delaware and surrounding states.



*Table 1: Compared to neighboring states, Delaware has the lowest percentage of patients with commercial coverage receiving any opioid-related treatment*

State	2014	2015	2016
<b>Delaware</b>	<b>28.62%</b>	<b>27.25%</b>	<b>19.77%</b>
New Jersey	32.31%	35.32%	30.31%
Pennsylvania	39.39%	35.34%	32.66%
Maryland	33.38%	38.77%	34.45%

*Source: Analysis of The MarketScan® Commercial Claims and Encounters (MarketScan) Database from Truven Health Analytics.\**

The ability of any state to conduct oversight of employer-sponsored health insurance is limited by the federal Employee Retirement Income Security Act of 1974 (ERISA), which prohibits states from regulating self-insured plans in which the employer bears the financial risk and pays another entity to administer the plan.<sup>124</sup> According to an estimate from the Delaware Department of Insurance, at least 32 percent of residents are covered by a self-insured plan.<sup>125</sup> This regulatory environment means that state agencies do not have the full range of policy tools that could be applied to increase access to treatment in the same way that state Medicaid programs have historically administered rules and regulations.

To address this gap, states such as Pennsylvania, Ohio and California have convened insurers to develop voluntary principles that guide how they cover treatment for OUD.

### *State Examples*

#### Pennsylvania

In the fall of 2017, representatives from the state’s largest insurers—including Aetna and Highmark, Delaware’s two largest commercial payers—met with state agencies to discuss aligning commercial policies for accessing OUD treatment with Medicaid policies. In October 2018, Governor Tom Wolf announced that the state had made an agreement with the insurers to remove prior authorization for medications for OUD and to place these medications in the lowest patient cost tier in their pharmacy benefits. However, this agreement did not apply to self-insured plans.<sup>126</sup>

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\* These data show the percentage of individuals in the MarketScan commercial data with opioid related problems who are receiving opioid related treatment. This data set contains reimbursed healthcare claims for persons enrolled in over 250 medium and large employer-sponsored health plans. These data represent approximately 56 million enrollees per year, an estimated one third of people covered by employee-sponsored health insurance plans. The number of Delaware and enrollees represented in MarketScan were relatively stable from 2011-2016. Because the MarketScan data only includes data on the commercially insured from a select group of employers, the actual treatment access rates in the commercial population may differ.

## Ohio

In October 2017, Ohio Attorney General Mike DeWine convened a task force of private insurers. After several meetings, the task force released a set of recommendations in June 2018. These recommendations included prevention, intervention, and treatment for OUD. The task force members agreed that insurers should eliminate or expedite prior authorizations for MAT and raise reimbursement rates for substance use treatment to be commensurate with rates for other conditions.<sup>127</sup>

## California

Smart Care California is a partnership of the state's largest insurers, the Department of Health Care Services, the state's health insurance marketplace, and the public employees retirement system.<sup>128</sup> In 2017, the partnership developed a checklist of practices that health plans and purchasers should follow to prevent and treat OUD.<sup>129</sup> These practices include ensuring that provider networks are adequate to meet the needs of members, creating incentives for primary care providers to prescribe buprenorphine, and providing case management to help people with OUD access treatment.

In 2017 and 2018, Smart Care California surveyed insurers to monitor the adoption of the checklist. Although none of the practices have been universally adopted to date, the state has seen increased take-up of several. For example, in 2017, only 32 percent of plans offered provider education and support for buprenorphine prescribing, but in 2018, 69 percent had adopted this practice and an additional 19 percent were in the planning stages. Additionally, by 2018, nearly all plans (92 percent) had removed authorization requirements for buprenorphine, while just a year earlier, only about a third of plans had adopted this practice.<sup>130</sup>

Convenings have also occurred at the national level. For example, sixteen insurers (including Aetna and Cigna—two of Delaware's largest carriers) have signed on to eight “national principles of care” developed by Pew and Shatterproof, a national nonprofit organization whose work focuses on ending the addiction crisis. These principles include the following consensus-driven commitments:

- Universal screening for SUD across care settings,
- Individualized assessment and treatment planning,
- Rapid access to appropriate care,
- Adjustments to treatment as necessary,
- Coordinated or integrated behavioral and medical care,
- Behavioral health interventions such as cognitive behavioral therapy,
- Access to all three FDA-approved medications for OUD, and
- Recovery and support services such as housing.<sup>131</sup>

