



Spotlight on Colorado

Best Practices and Next Steps
in the Opioid Epidemic

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COLORADO
MEDICAL SOCIETY

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Roadmap to Ending Colorado's Opioid Epidemic

The American Medical Association (AMA) and Manatt Health are undertaking an in-depth analysis of four states' responses to the opioid epidemic to identify best practices and next steps where further action is needed. In this spotlight analysis of Colorado's response to the epidemic, we analyze the state's efforts in three areas: substance use disorder treatment (SUD), pain management, and harm reduction. Highlights include:

Where Colorado Is Succeeding

- **New efforts to expand treatment.** In May 2018, Colorado adopted a package of laws to address the epidemic, including taking an initial step to reduce prior authorization barriers to medication assisted treatment (MAT);¹ new funding to expand the workforce of physicians and other health care professionals in rural and underserved areas; and plans to open up Medicaid coverage of SUD treatment provided in residential settings.
- **New parity policy.** Colorado also enacted a 2018 law establishing an office of the ombudsman to assist state residents in accessing behavioral health care and requiring the Division of Insurance to report on compliance with mental health and substance use disorder parity laws.² The division is conducting market conduct examinations to assess compliance.
- **Opioid alternatives in Medicaid.** The state has expanded access to non-opioid pain management strategies in Medicaid, including coverage of non-opioid prescription medications as well as alternative therapies, such as physical therapy and occupational therapy, as well as a new option for up to six behavioral health visits offered in a primary care setting to support screening and early intervention.

"Right now, we have a 90 percent treatment gap for patients with substance use disorders. Theoretically, this situation would be similar to a cancer patient going to a treatment center and being told, "Sorry, we can only give treatment to one out of ten people."

Rob Valuck, Director, the Colorado Consortium for Prescription Drug Abuse and Prevention, February 2, 2018

- **Engaging the provider community.** Colorado has an impressive array of stakeholders led by the Colorado Consortium for Prescription Drug Abuse Prevention, which includes more than 500 individual and organization representatives, including the Colorado Medical Society, state and federal agencies, numerous health care professional organizations, public health officials, and nonprofit organizations. The Consortium's public health focus has played a leading role in shaping the state response aimed at addressing the epidemic, including action-oriented workgroups and one of the most comprehensive data surveillance dashboards in the country.
- **Initial success of pilot projects.** The six-month Colorado Opioid Safety Pilot reduced the use of opioids in 10 emergency departments by 36 percent using effective alternatives to opioids, such as lidocaine injections. This successful project is now being implemented in hospitals statewide. Kaiser Permanente offers its members the Integrated Pain Service, an eight-week program for those who are high-risk opioid patients and want to learn about and have options for alternative ways to manage pain. Colorado emergency departments also are seeing success with initiating patients on buprenorphine and helping refer them to treatment.
- **Expanding naloxone access.** The state was one of the first to enact sweeping naloxone access laws and continues to further policies, including implementing a standing order for naloxone, adopting Good Samaritan protections, eliminating prior authorization for naloxone in Medicaid, and implementing other efforts to distribute naloxone to help save lives from overdose.



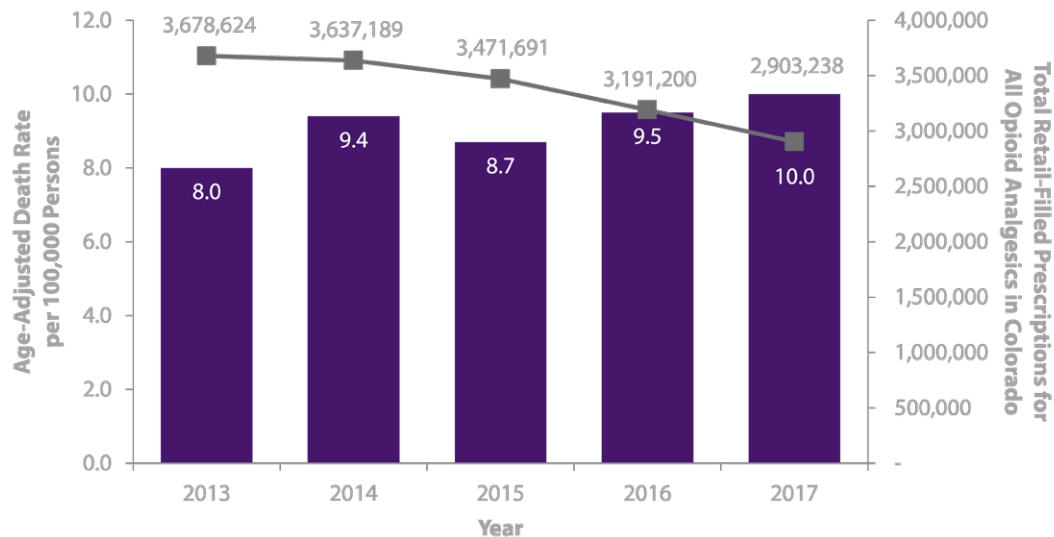
Where Colorado Can Build on Its Accomplishments

- **Eliminate barriers to treatment, including through mental health and substance use disorder (SUD) parity enforcement.** Further efforts to remove prior authorization barriers for patients; continue building state infrastructure to remove barriers to adequate networks and address workforce shortages; and continue to expand enforcement of mental health and SUD parity laws through audits and active review of benefits packages, prior authorization policies, and cost-sharing obligations.
- **Expand access to providers of medication-assisted treatment (MAT).** Especially in the 31 counties without access to MAT providers, it is critical to expand access to treatment through statewide, sustainable initiatives that incentivize providers to offer MAT, and to ensure physicians and patients can access services ranging from physician consults to behavioral and mental health care services to housing, employment and other resources that often are part of a well-established hub-and-spoke model.
- **Leverage successful pilots.** Identify and learn from best practices in the state to provide comprehensive, multimodal pain care (e.g., Colorado Opioid Safety Pilot)—and work closely with stakeholders to review and reform benefit design and formulary requirements to ensure patients have access to non-opioid alternatives.
- **Foster connections to treatment.** Build on the state's naloxone access successes through statewide education efforts with physicians and other key stakeholders, linking patients whose lives were saved with evidence-based treatment to begin and sustain recovery, and leverage the Consortium's surveillance efforts to identify where the state can target state and federal grant dollars to expand access to treatment.
- **Conduct timely, practical evaluations.** Evaluate the policies, programs, and other efforts in the state to determine what is truly working to improve patient care and reduce opioid-related harms, including understanding relationships between current policies and clinical outcomes to further successful efforts while amending those that may be having unintended consequences.

I. Introduction

Colorado has addressed the opioid epidemic with an array of public and private initiatives. In 2013, Governor Hickenlooper launched a yearlong process to develop the Colorado Plan to Reduce Prescription Drug Abuse—one of the first statewide comprehensive efforts in the nation. The process involved national experts and more than 200 stakeholders, and resulted in the establishment of the Colorado Consortium for Prescription Drug Abuse Prevention, which includes representatives from the Colorado Medical Society, state and federal agencies, and a broad array of health care professionals, public health officials, and nonprofit organizations. The Consortium has played a leading role in shaping the state response to opioid misuse and diversion, and it also addresses stimulants and sedatives as well as heroin and other illicit drugs. There has been a 21 percent reduction in opioid prescriptions since 2013, but the loss of life and emotional toll of the epidemic continue.³ Although Colorado's death rate from opioid overdoses dropped from 2014 to 2015, it rose again in 2016 (Exhibit 1). This is consistent with national trends that demonstrate it will take more than cutting opioid prescriptions to end Colorado's—and the nation's—opioid epidemic.

Exhibit 1. Opioid-related Overdose Deaths in Colorado



Sources: IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017, <http://files.constantcontact.com/ce920c6e201/a7d6f6a0-5735-440b-89e9-37c8b973bab4.pdf?ver=1524258585000>; Colorado Department of Public Health and Environment, *Colorado Opioid Profile*, 2017, <https://drive.google.com/file/d/1NdB4s5g4IVSW8vCsWI288ONdtvzWiXNi/view>.

Considering this challenging environment, it is important to identify promising practices in states such as Colorado, review the available evidence on the extent to which they are working, and identify potential next steps.

This spotlight analysis primarily highlights the work of two agencies—the state Medicaid agency (the Colorado Department of Health Care Policy and Financing [HCPF]) and the Division of Insurance (DOI), housed within the Department of Regulatory Agencies—which are at the forefront of the fight. These two agencies address coverage issues that determine what care is accessible and affordable to the approximately 20 percent of Coloradans covered by Medicaid and 59 percent with individual or group insurance coverage.⁴ There are, however, many other agencies involved in Colorado’s broad interagency initiatives, and the work of all those agencies merits the same close scrutiny we have given the DOI and Medicaid in order to have a full picture of the state’s efforts.

