Health District
OF NORTHERN LARIMER COUNTY

02/20/2024

STAFF: DAVID NAVAS POLICY ANALYSIS

HB24-1045: TREATMENT FOR SUBSTANCE USE DISORDERS

Concerning treatment for substance use disorders.

Details

Bill Sponsors:	House – *Armagost (R), deGruy-Kennedy (D),* Rep. Young (D) Senate – *Mullica (D), Will (R),* Jacquez-Lewis (D), Priola (D)
Committee:	House Health and Human Services Committee
Bill History:	**01/10/24-** Introduced in the House- Assigned to Health & Human Services Committee
Next Action:	**02/20/24**- Hearing in House Health & Human Services Committee
Fiscal Note:	2/16/24

Bill Summary

There are various provisions in this legislation aimed at improving treatment for substance use disorders (SUDs), including, but not limited to:

- Prohibiting prior authorization based solely on drug dosage for substance use disorder medications.
- Mandating reimbursement for licensed pharmacists prescribing/administering medication-assisted treatment (MAT).
- Requiring the Commissioner of Insurance is to review network adequacy rules the maintain adequate SUD treatment and behavioral health providers.
- Establishing the Behavioral Health Diversion Pilot Program to award grants to 2-5 district attorneys to divert those with a behavioral health disorder from the criminal justice system.
- Authorizing licensed clinical social workers and licensed professional counselors to provide supervision to individuals seeking certification as addiction technicians and addiction specialists.
- Including grants to provide training and ongoing support to pharmacies and pharmacists who are authorized to prescribe, dispense, and administer MAT through the Medication-Assisted Treatment Expansion Pilot Program.
- Requires the Department of Health Care Policy and Financing (HCPF) to seek federal authorization to provide screening, brief intervention, administration of MAT, case management and care coordination services through the MAT program to persons up to 90 days prior to release from jail.
- Requiring SUD treatment to be reimbursed at the same rate for telehealth as it is for in-person services.
- Directing the Division of Insurance (DOI) to assess utilization management practices' impact on behavioral health service access and insurer policies.

Issue Summary

Substance use disorders (SUDs) are a complex and multifaceted disease that has significant social, health, and economic implications. Diagnosis is often based on behavioral health criteria, including physical dependence or the inability to control substance use, interpersonal problems caused by substance use, and

dysfunction at home, work, or school.[1] Medications like methadone, buprenorphine, and naltrexone have demonstrated efficacy in treating opioid use disorder (OUD).[2] Medications for a substance use disorder (also known as medication assisted treatment or MAT or medication for an opioid use disorder or MOUD) consistently reduces the likelihood of emergency department visits and hospital admissions compared to untreated individuals with an OUD, which play a key role in reducing costs and over utilization of health care services.[3]

Studies have highlighted various barriers to accessing treatment, including travel distance to treatment centers and workforce shortages, which disproportionately affect rural and economically disadvantaged areas. One study showed that there is a statistically significant difference between drive times to an opioid treatment facility versus a local pharmacy suggesting that this barrier may be reduced with pharmacy-based dispensing of methadone maintenance.[4] A study of daily attendance to opioid treatment programs (OTPs) showed that those living more than 10 miles from an OTP were more likely to miss methadone doses than those who lived within 5 miles of the program.[5]

The scarcity of behavioral health professionals is undermining people's ability to get timely care. Nearly half of the U.S. population (47%) is living in a mental health workforce shortage area.[6] Some populations, like rural areas or economically stressed cities, are disproportionately impacted by workforce shortages.[7] Many barriers to accessing evidence-based treatment for SUD, particularly MAT, are related to the workforce. Barriers include workforce shortages for certain providers, insufficient training, education and experience, lack of institutional and clinician peer support, provider stigma, inadequate reimbursement or burdensome reimbursement procedures. Telehealth has been shown to improve access to care, especially for rural populations.[8] It can produce similar results to in-person treatment, reduce the burden of travel, and help reduce the perception of stigma. There is also a growing evidence base to support the benefit of telehealth in access to SUD-related care[9]. The four most common modes of telehealth in SUD treatment programs are computerized assessments (45%), telephone-based recovery support (29%), telephone-based therapy (28%), and video-based therapy (20%). A comparison study of medication treatment for opioid use disorders found

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[1] Altaf Dar, M., Gani, I., & Ara, I. 2023. Overview of substance use disorder and available treatments. International Journal of Current Research in Physiology and Pharmacology, 3–7. Retrieved from https://www.ijcrpp.com/index.php/ijcrpp/article/view

[2] Bell James; Strang, John. 2020. Medication Treatment of Opioid Use Disorder. Biological Psychiatry Volume 87, Issue 1, Pages 82-88,ISSN 0006-3223, https://doi.org/10.1016/j.biopsych.2019.06.020.