The American Medical Association has also urged all payers, including private insurers, to cover MAT and remove administrative barriers to treatment, such as prior authorization.<sup>132</sup>

While such guiding principles create a necessary starting point that can ultimately deliver better outcomes for patients, concrete goals and reportable metrics will help the Behavioral Health Consortium (BHC) and other invested parties monitor progress and make adjustments, as needed. The BHC can look to work completed at the national level and initiatives in other states to guide the development of measures that can be used to assess the success of these new policies in increasing access to treatment. The National Quality Forum has developed and evaluated a set of measures for behavioral health and substance use.<sup>133</sup> The University of Vermont evaluated the state's hub and spoke OUD intervention with both quantitative and qualitative metrics to answer questions including whether changes have helped provide adequate access to OUD treatment.<sup>134</sup> The University of Maryland, Baltimore County evaluated the state's Opioid Health Home intervention, producing data on patient participation patterns, health care utilization trends such as emergency department use and length of inpatient hospital stays, health care quality outcomes such as hospital readmissions, as well as impacts on health care costs.<sup>135</sup>

### *Solution*

The BHC should form a task force to develop policies and procedures to increase access to coordinated, high quality, evidence-based substance use treatment for privately-insured Delawareans that will be implemented by private insurers. Members of this task force should include representatives from the following groups:

- The private insurance industry,
- A broad spectrum of employers, including the Delaware Division of Statewide Benefits,
- The State Chamber of Commerce,
- A member of the provider community who serves on the BHC,
- The Department of Insurance,
- The Delaware Department of Justice (DOJ), and
- The Division of Substance Abuse and Mental Health (DSAMH).

Pew can serve as an advisor to the state on the composition and mission of this task force in 2019 and help the state identify promising practices from other states and payers.

Businesses are a particularly important stakeholder given their role as both health care purchasers and employers. Nationally, people with OUD have higher health care costs than others—\$15,500 higher annually according to one study.<sup>136</sup> OUD also reduces productivity when people with OUD and their caregivers miss work or cannot fully function on the job.<sup>137</sup>

To support the work of the task force and identify specific areas for improvement and collaboration, the Delaware DOJ and the Eligibility and Enrollment Division within DSAMH should jointly prepare a report on private insurance coverage decisions no later than June 2019. This report should include the following elements:

- Data on the number of complaints the offices receive about denials,
- The reasons these denials are made, and
- How these disputes have been resolved.

The task force should also host a forum to hear from patients with private insurance about their experiences in accessing treatment for OUD. This report and forum will provide clarity on the challenges people with private insurance face when seeking treatment and will therefore help the task force create a set of practices that meets the needs of people in Delaware.

By September 1, 2019, the task force should provide to the BHC an agreed upon set of practices which will establish insurers in Delaware as national leaders in combatting the opioid epidemic. Using data from sources that may include the Delaware Health Information Network (DHIN) and the Delaware Opioid Metric Intelligence Project (DOMIP), the task force should establish a set of reportable metrics that answer treatment access questions, such as the percentage of privately-covered individuals with an OUD diagnosis who have received some form of evidence-based treatment, as well as treatment retention rates. These quality measures can also be structure- and process-oriented, such as the ratio of available care coordinators and care managers to the number of people who have an OUD diagnosis. The Division of Insurance should annually survey plans on their progress towards implementing these practices.

# Underserved Populations

## Background

Justice-involved individuals (people who are incarcerated, recently left incarceration, or are on probation or parole) have high rates of substance use disorder (SUD). Nationally, from 2007-2009 (the latest nationwide data available), 58 percent of people in prison and 63 percent of people serving sentences in jails met the medical criteria for a SUD pertaining to opioids or other depressants (excluding alcohol), marijuana, cocaine, methamphetamine or other stimulants, hallucinogens, or inhalants, while only 5 percent of the total general population age 18 or older met such criteria.<sup>138</sup> In Delaware, the Department of Correction (DOC) estimated that in 2017, 46 percent<sup>139</sup> of the over 6,300 people incarcerated<sup>140</sup> in the state had substance use issues.