Exhibit 2. AMA Priorities for Addressing the Opioid Epidemic

The AMA has developed a comprehensive set of recommendations aimed at ending the opioid epidemic. This spotlight analysis addresses multiple AMA priorities:

- **Increase access to high-quality, evidence-based treatment for opioid use disorder (OUD), including enforcing state and federal mental health and substance use disorder parity laws**
- **Support comprehensive, multidisciplinary, multimodal pain care, including non-opioid alternatives**
- **Reduce harm with naloxone and other efforts to help save lives from overdose and link patients to treatment**



II. Increasing Access to High-Quality, Evidence-Based Care for Substance Use Disorders (SUDs)

With an estimated 19.4 million cases of SUDs nationwide,⁵ there is an urgent need to make treatment more widely available, starting with MAT.⁶ Despite strong evidence that MAT is the most effective treatment option for many individuals with SUD, barriers to MAT persist, including stigma that keeps some patients and providers from utilizing MAT, inadequate provider networks, high cost-sharing for MAT, and prior authorization requirements that can impede access for patients whose willingness to seek treatment can quickly fade if they face a delay.⁷

Colorado has taken some notable steps to increase access to SUD treatment, especially MAT, in a variety of ways as detailed below, but more work is needed.

Expanding Access to Medication-assisted Treatment (MAT)

Colorado has expanded MAT treatment within Medicaid, which covers methadone and vivitrol (naltrexone extended-release injectable) given by a provider in the office without prior authorization. Medicaid continues to require a prior authorization for buprenorphine due to concerns about potential abuse.⁸ In May 2018, the state legislature passed House Bill 18-1007 to expand access to MAT in individual and group health plans. The legislation requires plans to authorize a five-day supply, without prior authorization, for at least one Food and Drug Administration (FDA)-approved form of MAT for the first request in a 12-month period.⁹ DOI has published a regulation to implement the law (see details in Exhibit 3), which went into effect on January 1, 2019.¹⁰

“We must all confront the intangible and often devastating effects of stigma. ... The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment.”

Patrice Harris, MD, AMA
President-elect and Chair of
the AMA Opioid Task Force

Exhibit 3. Regulation Implementing House Bill 18-1007 on Expanding Access to MAT

Individual and group health plans must:

- Provide a five-day supply of at least one of the FDA-approved drugs for MAT for the first request within a 12-month period without prior authorization
- Consider an authorization request for MAT as an urgent request, which requires the health plan to respond with a coverage determination within 24 hours
- In any denial notice, include information for patients on the expedited appeals process
- Establish standard and expedited processes to allow a beneficiary or their representative to request and gain access to clinically appropriate drugs not covered by the plan

Recommendation: While five days of MAT with no prior authorization is a good start, Colorado should consider stronger efforts to promote access to MAT, such as elimination of prior authorization for all forms of MAT in all health insurance products, and include all forms of MAT on the lowest cost-sharing tier of those products.

Local officials have taken action as well. In July 2018, Denver Mayor Michael Hancock released a five-year action plan for fighting the opioid epidemic, including expanded access to MAT and other SUD treatment in the Denver area. The city has devoted \$431,000 to a pilot program that includes a regional intake induction center for rapid treatment admissions. The program, centered at the Denver Health and Hospital Authority, will provide people with the opportunity to initiate treatment at any time of day or night, seven days a week. Those who begin MAT will receive a bio-psycho-social evaluation to inform an individualized treatment plan. The city will evaluate the success of the initiative using metrics such as the number of MAT inductions, the percent of individuals retained in treatment at 90 days, and the number of successful referrals to community-based care, defined as full enrollment within 48 hours.¹¹

Recommendation: Colorado should identify and evaluate local initiatives like Denver's "on demand" treatment pilot and expand successful ones to other large cities in the state to increase availability of 24/7 treatment access and warm handoffs across the state.

Expanding the Workforce and Encouraging More Substance Use Disorder Providers to Offer MAT

Colorado has made some progress in expanding access to MAT, but the state continues to face some daunting challenges, starting with the fact that fewer than one in three (29 percent) of the SUD treatment facilities in the state offer any form of MAT, and only seven facilities offer all three forms.¹² The state also has an acute shortage of buprenorphine providers. In 2018, there have been more than 375 new practitioners with the necessary federal requirements to provide buprenorphine in-office for the treatment of SUD,¹³ but it is not clear how many are providing SUD care with buprenorphine. Close to half of all counties—31 out of 64—had no place where a person could go for MAT. Some of these counties had overdose death rates well above the state average.¹⁴

“...close to half of all counties—31 out of 64—had no place where people could go for MAT.”

Colorado Health Institute

Among the steps that Colorado has taken to address the shortage of MAT providers is the creation of a program that offers loan repayment and scholarships to behavioral health specialists working in rural or urban areas where there is a lack of substance use disorder professionals. The state also has a two-year pilot program, operated through the University of Colorado College of Nursing, to expand the role of nurse practitioners and physician assistants in providing MAT in Pueblo and Routt counties, which are located far from the state’s large urban areas.¹⁵

The state also has used substantial portions of its federal SAMHSA grants to fund buprenorphine trainings for 400 physicians and advanced practice providers in primary care and community behavioral health practices. Additionally, two hospitals were awarded \$400,000 each to pilot programs to expand access to opioid treatment through the emergency department.¹⁶ Over the next two years, the state has set a goal of training an additional 425 individuals to prescribe MAT using federal grant funds.¹⁷

As Colorado pursues its workforce goals, it will be important to develop sustainable strategies for increasing access to MAT that move beyond pilot initiatives and time-limited grant-funded programs. For example, some states, such as Virginia, are revamping their Medicaid reimbursement policies to systematically provide higher reimbursement rates to providers who provide MAT as well as providing greater continuity of care and removing administrative barriers. A recent evaluation found that these efforts have greatly increased access to treatment for Medicaid patients in Virginia with opioid or other substance use disorders.¹⁸ It is

worth noting that some states and localities also have begun to limit the distribution of grant funding for substance use disorder treatment to only those facilities that offer access to MAT.¹⁹

Finally, we note that simply training and licensing more providers to offer MAT will not necessarily eliminate the gap in access to MAT. Some physicians take the training simply to become better educated about SUDs, but do not take the next step and actually treat patients with an SUD. Reasons given include not wanting to take on a patient population with complex medical, mental health, and social and behavioral needs, including not having an adequate referral network. Others cite low reimbursement. Some say that they do not have the necessary support from their partners in medical practice or that the allied health professionals in their practice do not have the training to help provide necessary follow-up care. These are surmountable hurdles, but will require significant commitment by physicians and the state.

Recommendation: Establish systematic, statewide initiatives to finance training on MAT; increase Medicaid and commercial reimbursement rates to incentivize providers to be able to offer MAT to capitalize on the investments being made in training MAT providers.



Enforcing Mental Health Parity

SUD treatment is an essential health benefit (EHB) under the Affordable Care Act (ACA), which applies to individual and small group (1–100 employees in Colorado) coverage. More importantly, though, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurers cover medically supervised withdrawal services, residential services, and outpatient/partial hospitalization services for SUD to the same extent they are covered for physical health services.^{20,21}

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health and SUD parity is still a work in progress across all public coverage programs as well as commercial insurance.

Exhibit 4. Parity Enforcement

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health and SUD parity is still a work in progress across all public coverage programs as well as commercial insurance. Strong market conduct examination procedures combined with meaningful enforcement can help ensure compliance with state and federal parity requirements.

The DOI is committed to the enforcement of mental health and substance use disorder parity and has begun digging into the tough issues through market conduct examinations of 11 commercial insurers. The exam findings are expected to be published by spring 2019 and will provide a first look at whether Colorado insurers are meeting parity requirements.²² Whether specific parity violations are found in this first round of exams, however, the DOI already has indicated that further examinations and other appropriate follow-up will be necessary to ensure that the DOI is asking all the right questions in assessing parity compliance. We strongly encourage Colorado to conduct thorough and frequent examinations, publish the findings, and take appropriate enforcement actions to ensure insurers are meeting their legal obligations.

Enhancing Network Adequacy Oversight

One reason for parity violations could be that insurers lack adequate provider networks to meet the needs of SUD patients. The DOI has four separate network adequacy regulations, which address multiple topics, including insurer access plans, distance standards, provider ratios, and the availability of essential community providers.^{23,24,25,26} The DOI generally relies on carrier attestations of compliance, buttressed by complaint monitoring and investigation where there is a pattern of access complaints. Given the lack of SUD providers across much of the state, however, the DOI is working with behavioral health advocates to add a questionnaire investigating non-quantitative treatment limitations to its annual network adequacy reviews. This will help ensure that the DOI is proactive in assessing network adequacy as part of “front-end” rate and form review and in “back-end” compliance audits or market conduct examinations.

Recommendation: To ensure compliance with distance standards and other quantitative standards, the DOI should conduct front-end reviews of network plans to help ensure that consumers’ health insurance coverage options will have an adequate number of addiction medicine physicians and other health care professionals in a patient’s health insurance network.



For example, federal regulations provide that a physician may treat up to 30, 100, or 275 patients with buprenorphine, in-office, for the treatment of opioid use disorder (OUD). To help determine the total number of potential OUD patients that could be cared for in a network, the DOI could require health insurance companies to identify how many physicians are currently able to provide buprenorphine (a form of MAT) and how many patients they can treat. The DOI could even go a step further and require that health plans affirm how many of those MAT providers are actively seeing patients with OUD. This type of quantitative analysis is not only possible, but also essential to determine the workforce capacity in a health insurance network. Identifying network gaps will not automatically solve them, but it will engage insurers in doing their part to identify what is needed and take appropriate action to fill those gaps.