Despite the high prevalence of SUDs (including opioid use disorder) in correctional populations, facilities nationwide have not widely offered medication-assisted treatment (MAT) during incarceration and have rarely made systematic efforts to connect people to treatment upon release. This puts individuals reentering the community at a high risk for relapse, overdose, and death as established by multiple studies:

- A New York City study found that individuals discharged from jails were more than twice as likely to die from drug-related causes as other city residents within the two-week period post release.<sup>141</sup>
- A ten-year study of mortality after prison release in Washington state showed that overdose was the leading cause of death and that overdose deaths of former prisoners accounted for 8.3 percent of the overdose deaths among persons aged 15 to 84 years in the state from 2000 to 2009.<sup>142</sup>
- A 2017 Massachusetts report found that compared to the rest of the adult population, the opioid-related overdose death rate is 120 times higher for persons released from prisons and jails.<sup>143</sup>

A comprehensive system that addresses correctional population-specific needs, offers MAT induction and continuation during incarceration, and coordinates after care for high-risk individuals could produce a lower mortality rate from overdose in Delaware.

On January 7, 2019, leadership from the Department of Medicaid and Medical Assistance (Medicaid) and the DOC, representatives from the state's two Medicaid managed care organizations (MCOs) and the DOC's health care provider, and other stakeholders met to discuss the need for a comprehensive treatment and reentry system, the progress that has been made towards this goal, and additional steps the state must take. The recommendations in this report reflect the results of this discussion, additional conversations with stakeholders, and promising practices from other states.

### *A Note on Delaware's Unified Correctional System*

Delaware is one of six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) which runs a “unified public safety system,” meaning both jails and prisons within the state fall under state administration. This contrasts with most other states in which state-run prisons are only responsible for individuals serving sentences over one year, while counties or cities run jails and usually house individuals detained for sentences of one year or less, as well as pre-trial individuals. Unified systems provide state control over *all* detained individuals directly from booking and can more easily implement new or enhanced treatment programs. Single jurisdiction control would likely facilitate the continuance of MAT for individuals who enter the system already on any form of treatment. Nevertheless, the variation in individual average length of stay and prior notification, including among community treatment providers and managed care organizations, of individuals’ release across jails and prisons remains a challenge for health care delivery even under a unified system.

## Recommendations

**Recommendation 7:** The General Assembly should consider appropriating sufficient funding for the Delaware Department of Correction to expand its provision of all three forms of FDA-approved medication-assisted treatment to all persons with opioid use disorder in any Delaware correctional facility.

## Problem

Most people with OUD in Delaware correctional facilities cannot access MAT.

## Background

Several decades of research consistently show the benefits of providing substance use disorder treatment for individuals with criminal justice system involvement.<sup>144</sup> The Legal Action Center, a non-profit organization that advocates for people with HIV/AIDS, substance use, and criminal justice involvement, suggests that prisons and jails should provide MAT to individuals with opioid use disorder (OUD).<sup>145</sup> The American Society of Addiction Medicine (ASAM) and the American Correctional Association recommend people in correctional facilities with OUD be evaluated for continued MAT when already taking the medication upon entry.<sup>146</sup>

The need to continue 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 under the Americans with Disabilities Act and the constitutional right to health care in jails and prisons. While this ruling applied to one person in one jail, similar lawsuits<sup>147</sup> have been filed in Maine and Washington state. These cases may portend a future change to the standard of care in correctional facilities that includes access to all three medications.

The three FDA approved medications—buprenorphine, methadone, and naltrexone—vary in contraindications (conditions for which a medication should *not* be prescribed), interactions with

medications used to treat other conditions, and potential side effects. Patients also differ in the medication they prefer.<sup>148</sup> Because of these factors, the decision regarding the right medication to take for OUD should be made jointly by the prescriber and the patient; prisons and jails should offer all three medications so that clinicians can offer the most effective treatment for every individual.

Rhode Island recently started such a program--with encouraging results. In July 2016, the Rhode Island Department of Corrections received a \$2 million appropriation to expand its pre-existing MAT services. With these funds, the state offers all three medications as clinically appropriate by contracting with an already-operating outpatient provider of opioid treatment in the state. This contract includes a universal screen for OUD upon commitment to the DOC, with immediate referral to the medical contractor, MAT induction for those screening positive, and continuation for anyone already receiving medication.<sup>149</sup>

In the twelve-month period from Oct 1, 2016 to September 30, 2017, Rhode Island provided MAT to 896 individuals in correctional facilities. Sixty three percent were on MAT at commitment while the remainder were initiated soon after.<sup>150</sup> On average, the state provided MAT to 303 individuals each month in the first six months of 2017. One hundred eighty people per month were treated with methadone, 119 with buprenorphine, and four with naltrexone.<sup>151</sup>

After implementing these reforms, Rhode Island saw a 61 percent decline in post-incarceration overdose deaths. This translated to a 12 percent reduction statewide.<sup>152</sup> Though the state is optimistic that providing MAT in correctional facilities will also save money,<sup>153</sup> data on potential cost savings are not yet available.