We encourage the DOI to carefully review the adequacy of OUD treatment capacity in each of the insurer's products.

Recommendation: Ensure that market conduct examinations use in-depth analyses and quantitative standards to evaluate insurers' compliance with network adequacy and mental health and SUD parity legal obligations, and take appropriate enforcement actions to ensure compliance with examination findings.

Supporting Frontline Providers With Care Management and Other Services

Providers on the front lines in offering buprenorphine and other MAT often need a range of support services, from help with initial assessments to care management services to referral options for complex cases. Colorado has taken initial steps in this area.

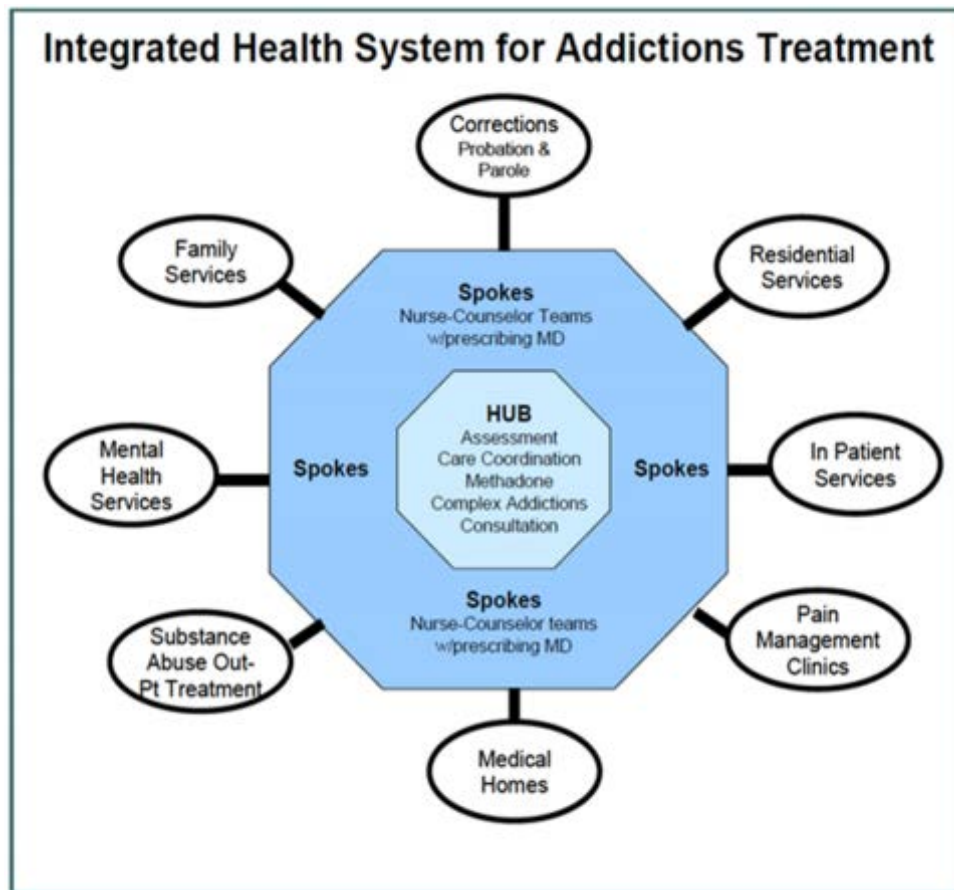
Emergency Departments Can Facilitate Warm Handoffs

The University of Colorado Health System's 10 hospitals are taking part in a multifaceted effort to address the epidemic, including by providing MAT. When a patient arrives in the emergency department (ED) and is identified as having an OUD, a social worker intervenes to conduct an in-depth screening. When a patient is willing, providers prescribe buprenorphine. A grant from the Colorado Office of Behavioral Health has increased resources to provide "warm handoffs" to community providers.²⁷ Denver emergency medicine physician Jason Hoppe, DO, emphasized in an interview that the program has been successful thus far because of widespread buy-in from hospital administrators, physician colleagues, physician assistants,

social workers, and other health care professionals. “Early findings have been that of 40 patients identified for needing treatment for a substance use disorder, all but one showed up for their first appointment, and more than half were still in treatment at 30 days. It’s hard work, but we’re making progress.”²⁸

To achieve its workforce goals, Colorado should consider adopting a systematic, statewide approach to ensuring that frontline providers have the resources they need. One model that continues to gain popularity nationwide as a means to encourage physicians to offer MAT is the “hub and spoke” model, which helps address the need of physicians and patients to have access to a wide range of medical, social, and other behavioral care services. There are other approaches that could work equally well, but as illustrated in Exhibit 5, the critical issues are ensuring that frontline providers have easy and direct access to the backup resources and support from experts often necessary to treat SUD patients.

Exhibit 5. Hub and Spoke Model²⁹



Treatment Workgroup Established by the Colorado Consortium for Prescription Drug Abuse Prevention

This workgroup seeks to address gaps in continuity of care and to support implementation of a chronic disease model of care for individuals with OUD and other SUDs.³⁰ The workgroup also has identified and published all opioid treatment programs in the state, but it is not clear how this information has been disseminated to primary care providers whose patients may need the help of an OTP or buprenorphine provider.³¹ Moreover, it is not clear how physicians and patients would be able to quickly identify whether those programs are in a commercial health insurance network or whether a program is accepting new patients.

Scholarship and Loan Programs

To help increase the pipeline of behavioral health providers, recent state legislation developed a loan repayment program for individuals who commit to providing services in health professional service areas. Additionally, the legislation created a scholarship program to help defray the education and training costs for obtaining certification as an addiction counselor.³²

Recommendation: Build on current programs and projects to establish systematic and statewide efforts to train and expand support for frontline providers of SUD treatment efforts, including screening, treatment, and referral resources.

Expanding Access to Residential Treatment

Like other states, Colorado historically has not covered residential treatment services for Medicaid beneficiaries with substance use disorders due to a federal ban on using Medicaid funds to offer mental health and SUD residential treatment services in facilities with greater than 16 beds for individuals ages 21 to 64 (known as the “Institutions for Mental Disease (IMD) exclusion.”) The Colorado legislature recently authorized the Medicaid agency to seek a waiver of the IMD exclusion.³³ The Governor has signed the bill into law, and the state is expected to pursue Medicaid coverage of IMD services in the months ahead. (Due to a recent change in federal law, the state may not necessarily require a waiver anymore to cover IMD services for a limited period of time, and the state will need to decide whether to take advantage of the recent federal law change or continue to pursue the waiver.) Research conducted by the Colorado Health Institute makes it clear that it will take some time to build up the capacity

required to treat everyone who needs such services. Moreover, the state will face a series of decisions as to how it will monitor and license residential treatment facilities receiving Medicaid funding, as well as how to ensure that people still are treated in the community when that is the more appropriate setting.³⁴

Recommendation: Eliminate the IMD exclusion as planned, while developing linkages and transitions to care upon exiting a residential facility. Provide appropriate oversight and credentialing of qualified treatment centers to ensure facilities offer all forms of MAT and linkages to community-based care.

Partnering With the Medical and Patient Communities to Further Support Screening, Removing Stigma, and Understanding Network and Benefit Design Barriers

To help identify barriers to SUD care faced by physicians and patients—as well as understand issues related to workforce capacity—the state could partner with the AMA and the Colorado Medical Society to conduct a survey of physicians. This survey could provide a ground-level view of the specific barriers to care facing patients and physicians and serve as a foundation for future efforts to guide actions that would result in increased access to MAT services. For example, this effort could help identify whether prior authorization or step therapy policies cause delays or denials of care, as well as whether health plan formulary and benefit design lead to the patient not being able to afford care or having to go without additional care, including behavioral health care, which has been shown to improve outcomes for SUD patients.

Screening Can Identify Those Who Need Treatment

Colorado is working to strengthen screening and referral to treatment for SUD by leveraging SAMSHA grants to conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) for adolescents in school-based health centers.³⁵ The state also devoted \$1.5 million to a competitive grant program, created by House Bill 18-1003, to operate an SBIRT program.³⁶

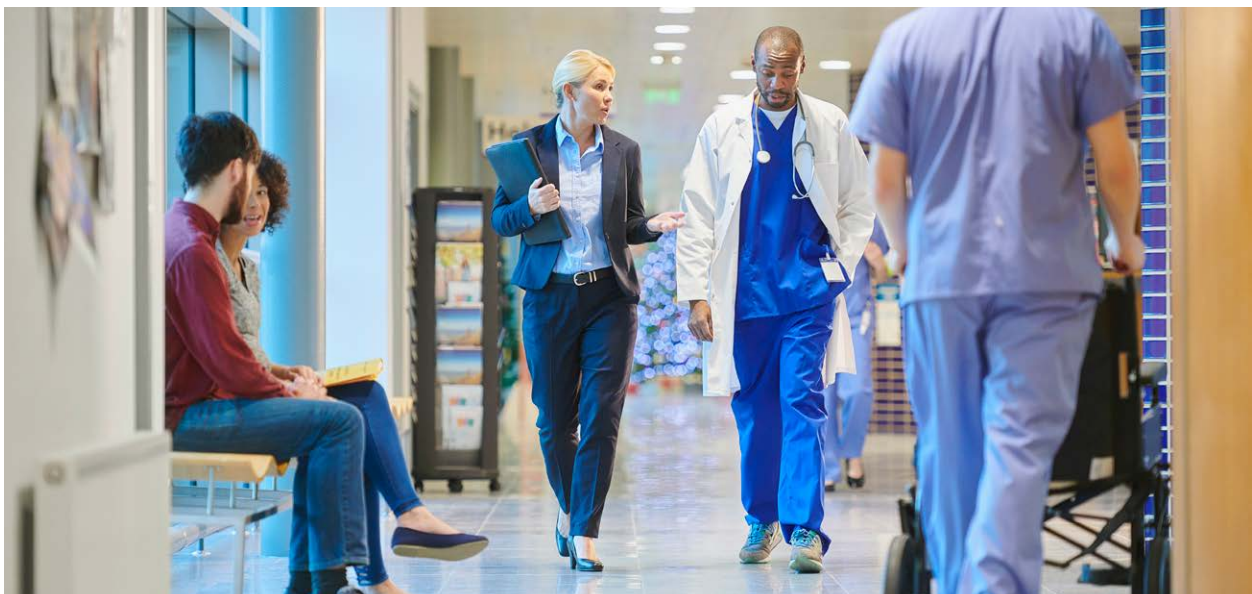
Although Medicaid will pay for SBIRT and state officials consider it a priority to increase use of SBIRT services, few providers currently provide this service. Indeed, on July 1, 2018, the Medicaid program began covering up to six behavioral health visits for Medicaid beneficiaries provided in a primary care setting, including for treatment of SUDs identified through SBIRT or

via other means. Services are reimbursed by the state on a fee-for-service basis and not subject to any prior authorization. By reducing barriers to securing treatment for behavioral health conditions that are identified in a primary care setting, it may encourage greater use of SBIRT and create stronger incentives for primary care providers to co-locate social workers in their offices.

Public Education Can Reduce Stigma and Encourage Individuals to Enter Treatment

Colorado's "Lift the Label" public education campaign aims to reduce the stigma associated with OUD. The campaign encourages individuals with opioid use disorder to seek treatment, and it is intended to de-stigmatize and demystify opioid use disorders and treatment options. While there are elements of the campaign's use of language that could better distinguish OUD from a patient exhibiting addictive behaviors, the campaign stresses the importance of medical treatment for individuals with an OUD; describes evidence-based treatment options, including the signs and symptoms of OUD; and prominently displays a hotline that individuals can call to get help. The campaign partner toolkit, available on the website, provides materials partners can distribute in the community, including information on where to obtain treatment.³⁷

Recommendation: Work with the medical and health care community at-large to better understand barriers to providing care, including the role that stigma plays, and evaluate those programs to determine whether to continue further support and/or how to scale throughout the state.



Best Practices and Next Steps for Increasing Access to High-Quality, Evidence-Based Care for Substance Use Disorders (SUDs)

Steps in the Right Direction	Next Steps
<ul style="list-style-type: none"> ■ Reducing prior authorization for MAT. Enacted legislation to require access to at least one FDA-approved MAT treatment for five days, once every 12 months, without prior authorization for individual and group health plans. Eliminated prior authorization in Medicaid for some forms of MAT. ■ Expanding SUD treatment capacity. Initiated several pilot projects and devoted funding to training additional MAT prescribers, increasing screening for OUD, and linking patients to treatment. ■ Initial action to enforce mental health and substance use disorder parity. Conducted market conduct examinations of leading commercial insurers to identify and address violations of mental health and SUD parity. ■ Reducing stigma. Developed Lift the Label campaign to fight the stigma associated with having an opioid use disorder and encourage individuals to seek treatment. 	<ul style="list-style-type: none"> ■ Completely remove prior authorization for MAT. This includes ensuring all forms of MAT are on the formulary on the lowest cost-sharing tier. ■ Further expand SUD providers offering MAT. Provide incentives, including higher reimbursement rates for MAT providers. Increase support services to frontline providers and require as a condition of receiving funding that SUD treatment centers provide or facilitate access to MAT. ■ Strengthen mental health and SUD parity enforcement. Build on existing market conduct exams to identify and quantify systematic gaps and enforce mental health and SUD parity requirements for all insurance coverage. ■ Strengthen network adequacy standards. Strengthen network adequacy oversight and enforcement in Medicaid and commercial insurance for SUD providers, particularly to help ensure a sufficient number of providers who deliver MAT and mental health care. ■ Assess barriers among physicians to providing SUD services. Partner with the AMA and Colorado Medical Society on outreach to physicians to identify barriers to providing SUD services, including the role that stigma plays.

III. Providing Comprehensive Care to Patients With Pain

Even as physicians and patients work to reduce opioid-related misuse, millions of Americans still have chronic pain and require help, including opioid analgesics as part of the therapeutic regimen. In 2016, the latest year for which data are available, the CDC estimates that “20.4% (50.0 million) of U.S. adults had chronic pain and 8.0% of U.S. adults (19.6 million) had high-impact chronic pain.”³⁸ Colorado, like all states, has placed considerable emphasis on decreasing patient exposure to opioid analgesics, and between 2013 and 2017, opioid prescriptions have decreased in Colorado by more than 21 percent.³⁹ What is less clear, however, is whether this reduction has been primarily targeted at patients with chronic pain, patients with an acute pain episode (e.g., outpatient surgery), or other situations. While the decrease in opioid supply is generally supported by nearly all stakeholders, it is critical that patients who depend on opioid therapy for pain relief, who have been long-term patients and functional on opioid therapy, and who do not misuse opioids not be targeted, non-consensually tapered, or adversely affected by policies designed to reduce opioid supply.

At the same time, there is a clear imperative to increase the options for the treatment of pain beyond opioid therapy. Colorado has sought to expand access to alternative pain management strategies, particularly in Medicaid, and to recognize that people already physically dependent on or in need of opioid analgesics may require special care.⁴⁰

While this spotlight primarily addresses areas of regulatory policy and implementation, efforts to improve prescribing practices are an overarching issue that Colorado stakeholders have made a top priority. The Colorado Department of Regulatory Agencies took an important first step in 2014 when it provided voluntary guidance to physicians and other prescribers in its “Guidelines for Prescribing and Dispensing Opioids.”⁴¹ “These guidelines and other improvements and education in all areas of prescribing are essential to help treat pain effectively from the outset,” said Kathryn Mueller, MD, MPH, medical director, Colorado Division of Workers’ Compensation.



Expanding Coverage of Alternative Pain Management Strategies

Coverage of Alternative Treatments for Chronic Pain

Colorado's Medicaid program has taken several steps to increase access to a variety of non-opioid pain treatments. Alternative pain treatments include over-the-counter medications such as ibuprofen and acetaminophen, prescription medications that do not include opioids; local anesthetics such as steroidal lidocaine patches or injections; and physical therapy, occupational therapy, cognitive behavioral therapy, and other medical, physical, and mental health services.

Colorado Medicaid covers non-opioid pain relievers such as anti-epileptics (e.g., Lyrica and Neurontin) without prior authorization, and covers the antidepressant duloxetine (e.g., Cymbalta) without prior authorization when it is used for fibromyalgia, neuropathic pain, or chronic musculoskeletal pain. Lidocaine patches are also available with no prior authorization.⁴²

In the new Medicaid formulary, which went into effect July 1, 2018, the agency changed the "fibromyalgia" class to a "non-opioid analgesic class" and a "topical non-opioid analgesic" class to help make it easier for providers to understand non-opioid treatment options. Medicaid also increased payment rates for physical therapy (PT). The increase led to a larger number of PT providers participating in Medicaid, and the provision of more PT services.



Exhibit 6. Examples of Treatment Options for Acute and Chronic Pain, and Coverage of These Treatments in Colorado Medicaid

Opioids	Non-opioid Pharmaceuticals	Non-pharmaceutical Treatments	Alternative Treatments
Vicodin	NSAIDS* (Diclofenac, Meloxicam, etc.)	Sympathetic Nerve Blocks	Acupuncture
Oxycodone*	Acetaminophen	Lidocaine Patches and Gels*	Massage
Tramadol*	Anti-epileptics* (Lyrica and Neurontin)	Transcutaneous Electrical Nerve Stimulation (TENS) Unit	Mindfulness Meditation
Percocet*	Antidepressants (Amitriptyline and Cymbalta*)	Steroid Injections	Yoga
Hydrocodone*		Physical Therapy*	

Sources: Colorado Department of Health Care Policy and Financing, Preferred Drug List, <https://www.colorado.gov/pacific/sites/default/files/PDL%20effective%2010-01-2018.v7.pdf>; interviews with state officials.