Rhode Island's experience is particularly relevant for Delaware because both states have unified public safety systems and expanded Medicaid eligibility. However, one important difference is that all of Rhode Island's correctional facilities are located on a single campus,<sup>154</sup> while Delaware has facilities across the state.<sup>155</sup>

While this may add logistical complexity to offering medications statewide, Delaware is primed to implement an expanded treatment system in its correctional facilities since the state already offers all three forms of MAT to some individuals. Since November 2017, participants in a DOC residential drug treatment program (Key-Crest) have been offered naltrexone—an FDA-approved medication to treat OUD—prior to release, but only 34 people have accepted an injection in twelve months. In late 2018, the DOC also started a pilot program which continues buprenorphine treatment for individuals who are detained for a probation violation and are already taking the medication. As of early December 2018, 10 people had received this continued treatment. Finally, pregnant patients have long been inducted or maintained on methadone because of the risk to the fetus caused by discontinuation.<sup>156</sup>

Although these initiatives are important, most people with OUD in correctional settings do not receive MAT. One reason for this treatment gap is lack of funding. An August 2017 treatment needs assessment commissioned by the Delaware Department of Justice estimated that it would

cost \$144,000 a year to provide methadone to 100 individuals and \$576,000 a year to provide name-brand buprenorphine-naloxone to 100 individuals.<sup>157</sup>

The Division of Substance Abuse and Mental Health (DSAMH) made a two-year funding commitment to the DOC of \$350,000 to expand MAT in correctional facilities beginning in early 2019.<sup>158</sup> This funding will allow the DOC to develop the policies and security procedures necessary to implement MAT in all facilities and provide services over two years, but currently there is no sustained source of funding.

### *Solution*

Everyone with OUD in Delaware correctional facilities should be able to access the medication that is appropriate for them based on clinical criteria and personal preferences. To make this possible, the state should take the following steps:

- 1) The DOC should develop the internal policies and procedures necessary to provide all three forms of medication in all facilities. These policies should include routine screening for OUD upon entry and procedures for helping people with OUD access continued treatment when returning to the community, in accordance with the reentry process outlined in Recommendation 8.
- 2) The DOC should use the \$350,000 it will receive from DSAMH in 2019 to amend its behavioral health contract to expand MAT services to the maximum possible number of people with OUD given this amount. The DOC should consider phasing facilities in to this expansion to help the department understand the logistical challenges of widely offering all three forms of MAT.
- 3) During calendar year 2019, the DOC should use this phased-in expansion to prepare an analysis of the number of people in Delaware correctional facilities with OUD, a projection of future need, the per patient cost of providing each medication including pharmaceutical, health service, and security expenses, the mix of medications used, and the number of patients served using DSAMH funding. This analysis should be the basis of a funding request for providing all three forms of opioid medication in all facilities that will be submitted to the Governor and General Assembly for the fiscal year 2021 budget.
- 4) The General Assembly should appropriate these funds. The DOC should then amend its behavioral health contract to provide all three forms of MAT in all correctional facilities.

By taking these steps, Delaware will be a national leader in treating underserved populations by providing all three forms of MAT to treat people with OUD in correctional facilities.

**Recommendation 8:** Medicaid, with input from the Department of Correction, should amend its contracts with managed care organizations to require care management for people with high care needs returning to the community, including individuals with OUD.

### *Problem*

People with OUD leaving Delaware correctional facilities are not connected with needed care to prevent relapse and overdose after release.