* Indicates this treatment is covered by Colorado Medicaid. Sympathetic nerve blocks, TENS units, and steroid injections may also be covered; information was unavailable on these categories.



Opioid Alternatives for Acute Pain

The Colorado Opioid Safety Pilot, run by the Colorado Hospital Association, was a six-month pilot in eight Colorado hospital EDs and two freestanding EDs to reduce the administration of opioids by ED clinicians. The initiative used guidelines developed by the Colorado Chapter of the American College of Emergency Physicians that recommend the use of alternatives to opioids (ALTOs) as a first-line treatment for pain rather than opioids.

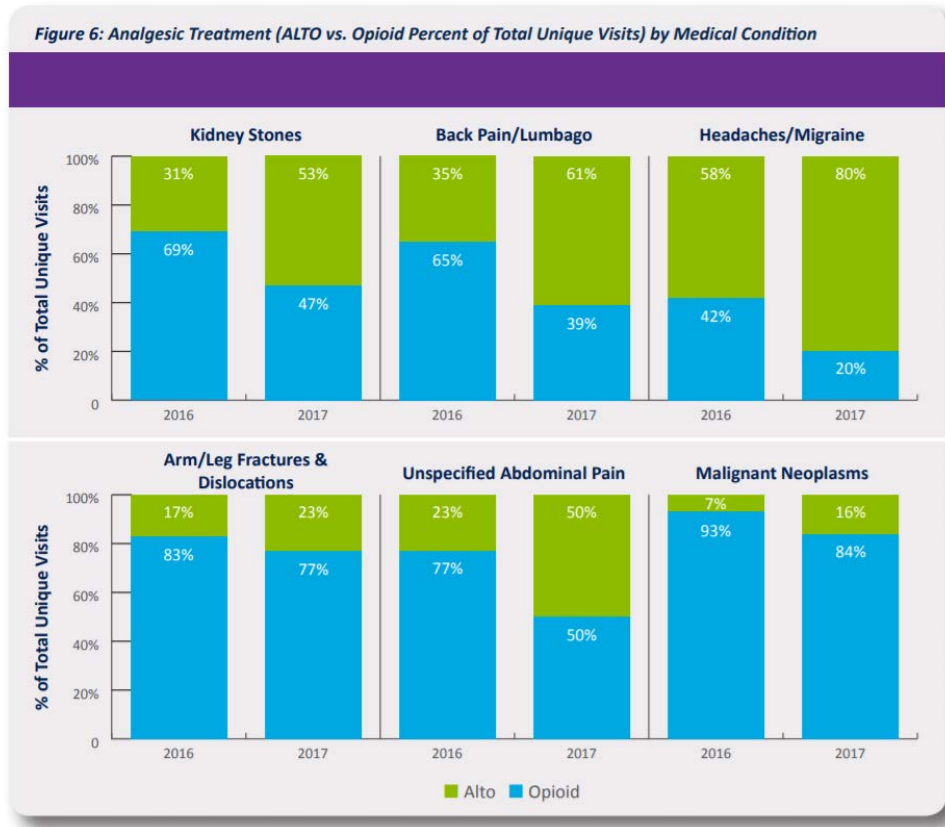
The EDs achieved a 36 percent reduction in opioid administrations during the pilot period compared to the same time period in the prior year. The initiative introduced new procedures, such as using non-opioid patches for pain and using ultrasound to “look into the body” and help guide targeted injections of non-opioid pain medicines. Doctors also used non-opioid interventions including ketamine and lidocaine, an anesthetic commonly used by dentists. Lidocaine’s use in the project’s EDs rose 451 percent. Ketamine use was up 144 percent.^{43,44} Based on the success of the pilot, the Colorado Hospital Association is working to implement the program in EDs statewide.⁴⁵

Exhibit 7. Does It Work and Can We Afford It? The Cost and Effectiveness of Non-opioid Pain Relief.

Alternative pain management strategies work just as well for many people as opioids and can be less expensive.⁴⁶ While some non-opioid treatments are expensive, this is not uniformly the case. As the CDC explains, “Although there are perceptions that opioid therapy for chronic pain is less expensive than more time-intensive non-pharmacologic management approaches, many pain treatments, including acetaminophen, NSAIDs, tricyclic antidepressants, and massage therapy, are associated with lower mean and median annual costs compared with opioid therapy, while COX-2 inhibitors, SNRIs, anticonvulsants, topical analgesics, physical therapy, and CBT are also associated with lower median annual costs compared with opioid therapy.”⁴⁷

Recommendation: Evaluate payer and clinical efforts to enhance access to non-opioid pain care while simultaneously encouraging reductions in opioid prescribing. Such evaluation should focus on patient outcomes and opioid-related harms, including whether policies are improving pain care and function, and whether patients are turning to nonmedical forms of pain relief if they cannot access appropriate pain care services.

Exhibit 8. Results of the Colorado Opioid Safety Pilot



Leveraging Physicians' Efforts and Educating Patients About Pain Management

One of the potential best practices in Colorado is Kaiser Permanente's Integrated Pain Service, an eight-week program for Kaiser members who are high-risk opioid patients and want to learn about alternative ways to manage pain. The program focuses on integrated care with group education and individual patient care provided by doctors, clinical pharmacists, mental health therapists, physical therapists, and nurses. Patients can meet with the provider team all at once or in groups. Kaiser researchers tracked more than 80 patients over the course of a year and found the group's ED visits decreased 25 percent. Inpatient admissions dropped 40 percent, and patients' opioid use declined significantly.⁴⁸ While the Kaiser effort benefits from being within an integrated system, the positive outcomes demonstrate the need for similar efforts in the commercial market.

Extending Medicaid Best Practices to Commercial Coverage

Colorado's efforts demonstrate important new strategies for pain management. Medicaid has made strides in ensuring access to non-opioid pain treatments. The state could actively encourage all commercial insurers to adopt similar comprehensive pain management strategies across business lines, recognizing that the regulatory framework for commercial insurance is different than for Medicaid. Medicaid sent a letter to commercial insurers encouraging them to follow Medicaid's lead on pain management practices but received no responses, suggesting it would take a concerted effort to better align practices across Medicaid and the commercial market.

Chronic Pain Disease Management Program: Medicaid began operating a Chronic Pain Disease Management Program in 2015. The program connected pain management specialists from around the country with primary care physicians (PCPs) in Colorado who treat Medicaid members with chronic pain. In its second year, the program added a buprenorphine telehealth component that connected PCPs prescribing suboxone with specialists to learn more about treating individuals with opioid use disorder. Although the program got positive feedback from participating providers, it was discontinued after the Centers for Medicare & Medicaid Services disallowed the use of federal Medicaid matching payments for the program.^{49,50,51} Under a recent federal law change, it is possible that the federal government will again allow Medicaid funds to be used in this way.⁵²

Many insurers in Colorado (and across the nation) already have limited the dose and quantity of opioid prescriptions for acute pain, but as these restrictions become more rigorous under 2018 legislation in Colorado that limits opioid prescriptions, it is imperative that the pain management specialists, ED physicians, and other medical personnel not face the dilemma of having no affordable option to offer patients in pain other than opioids in cases where that is not the best option. This also includes having regulators review benefit design and utilization management requirements to understand the level of coverage for modalities including neuromodulation, cognitive behavioral therapy, mental health care, physical and rehabilitative



therapies, and other therapies such as acupuncture, massage therapy, and mindfulness. Availability of these modalities is key both to treating acute and chronic pain and to treating common co-morbidities such as depression, anxiety, and sleep disturbances.⁵³ Moreover, there should be particular care paid to patients who are stable and functional on long-term opioid therapy to ensure that the state's and insurers' policies—as well as pharmacy benefit management companies (PBM) and corporate pharmacy policies—intended to reduce opioid prescribing do not have unintended consequences and increase patient suffering.

Recommendation: Build upon the success of ALTO and Kaiser Permanente to provide comprehensive, multidisciplinary, multimodal pain care through direct pressure on commercial and self-insured health plans to do more for patients than simply restrict access to opioid analgesics. Require health plans to ensure that opioid restriction policies have sufficient flexibility to protect patients who are stable and functional on opioid therapy.

Ensuring Prescription Drug Formularies Meet Two Tests

Formulary review is the primary regulatory tool available to the DOI for ensuring adequate pain medications are available and affordable to patients. Formularies are an important tool for insurers and PBMs to manage their pharmacy benefit in the face of escalating drug prices, but formularies should meet two basic tests: non-opioid alternatives should be available on the formulary, and use of formulary tiers, prior authorization, and other utilization management tools, if used at all, should be used responsibly and sparingly to make access affordable and timely. Exhibit 11, below, describes common utilization management techniques that may serve as barriers to obtaining non-opioid pain management. Formularies that are overly restrictive may constitute benefit design discrimination, which is prohibited by the ACA.

The DOI issued a regulation in June 2018 that replaced a long-standing bulletin with a regulatory standard that could be applicable to how certain pain medications are placed on formulary tiers. The regulation states that DOI will consider placement of 50 percent or more of all drugs used to treat a specific condition on the highest-cost tiers as discrimination against individuals who have chronic conditions requiring treatment with those drugs.⁵⁴ We encourage the DOI to consider the applicability of this regulation to pain medications and to work with insurers to ensure that formularies are posted online, they clearly identify the cost-sharing responsibilities of patients, and they are regularly updated so that patients can clearly see the extent to which their health insurance plan covers non-opioid alternatives.

Exhibit 9. Coverage of Non-opioid Alternatives

While legislators shine a light on opioid prescribing patterns, the DOI has the data, collected through rate and form review, to shine an equally bright light on whether the most common non-opioid pharmaceuticals for treating pain are covered and their cost-sharing and utilization management requirements do not constitute benefit design discrimination against patients with pain.



Exhibit 10. Common Utilization Management Techniques

Tiering	Insurers divide drugs into coverage tiers, typically with cheaper generic drugs or lower-cost brand-name drugs on lower tiers, and more expensive drugs placed on higher tiers. Drugs on the higher cost-sharing tiers can have prohibitive out-of-pocket costs.
Prior Authorization	Requires insurer approval for the specific patient before a drug listed on the formulary can be dispensed.
Step Therapy	Requires a patient try a drug that is typically on a lower cost-sharing tier before covering a higher-cost drug.

Recommendation: Require commercial insurers to post up-to-date formularies online, with clear designation of commonly used non-opioid pain alternatives, including non-pharmacologic options. Ensure that formularies do not violate benefit design discrimination standards by, for example, placing non-opioid alternatives on higher cost-sharing tiers or applying prior authorization and step therapy requirements that will impede access to non-opioid and non-pharmacologic pain care alternatives.

Partnering With the Medical Community to Better Understand Barriers to Pain Management

Because not all of Colorado's pain patients are in Medicaid or receive care in an ALTO or Kaiser setting, it is important to help identify barriers to pain management faced by physicians and patients to provide the baseline data for where DOI and other stakeholders should focus efforts. One option is for DOI to identify a ground-level view of how initiatives to date are working to ensure patient access to pain care, including barriers to non-opioid alternatives by specific insurers, and to guide further initiatives as necessary. This effort would include analysis of payment and benefit design that could enhance access to comprehensive pain care services, such as ensuring that behavioral health and medical care services could be provided on the same day, with reasonable exceptions, for example, when periodic snow conditions may make travel impractical or unsafe in certain rural areas. In addition, this would include analysis of whether access to pain medicine specialists and others who provide multimodal pain care services are available in terms of time and distance standards.

Recommendation: Conduct a thorough review of how patients access pain care services and the barriers patients face, including formulary and benefit design and provider experiences. This will require DOI and other agencies to work closely with the medical and health professional communities as well as with insurers and employers.



Best Practices and Next Steps for Providing Comprehensive Care to Patients With Pain

Steps in the Right Direction	Key Next Steps
<ul style="list-style-type: none"> ■ Increasing use of ALTOs for acute pain. In emergency departments, pair a focus on reducing opioid use with access to alternatives such as non-opioid pharmacologic options, which might include non-opioid patches for pain, ultrasound to guide targeted injections, and ketamine and lidocaine, as well as cognitive and behavioral therapies and other non-pharmacologic options. ■ Removing barriers to non-opioid alternatives for management of chronic pain. Medicaid balances efforts to reduce opioid exposure by increasing availability to non-opioid pharmacologic alternatives for pain, such as physical therapy, cognitive behavioral therapy and other modalities as well as multiple non-opioid pharmacologic options without prior authorization. 	<ul style="list-style-type: none"> ■ Expand coverage of alternative pain management. Work with commercial insurers to offer a full array of comprehensive pain management options, including non-opioid medications, behavioral health and other modalities. Ensure that these options are readily available and affordable by eliminating or easing prior-authorization requirements and reducing cost-sharing. If ALTO works in the ED, how can it be brought to other care settings? ■ Identify strategies to increase use of multimodal, multidisciplinary pain care. Partner with the AMA and Colorado Medical Society to identify barriers to non-opioid and non-pharmacologic medications and services. ■ Evaluate how payers' and other policies focused on non-opioid pain alternatives have affected patients' pain care. As Medicaid shows leadership in advancing non-opioid pain care, it will be important to identify whether those policies are improving patient outcomes. Simultaneously, it is vital that regulators and others evaluate policies by health insurance companies, PBMs, and corporate pharmacy chains to determine whether those policies have unintentionally caused increased patient harm.

IV. Enhancing Access to Naloxone

Without naloxone, the opioid-reversal agent, thousands more would likely be dead in Colorado.⁵⁵ The AMA and CMS were proud in 2015 to strongly support Colorado Senate Bill (S.B.) 15-053—sponsored by Senator Irene Aguilar, MD—that was one of the first bills in the nation to allow for the prescription and dispensing of naloxone to an individual patient at risk of experiencing an opioid-related overdose; a family member, friend, or other individual in a position to assist an individual at risk of experiencing an opioid-related overdose; an employee or volunteer of a harm reduction organization; and first responders. Colorado also has adopted a Good Samaritan law to protect third parties who help treat overdose victims with naloxone,⁵⁶ and used funding from settlements with pharmaceutical companies and federal grants to distribute naloxone to law enforcement, first responders, and community members.⁵⁷

Since then, Colorado has taken a number of steps to promote access to naloxone, a prescription medication that can reverse an overdose from opioids.

Standing Orders

S.B. 15-053 also provided for standing orders, authorizing the chief medical officer of the Colorado Department of Public Health and Environment (CDPHE) to issue a standing order for naloxone to be dispensed by pharmacies and harm reduction organization employees and volunteers. A standing order allows an individual to receive naloxone from a pharmacy or harm reduction organization without a patient-specific prescription from a medical professional. CDPHE Chief Medical Officer Larry Wolk, MD, has issued a standing order to make naloxone available to both SUD patients and third parties.⁵⁸



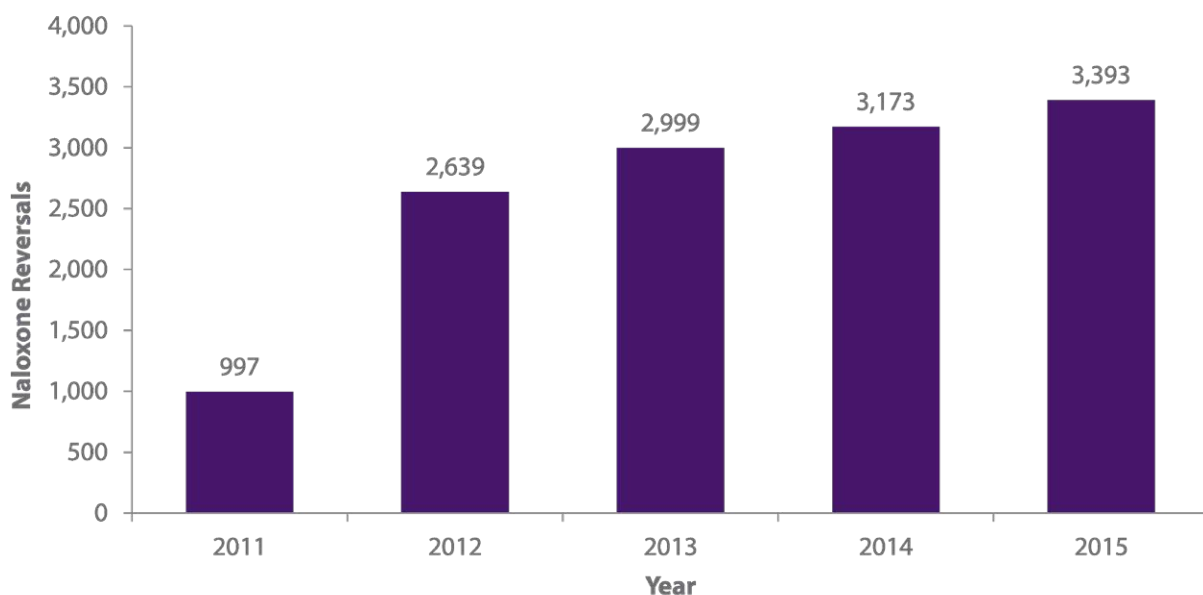
Removing Barriers to Naloxone

Medicaid provides access to naloxone without prior authorization, which is another practice that could be extended to commercial insurers as part of DOI's formulary review process. The "Stop the Clock" website includes a map that provides the locations of more than 500 pharmacies in more than 50 towns and cities that carry naloxone, although it is not clear whether all pharmacies always have the medication in stock.⁵⁹ Boulder County is one example of how a local jurisdiction is working to provide accurate information and easy access to naloxone. The Colorado attorney general reports that there are at least 130 law enforcement departments in Colorado that carry naloxone, with more than 225 law enforcement and fire department personnel trained. This is an increase from only 23 agencies carrying naloxone in 2015.⁶⁰

Some physicians and other health care professionals also may not have a clear understanding that naloxone is not just for those who misuse opioids, but should be considered for any patient at risk of overdose. The AMA Opioid Task Force has a guide to help explain clinical and other indications for co-prescribing naloxone.⁶¹

We encourage the state to continue to partner with the medical and broader stakeholder community to enhance access to naloxone.