## Background

Connecting people with an OUD with health care as they leave prisons and jails is important to facilitate a smooth transition to community life and may, in fact, save lives. Approximately 95 percent of individuals serving a sentence in state prisons reenter the community.<sup>159</sup> For people on pre-trial detention, this return can happen quickly. Each week in 2016, more than half of the national jail population turned over.<sup>160</sup>

Delaware has long made efforts to help people leaving the custody of the DOC connect to community resources. In 2009, through Executive Order No. 7, the state adopted the Individual Assessment, Discharge, and Planning Team (I-ADAPT) reentry process.<sup>161</sup> I-ADAPT was developed in collaboration with the Departments of Correction, Health and Social Services, Education, Labor and the Delaware State Housing Authority. The goal was to create a reentry process that would meet each individual's needs, including obtaining identification documents, enrolling in public benefit programs, and providing assistance with housing, education, and job training.<sup>162</sup>

However, limited reentry services are available for the specific needs of people with OUD. They are principally provided through the Key-Crest program which, among other services, began in 2017 to offer participants one or two naltrexone injections prior to release. The aftercare component includes group sessions, counseling, and development of an individualized plan so that each person knows how and where to obtain ongoing monthly naltrexone treatment.<sup>163</sup> While this does help the limited number of people with OUD who opt in to Key-Crest access naltrexone, Delaware does not have a systematic approach to help them access methadone or buprenorphine.

Most recently, Governor Carney established the Delaware Correctional Reentry Commission.<sup>164</sup> This body is directed to build on current state initiatives, including I-ADAPT, to improve reentry processes and reduce recidivism. While the Commission is not charged with helping people returning to the community connect with substance use treatment, it will provide recommendations to increase employment and housing, which supports the recovery of people with OUD. During Pew's roundtable discussion with Medicaid and DOC leadership, several participants mentioned homelessness as a barrier to both recovery and successful reentry.

A systematic approach to reentry would help people returning to the community from incarceration as they face many challenges, such as finding employment and safe housing.<sup>165</sup> For individuals with OUD, the period immediately after discharge from incarceration is a particularly dangerous time for overdose and death<sup>166</sup> due to reduced physiologic tolerance for opioids after a period of presumed abstinence. This makes connecting people with OUD to care upon release vital for any state's efforts to reduce mortality rates from overdose.

However, in this difficult transition period, maintaining access to healthcare is not a priority for everyone. In a 2011 study, researchers interviewed people who had returned from prisons to the Denver, Colorado area to learn about their experience in accessing care in the two months following release. Many said they delayed accessing care until they had employer sponsored health coverage. (This study was conducted before Colorado expanded Medicaid in 2014).<sup>167</sup>

Ensuring that eligible people have Medicaid coverage immediately upon release and that individuals with OUD have care management services can help people reentering the community navigate the transition period and get the care they need.

Several factors currently prevent Delaware from connecting individuals reentering the community to care:

- As of fiscal year 2018, Delaware is one of only 16 states that terminates Medicaid eligibility for individuals detained awaiting trial and one of only 13 that terminates eligibility for individuals serving a sentence.<sup>168</sup> Individuals must reapply for benefits before their release date, adding additional administrative burdens to the DOC and the individual. While the state is working to change this, new rules have not yet been finalized.
- When persons leaving DOC facilities apply for Medicaid benefits, they do not select an MCO and these benefits are not automatically turned on at the time of the release. Instead, the individual must call Delaware Health and Social Services after release to finalize enrollment. According to an evaluation of the I-ADAPT process, approximately 20 percent of people who apply never complete this final step.<sup>169</sup>
- There is no process for the DOC to communicate with the Medicaid managed care organizations (MCOs). MCOs are therefore unaware of which new enrollees are returning to the community from incarceration and, of this group, which have health needs that require immediate care management services, such as OUD. The MCOs also lack access to DOC health records that would help them effectively serve their enrollees. Further, without knowing enrollees' reentry status, MCOs are unable to track their health care utilization, which could inform future improvements to the DOC's handoff process.
- Medicaid MCOs currently are unable to have contact with their future enrollees prior to them reentering the community. This prevents the MCOs from developing a care plan before a person's release. Instead, community providers including Connections, La Red, and Westside report attempting to connect with people leaving incarceration informally, such as through referrals from probation officers and word of mouth.

Other states have developed processes for ensuring that high needs individuals, including people with OUD, get the care they need when they leave correctional facilities.