Exhibit 11. Statewide Naloxone Reversals



Source: CDPHE and Colorado Department of Behavioral Health.⁶²



Best Practices and Next Steps for Enhancing Access to Naloxone

Steps in the Right Direction	Key Next Steps
<ul style="list-style-type: none"> ■ Standing order. Issued standing order for naloxone prescriptions to enable persons without a patient-specific prescription to obtain naloxone from a pharmacy or harm reduction organization. ■ Eliminating prior authorization. Eliminated prior authorization for naloxone in Medicaid. ■ Eliminating quantity limits. Eliminated restrictions on the number of naloxone prescriptions that a consumer can fill in both Medicaid and commercial products. ■ Broad stakeholder support. The medical, law enforcement, and public community efforts to support enhanced naloxone access have had a direct result on saving lives from overdose. 	<ul style="list-style-type: none"> ■ Eliminating prior authorization. Eliminate prior authorization for naloxone in commercial plans. ■ Addressing stocking issues. Conduct active review, such as through audits or “secret shopper” surveys, to identify where local pharmacies need encouragement to carry naloxone. ■ Promote co-prescribing in commercial market. The AMA and Colorado Medical Society are eager to work with the state to continue to educate physicians about co-prescribing naloxone to patients at risk of overdose. ■ Link naloxone saves to treatment. Using the data dashboards and other information to link persons saved with naloxone to treatment.

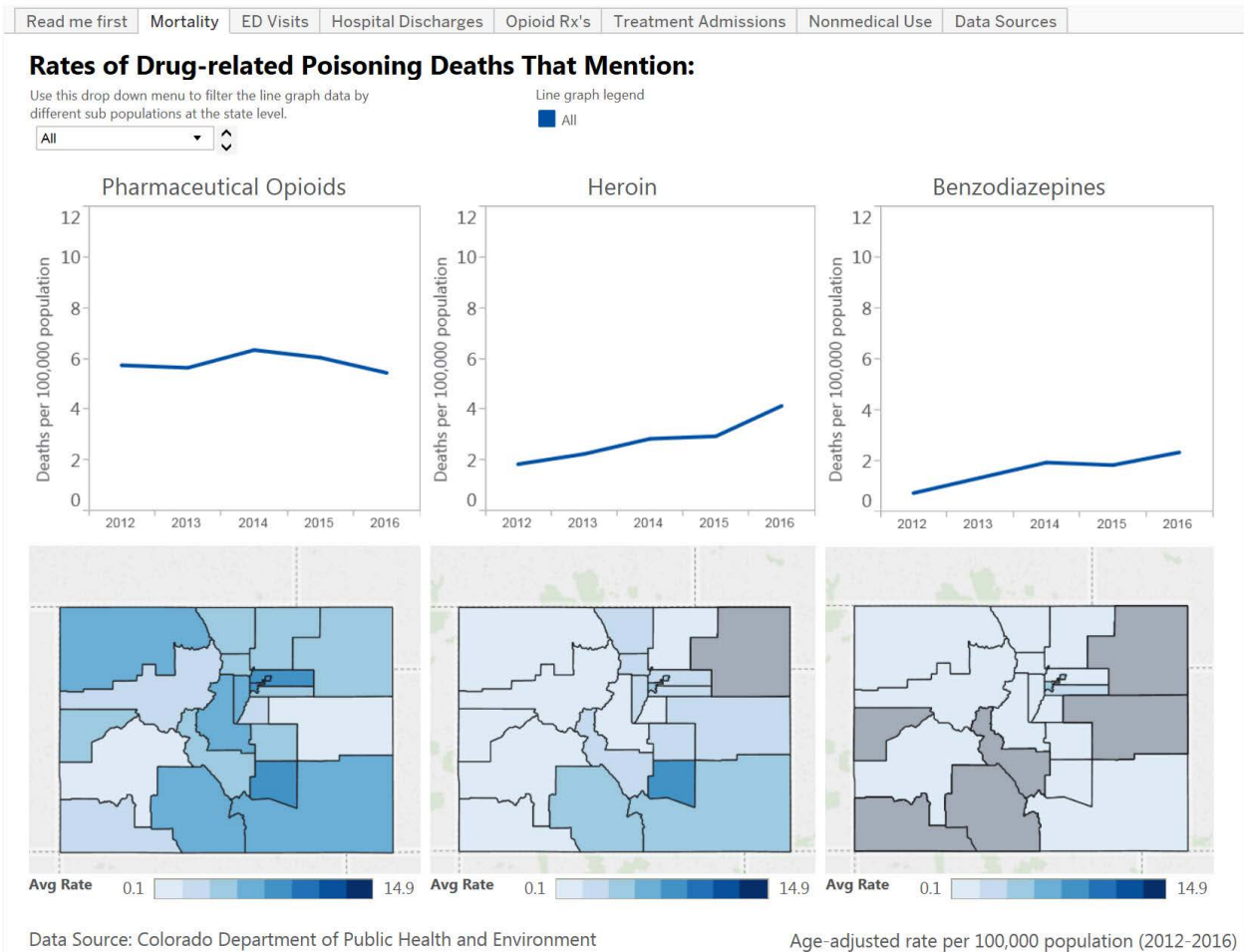
V. Evaluation

The widespread efforts in Colorado to increase access to SUD treatment, comprehensive pain care, and naloxone make it all the more important to evaluate these initiatives to help determine what is working to improve patient care and reduce death and other opioid-related harms. Given the number of Coloradans still needing high-quality, evidence-based care, it is clear, however, that much more work remains, making it critical to evaluate on an ongoing basis which state policies are working as intended, how the policies work together, their impact(s) on patients, and what additional action may be required, including re-evaluating policies that may be having unintended consequences.

Colorado has made a number of efforts to gather and report data on the size and scope of the epidemic, some of them driven by provider organizations or private/public partnerships. For example, the Consortium has developed one of the nation's most comprehensive dashboards, which provides data on mortality, ED visits, hospital discharges, opioid prescriptions, treatment admissions, and nonmedical use of pain relievers⁶³ (see Exhibit 12 below). The Consortium reports that this data can be used to help direct state and local resources to areas of greatest need.



Exhibit 12. Consortium Dashboard, Opioid and Benzodiazepine-related Mortality



Source: <https://public.tableau.com/profile/omni#!/vizhome/RXConsortiumdashboard/Readmefirst>.

At the same time, Colorado, like nearly all states, has not developed a statewide, systematic way to track the effectiveness of its interventions—both legislative and regulatory and those implemented on a pilot project basis. One notable exception is that the recently passed legislation limiting opioid prescriptions sunsets on September 1, 2021, which should create an opportunity to evaluate the bill's impact.⁶⁴ More such evaluations, however, could prove useful to Colorado, as well as other states looking for concrete evidence of the effectiveness of policy interventions.



Best Practices and Next Steps for Evaluation

Steps in the Right Direction	Key Next Steps
<ul style="list-style-type: none">■ Dashboard. Established a dashboard that provides county-level data on key opioid metrics, such as opioid-related mortality, treatment admissions, and nonmedical use of pain relievers.	<ul style="list-style-type: none">■ Systemic review of the effectiveness of policy interventions. Work with foundations, local universities, and internal state resources to systematically evaluate which state policies are working as intended, how the policies work together, their impact(s) on patients, and what additional action may be required, including re-evaluating policies that may be having unintended consequences.■ Turning data into action. Build on the dashboard to identify how to transform the data surveillance into public health interventions (e.g., areas of high mortality may need greater coordination between pharmacies, payers, and providers to ensure greater naloxone access).

Endnotes

- ¹ Colorado Legislature, House Bill 18-1007. Approved by Governor Hickenlooper May 21, 2018. Available at <http://leg.colorado.gov/bills/hb18-1007>.
- ² Colorado House Bill 18-1357, An Act “concerning access to behavioral health care services, and, in connection therewith, establishing an ombudsman for behavioral health access to care to assist consumers in accessing care, requiring the commissioner of insurance to report on compliance with mental health parity laws, and making an appropriation.” Signed by Gov. Hickenlooper May 24, 2018. Available at https://leg.colorado.gov/sites/default/files/documents/2018A/bills/2018a_1357_signed.pdf.
- ³ IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017.
- ⁴ Henry J. Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2017, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22colorado%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Note that group coverage includes self-insured coverage, which is not subject to most state regulation.
- ⁵ Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health, <https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report>.
- ⁶ The Substance Abuse and Mental Health Services Administration defines MAT as the use of medications in combination with counseling and behavioral therapies to provide a “whole-patient” approach to the treatment of SUDs. SAMHSA: Medication Assisted Treatment, <https://www.samhsa.gov/medication-assisted-treatment>.
- ⁷ PubMed.gov, Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence, July 8, 2009, <http://www.ncbi.nlm.nih.gov/pubmed/19588333>; JAMA Network, Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial, February 2006 <http://archpsyc.jamanetwork.com/article.aspx?articleid=209312>; PubMed.gov, Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone, Sep. 4, 2003, <http://www.ncbi.nlm.nih.gov/pubmed/12954743>.
- ⁸ Colorado Department of Health Care Policy and Financing, “Colorado Department of Health Care Policy and Financing Preferred Drug List,” effective July 1, 2018. Accessed at https://www.colorado.gov/pacific/sites/default/files/PDL%20effective%2007-01-2018%20final2_1.pdf.
- ⁹ Colorado Legislature, House Bill 18-1000, Approved by Governor Hickenlooper May 21, 2018. Accessed at http://leg.colorado.gov/sites/default/files/documents/2018A/bills/2018a_1007_signed.pdf.
- ¹⁰ <https://www.sos.state.co.us/CCR/eDocketDetails.do?trackingNum=2018-00518>.
- ¹¹ https://www.denvergov.org/content/dam/denvergov/Portals/771/documents/CH/Substance%20Misuse/DDPHE_OpioidResponseStrategicPlan.pdf.

- ¹² Nationally, 41% of opioid treatment providers provide at least one form of MAT, and 3% provide all forms. Opioid & Health Indicators Dataset, AMFAR, http://opioid.amfar.org/indicator/AMAT_fac.
- ¹³ Number of DATA-Waived Practitioners Newly Certified Per Year, https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=CO.
- ¹⁴ Colorado Health Institute, “Miles Away from Help,” Last updated May 30, 2017, accessed at <https://www.coloradohealthinstitute.org/research/miles-away-help>.
- ¹⁵ “Substance Abuse Trend and Response Task Force. Twelfth Annual Report,” https://coag.gov/sites/default/files/contentuploads/oce/Substance_Abuse_SA/SATF-reports/12th_annual_substance_abuse_task_force_report_2017_final.pdf.
- ¹⁶ https://drive.google.com/file/d/1-RoKqZjIX1yD3Z4gkYG2-9B2dEifd_4D/view.
- ¹⁷ <https://drive.google.com/file/d/1ZQ0EbBf88rs65qObSRhglC61PhEwYhxp/view>.
- ¹⁸ http://hac.virginia.gov/committee/files/2017/10-16-17/V_a%20-%20DMAS%20Handout.pdf.
- ¹⁹ Recovery homes or sober living homes are privately operated residences for a small number of recovering addicts who support each other through therapy and Narcotic Anonymous or Alcoholics Anonymous meetings. Feldman, Nina. Many ‘Recovery Houses’ Won’t Let Residents Use Medicine To Quit Opioids, <https://www.npr.org/sections/health-shots/2018/09/12/644685850/many-recovery-houses-wont-let-residents-use-medicine-to-quit-opioids>.
- ²⁰ The Mental Health Parity and Addiction Equity Act of 2008 is federal legislation that bars group health plans and health insurers that provide mental health and SUD benefits from imposing less favorable limitations than those for medical and surgical benefits. The Center for Consumer Information & Insurance Oversight: The Mental Health Parity and Addiction Equity Act (MHPAEA) Factsheet, https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.
- ²¹ Colorado Department of Health Care Policy and Financing, Parity FAQs, <https://www.colorado.gov/pacific/sites/default/files/Mental%20Health%20Parity%20FAQ.pdf>.
- ²² As part of a federal grant awarded by the Center for Consumer Information & Insurance Oversight on October 31, 2016, the DOI “will develop a parity compliance worksheet and then require all carriers to complete the worksheet for its plans. The worksheet will require the insurance plan issuer to submit data related to parity compliance including the financial requirements, Quantitative Treatment Limitations, and Non-Quantitative Treatment Limitations applied for both medical/surgical benefits and behavioral health benefits. The Division will also develop educational materials and expand consumer-friendly outreach campaigns to help consumers understand their rights under the mental health parity laws, including how to file appeals, and provide information about issuer non-compliance.” <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/co-cpg.html>.
- ²³ Department of Regulatory Agencies, Division of Insurance, Amended Regulation 4-2-53, <https://drive.google.com/file/d/17Q26uz7BopuEeMC4wSlTn-51oUjBoy3/view>.
- ²⁴ Department of Regulatory Agencies, Division of Insurance, Amended Regulation 4-2-54, <https://drive.google.com/file/d/1ciCt4aqHD3M2r79ovd-BrRJmcjzOeEwl/view>.

- ²⁵ Department of Regulatory Agencies, Division of Insurance, Amended Regulation 4-2-55, <https://drive.google.com/file/d/1wYh32Kn5XqLUL5QVSWpBxakJBGdSYi6e/view>.
- ²⁶ Department of Regulatory Agencies, Division of Insurance, Amended Regulation 4-2-56, https://drive.google.com/file/d/1f2kM513msoMDfM_W9UZqdzWs8ppYDiOi/view.
- ²⁷ <https://www.uchealth.org/today/2018/08/17/uchealth-emergency-departments-address-opioid-crisis-reduce-number-of-pills-prescribed/>.
- ²⁸ Interview with Jason Hoppe, DO, Assistant Professor of Surgery, Division of Emergency Medicine, University of Colorado Denver. November 4, 2018.
- ²⁹ Source: Vermont Department of Health, http://www.leg.state.vt.us/jfo/healthcare/Health%20Reform%20Oversight%20Committee/2016_10_25/Status%20of%20Opioid%20Treatment%20Efforts%20-%20Chen.pdf.
- ³⁰ <http://www.corxconsortium.org/treatment-work-group/>.
- ³¹ <http://www.corxconsortium.org/wp-content/uploads/OTP.pdf>.
- ³² Colorado Legislature, Senate Bill 18-024. Approved by Governor Hickenlooper May 21, 2018. Accessed at <http://leg.colorado.gov/bills/sb18-024>.
- ³³ <https://www.coloradohealthinstitute.org/research/options-residential-and-inpatient-treatment-substance-use-disorder>.
- ³⁴ On October 24, 2018, the president signed into law the SUPPORT Act, a bill aimed at addressing the opioid epidemic that, among other things, gives states the authority to eliminate the IMD exclusion via a simple state plan amendment. There, however, are some limitations on the state option, and Colorado will need to evaluate whether the new state plan option offers a more favorable way to eliminate the IMD exclusion than the waiver pathway.
- ³⁵ Colorado Department of Human Services, Screening, Brief Intervention and Referral to Treatment, <https://www.colorado.gov/pacific/cdhs/screening-brief-intervention-and-referral-treatment-sbirt>.
- ³⁶ Grants will go to one or more organizations, and will require online and in-person evidence-based training on SBIRT for health care professionals statewide, including providers who serve women of childbearing age; consultation and technical assistance for health care providers, health care organizations, and stakeholders; coordination with primary care, mental health care, integrated health care, and substance use prevention, treatment, and recovery efforts; and development of a patient education tool on the risks of substance use during pregnancy. Colorado Legislature, House Bill 18-1003.
- ³⁷ <http://liftthelabel.org/>.
- ³⁸ CDC: Morbidity and Mortality Weekly Report, September 14, 2018, <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6736a2-H.pdf>.
- ³⁹ IQVIA.
- ⁴⁰ Colorado also continues to expand its regulation of prescriptions for legal opioids. Senate Bill 22, passed in May 2018, limits initial opioid prescriptions to seven days and allows for one refill of seven days. Medicaid also implements MME limits, currently set at 250 MME per day.

- ⁴¹ The Colorado Department of Regulatory Agencies first adopted the “Guidelines for Prescribing and Dispensing Opioids” on October 15, 2014, and revised them on March 16, 2018. The guidelines have been adopted by the Colorado Dental Board, the Colorado Medical Board, the State Board of Nursing, the State Board of Pharmacy, the Nurse-Physician Advisory Task Force for Colorado Healthcare, the State Board of Optometry, and the Colorado Podiatry Board, and are endorsed by the Colorado State Board of Veterinary Medicine. They are available at <https://drive.google.com/file/d/19xrPqsCbaHHA9nTD1FI3NeCn5kwK60zR/view>.
- ⁴² Colorado Department of Health Care Policy and Financing, “Colorado Department of Health Care Policy and Financing Preferred Drug List,” effective July 1, 2018. Accessed at https://www.colorado.gov/pacific/sites/default/files/PDL%20effective%2007-01-2018%20final2_1.pdf.
- ⁴³ Colorado Hospital Association, “Colorado Hospitals Achieve 36 Percent Reduction in Opioid Administration,” January 25, 2018. Accessed at <https://cha.com/colorado-hospitals-achieve-36-percent-reduction-in-opioid-administration>.
- ⁴⁴ <https://cha.com/wp-content/uploads/2018/06/CHA-Opioid-Pilot-Results-Report-May-2018.pdf>.
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- ⁴⁶ Nahin RL, Boineau R, Khalsa PS, Stussman BJ, Weber WJ. Evidence-based evaluation of complementary health approaches for pain management in the United States. *Mayo Clinic Proceedings*. 2016;91(9):1292–1306.
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- ⁵⁵ See, for example, stories of first responders and others in multiple areas of the state becoming trained to administer and use naloxone to those experiencing an opioid-related overdose: <https://www.denverpost.com/2017/04/28/opioid-overdoses-naloxone/>, <https://the-journal.com/articles/82649>, and http://www.timescall.com/opinion/letterstotheeditor/ci_31648634/amanda-bent-naloxene-is-saving-lives-colorado.
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