In Ohio, the Department of Rehabilitation and Correction works with the state's Medicaid agency to ensure that all eligible individuals are enrolled in Medicaid and select an MCO ninety days before release. Additional care management services are provided to enrollees with "chronic risk indicators," defined as having hepatitis C or HIV, being pregnant, or having been diagnosed with two or more of the following: a chronic condition, a mental illness, or a SUD. These individuals' medical histories are shared with managed care staff who develop pre-release transition plans, review and refine them with enrollees via videoconference, and follow up within five days of release.<sup>170</sup>

Louisiana takes a similar approach, defining high needs individuals as persons with a serious mental illness, cancer, HIV, a disability, or moderate to severe SUD in combination with a serious

mental illness.<sup>171</sup> All high needs beneficiaries receive at least one pre-release contact by their selected MCO, and the MCOs serving these individuals receive a higher capitation rate.<sup>172</sup>

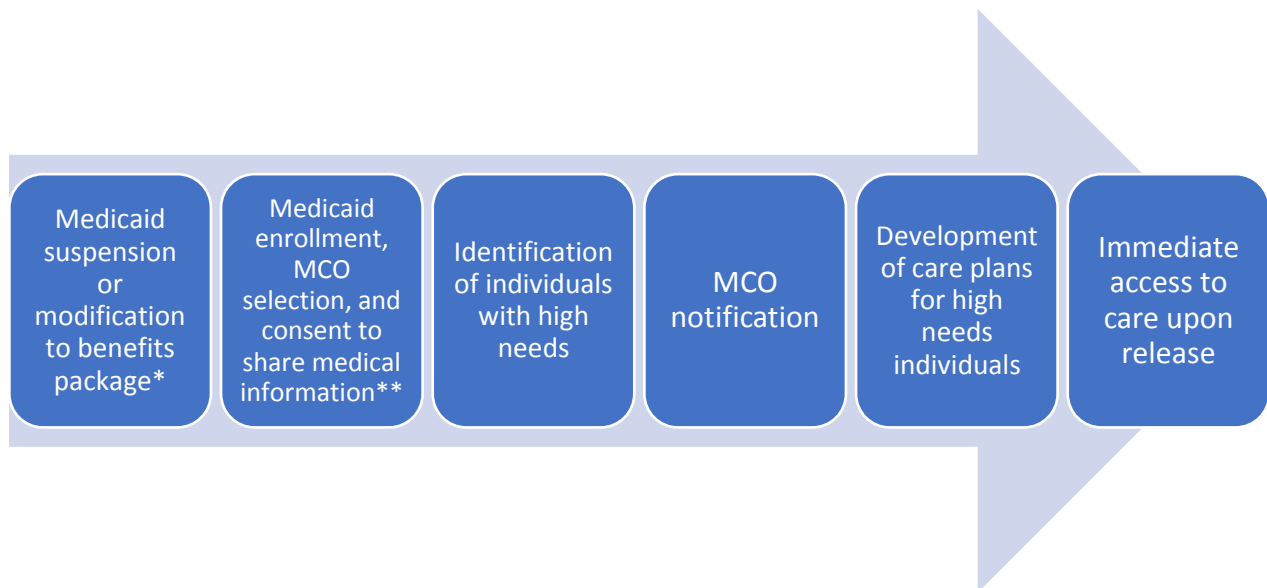
Similarly, the Arizona Health Care Cost Containment System (Arizona's Medicaid agency) defines high needs enrollees as individuals with chronic physical and/or behavioral diagnoses or other complex health needs and requires that each MCO "reach in" to identified enrolled reentrants with such needs prior to their release.<sup>173</sup> Care appointments as appropriate must be scheduled to occur within one week of the member's release.<sup>174</sup> Each MCO must have a designated justice liaison to work with the state's DOC and jails' representatives on issues regarding high needs individuals.<sup>175</sup>

Pew recommends the creation of a systemic process for connecting people with OUD to ongoing treatment when reentering the community. Should this process be created, multiple Delaware community-based providers indicated their willingness to work with the reentry population to ensure that their health needs, including treatment for OUD, are met.

### *Solution*

To ensure that people with OUD leaving correctional facilities can immediately access treatment upon release, the Division of Medicaid and Medical Assistance (Medicaid) and the Department of Correction (DOC) should collaborate in developing a reentry process that facilitates seamless connections to OUD treatment upon release (see Figure 3 below). To implement this process, Medicaid should amend its contract with its managed care organizations (MCOs).

Figure 3: A model for linking people with OUD to care following release from Delaware correctional facilities



*\*The DOC and Medicaid are working to make this change.*

*\*\*People leaving Delaware correctional facilities currently apply for coverage. They do not select an MCO and are not all asked for consent to share medical information.*

*Note: This figure is based on steps taken in Arizona, Ohio, and Louisiana to connect people with OUD to care when reentering the community from prison.*

Specifically, Pew recommends Medicaid and the DOC employ the following strategies:

- 1) Medicaid suspension or modification to benefits package.** If enrolled in Medicaid upon entry, enrollment should not be terminated. The Division of Medicaid and Medical Assistance should finalize ongoing efforts to amend Title 16 § 14120 of the Delaware administrative code to either suspend benefits for incarcerated persons or assign them to an inpatient-services only benefits package, which, as a byproduct, would also allow seamless coverage for any inpatient hospital stays over 24 hours that occur during incarceration. This is the only type of care that Medicaid covers for people in jails and prisons.
- 2) Medicaid enrollment, MCO selection, and consent to share medical information.** If not already enrolled in Medicaid upon entry, individuals should apply prior to release. The application process should include MCO selection and consent to share medical information. Currently, eligible individuals in Delaware correctional facilities apply for Medicaid coverage prior to release but do not select an MCO, though Medicaid indicated to Pew that they are changing this process.

To help people apply for coverage and select an MCO, the DOC should provide enrollment assistance. Medicaid should collaborate with the DOC to develop informational materials. The DOC should consider training people serving long sentences to help people about to be released with the enrollment process. Ohio has trained over 150 incarcerated individuals to be Medicaid guides, educating those about to be released on the importance of health insurance, as well as assisting them to apply for Medicaid coverage.<sup>176</sup>

As part of the application process, the DOC should also include a consent form that asks each person for permission to release medical information to Medicaid, their selected MCO, and future clinicians. A similar process is already in place for participants in I-ADAPT, which indicates that doing so is feasible.<sup>177</sup>

For the pre-trial population, Delaware should begin Medicaid applications upon entry to the DOC, as is done in the Cook County, Illinois jail. This can help ensure that an application is submitted for everyone who enters DOC facilities, even when individuals are released after a short period of time or outside of business hours.<sup>178</sup>

**3) Identification of individuals with high needs.** The DOC and Medicaid should develop a definition for and identify people with high needs, which includes individuals with OUD and other SUDs. To develop a definition of high needs beneficiaries, Delaware could use the Medicaid definition of individuals who are eligible for a health home, which is having two or more chronic conditions (which can include SUDs), having one chronic condition and being at risk for a second, or having one serious and persistent mental condition. States can develop customized definitions that fit within these parameters.<sup>179</sup> Louisiana and Ohio both took this approach. Their definitions are as follows:

- Louisiana: being pregnant or having a serious mental illness, HIV, a disability as defined by the Social Security Administration, multiple medical issues that are poorly controlled, or a moderate to severe SUD in combination with a serious mental illness or a medical condition.<sup>180</sup>
- Ohio: being pregnant or having HIV, hepatitis C, or two or more of the following: a chronic condition, a mental illness, or a SUD.<sup>181</sup>

Because Delaware is not participating in CMS' Medicaid health homes program, the state could also choose to include individuals with a moderate to severe SUD in their definition of high needs without requiring a co-occurring illness.

**4) MCO notification.** MCOs should be notified that individuals who are about to enroll in their plan are to be released and receive health information regarding individuals with high needs. The Delaware DOC, Medicaid, and the Department of Technology and Information should work with the state's MCOs to develop a secure process for sharing information about reentry status and health needs. Participation in this new process should be incorporated into contract amendments with the MCOs. These amendments

should require designation of a single point of contact at the MCO, as well as offering the same at the DOC and Medicaid to facilitate information sharing.

In Ohio and Louisiana, the Departments of Corrections notify their state Medicaid agencies when individuals are to be released from their facilities. Separately, the DOCs upload medical information about individuals in the high needs group to a secure file transfer protocol site that the MCOs access directly. This information sharing allows Medicaid benefits to be activated immediately upon release and provides the MCOs with the information they need to manage care for high needs members reentering the community from incarceration.

**5) Development of care plans for high needs individuals.** Each MCO should contact high needs reentrants prior to release to develop a personalized care plan. After developing a definition for high needs reentrants, Medicaid should amend its MCO contracts to require the MCOs to accomplish the following:

- Contact each person who meets the state’s definition of high need before release and develop a care plan. This plan should include any necessary treatment for OUD and referrals for any other community and support services the individual may need, such as housing.
- Report quarterly to Medicaid on the healthcare utilization for high needs individuals, as well as other indicators. This will allow the state to evaluate the effects of their reentry process. Indicators Delaware may consider in reporting include the following:
  - The number of enrollees meeting the state’s definition of high needs;
  - The share of these enrollees the MCO contacted before release to develop a care plan;
  - The share of these enrollees who saw a provider within a week of release;
  - The share of these enrollees with OUD who saw an OUD treatment provider within 48-hours of release;
  - The number of primary care visits by this cohort;
  - The number of behavioral health visits by this cohort;
  - The number of filled prescriptions by this cohort;
  - The number of emergency department visits by this cohort;
  - The number of inpatient hospitalizations among this cohort; and
  - The number of deaths among this cohort.

These reports should compare the utilization of the high needs reentry population to a peer group of MCO members who are similar in age and gender to evaluate the effectiveness of pre-release care planning.

By December 2019, the Delaware DOC and Medicaid should report to the Behavioral Health Consortium their progress towards implementing these changes. Following the implementation

of this system, the DOC and Medicaid should prepare an annual report on the reentry process, incorporating indicator data provided by the Medicaid MCOs. These reports should be used to evaluate the reentry process and guide any future changes. By taking these steps, Delaware will establish a comprehensive, data-driven system for ensuring that people with OUD can access treatment after leaving state correctional facilities.

## Appendix: Data Sources

Data source & Sponsor	Sample	Strengths	Limitations	Technical Notes
MarketScan® Commercial Claims and Encounters (MarketScan) Database  Sponsor: IBM MarketScan Research	Reimbursed healthcare 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	<ul style="list-style-type: none"> <li>Excludes Medicaid and Medicare claims</li> <li>The number of employers and enrollees represented in the database fluctuates annually</li> </ul>	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	<ul style="list-style-type: none"> <li>May not capture the heaviest opioid users – those who may be unstably housed.</li> <li>Respondents may be less forthcoming with heroin use.</li> </ul>	For details on limitations, question changes, and methodology see <i>National Survey on Drug Use and Health: Methodological summary and definitions</i> and Introduction section of the <i>National Survey on Drug Use and Health: Detailed Tables</i> <sup>†</sup>

\* IBM, “IBM MarketScan Research Databases,” <https://www.ibm.com/us-en/marketplace/marketscan-research-databases>.

<sup>†</sup> Substance Abuse and Mental Health Services Administration, “National Survey on Drug Use and Health (NSDUH),” <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>.



Data source & Sponsor	Sample	Strengths	Limitations	Technical Notes
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)	<ul style="list-style-type: none"> <li>• Annual response rates may differ</li> <li>• Does not include all office-based prescribing of buprenorphine and naltrexone</li> </ul>	Data represent annual census on March 31 <sup>st</sup> ; For details on methodology, see the <i>Description of the N-SSATS, N-SSATS Background, and Item Response and Imputation</i> sections in annual reports*
Treatment Episode Data Set (TEDS)  Sponsor: SAMHSA	Admission and discharge-level data for U.S. substance use disorder treatment of persons 12 years and older reported in state agency data systems	Data represent national and state-level substance use disorder treatment admissions and discharges	<ul style="list-style-type: none"> <li>• Only includes data from substance use disorder treatment facilities that are captured in state agency data systems</li> <li>• Each record represents an admission or discharge, not a unique individual</li> </ul>	See the <i>About the Treatment Episode Data Set</i> section of the admissions and discharges reports <sup>†</sup>

\* Substance Abuse and Mental Health Services Administration, “National Survey of Substance Abuse Treatment Services (N-SSATS),” <https://www.samhsa.gov/data/data-we-collect/nssats-national-survey-substance-abuse-treatment-services>.

† Substance Abuse and Mental Health Services Administration, “Treatment Episode Data Set (TEDS),” <https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set>.

## Endnotes

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- <sup>1</sup> Office of the Lieutenant Governor Bethany Hall-Long, “Behavioral Health Consortium” (accessed January 15, 2019), <https://ltgov.delaware.gov/behavioral-health-consortium/>.
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