[3] Lewer, D., Freer, J., King, E., Larney, S., Degenhardt, L., Tweed, E. J., Hope, V. D., Harris, M., Millar, T., Hayward, A., Ciccarone, D., and Morley, K. I. 2020. Frequency of health-care utilization by adults who use illicit drugs: a systematic review and meta-analysis. Addiction, 115: 1011–1023. https://doi.org/10.1111/add.14892

[4] Kleinman, Robert A. 2020. Comparison of Driving Times to Opioid Treatment Programs and Pharmacies in the U.S. JAMA Psychiatry. 77(11):1163-1171. doi:10.1001/jamapsychiatry.2020.1624

[5] Amiri S, Lutz R, Socías ME, McDonell MG, Roll JM, Amram O. 2018. Increased distance was associated with lower daily attendance to an opioid treatment program in Spokane County Washington. Journal of Substance Use Treatment. 93:26–30

[6] Saunders, Heather; Guth, Medeline; Eckart, Gina. 2023. A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs. KFF. https://www.kff.org/mental-health/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/

[7] Counts, Nathaniel. 2023. "Understanding the U.S. Behavioral Health Workforce Shortage" (explainer), Commonwealth. https://doi.org/10.26099/5km6-8193

[8] Tuckson, R.V.; Edmunds, M.; Hodgkins, M.L. 2017. Telehealth. New England Journal of Medicine, Volume 377, issue 16, pages 1585-1592.

[9] L.A. Lin, D. Casteel, E. Shigekawa, M.S. Weyrich, D.H. Roby, S.B. McMenamin. 2019. Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of Substance Abuse Treatment, 101 pp. 38-49

lower dropout rates using telehealth modalities, retention being particularly important with ongoing treatment to improve mortality and other outcomes.[10]

This Legislation

Medication Assisted Treatment & Pharmacists

An insurance carrier that provides prescription drug benefits for SUDs must reimburse an in-network pharmacist to prescribe and/or administer MAT at a reimbursement rate equal to that provided to a physician, physician assistance, or nurse practitioner. The bill defines the term "Medications for Opioid Use Disorder" or "MOUD" as treatment for an opioid use disorder using medications approved by the FDA for that purpose and prescribed, dispensed, or administered in accordance with national, evidence-based guidelines. Pharmacists are allowed to dispense and administer any FDA-approved product for opioid use disorder, including MOUD, in accordance with federal laws and regulations.

Within six months of the bill being effective, the Pharmacy Board, Medical Board, and State Board of Nursing must develop a statewide drug therapy protocol for pharmacists to prescribe, dispense, and administer MAT. If the Boards cannot agree within that time frame, the Board of Pharmacy must collaborate with the Colorado Department of Public Health and Environment (CDPHE) to develop a statewide drug therapy protocol by May 1, 2025. Neither the protocol nor a collaborative pharmacy practice agreement have to be in place before a pharmacist may prescribe, dispense, or administer MAT, if it is otherwise authorize under law.

The bill requires Medicaid to reimburse a pharmacist prescribing or administering MOUD/MAT pursuant to a collaborative agreement at a rate equal to reimbursement rate for other providers.

Network Adequacy

By August 1, 2025, the Commissioner of Insurance must review network adequacy rules to ensure that they are sufficient to maintain an adequate number of:

- Substance use disorder treatment providers in underserved areas, and
- Cognitive behavioral health care providers in a carrier's network, including those that provide pain diagnoses services, allowing for access in all communities.

By September 30, 2025, the Commissioner must report the rule review findings to the Opioid and Other Substance Use Disorders Study Committee, including any recommended rule changes.

Clinical Supervision

The bill authorizes licensed clinical social workers (LCSWs) and licensed professional counselors (LPCs), if the professional has the necessary education or experience working with SUDs or behavioral health disorders, within their scope of practice to provide clinical supervision to individuals seeking certification as addiction technicians or addiction specialists.

Behavioral Health Diversion Pilot Program Grant

The Behavioral Health Diversion Pilot Program is established to award grants to at least 2, but no more than 5, judicial districts to provide diversion from the criminal justice system individuals who have a behavioral health disorder that requires early services and treatment that is reasonably expected to deter future

[10] Eibl, J. K., Gauthier, G., Pellegrini, D., Daiter, J., Varenbut, M., Hogenbirk, J. C., & Marsh, D. C. 2017. The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. Drug and Alcohol Dependence, 176, 133–138. https://doi.org/10.1016/j.drugalcdep.2017.01.048

criminal behavior. The program will be operated by the Office of the State Court Administrator, utilizing the existing Diversion Funding Committee. The bill specifies the following for the pilot program:

- The office must select between two and five district attorneys to participate, at least one of which is rural.
- The first round of grants must be awarded no later than four months of the bill's effective date.
- Awardees must provide status reports to the Judicial Department on determined dates.
- The county is responsible for selecting a program coordinator who will be responsible for developing all necessary criteria, developing all treatment plans, and coordinating care.
- The Behavioral Health Administration (BHA) must provide a list of approved assessors to perform clinical assessments in the county.
- If the assessor refers a defendant for treatment, the district attorney and eligible person may agree to their participation in the pilot program.
- Any statements made by the defendant during the clinical assessment must not be used for charging the defendant unless they commit a chargeable offense during the assessment.
- A candidate's participation in the program is optional and if they choose not to participate or are dismissed for non-compliance prosecution may proceed.
- Program participants complete a treatment program designed to provide the participant with the skills, training, and resources (including vocational assistance) needed to maintain recovery and prevent the participant from engaging in criminal activity.
- Program coordinators, participating district attorneys, and state court administrators are subject to various reporting requirements; and
- The Judicial Department must report by January 31, 2028, whether the pilot program should be continued. If it is not recommended, the program is repealed on June 30, 2028

MAT Expansion Pilot Program

The bill amends the existing MAT Expansion Pilot Program to allow pharmacists to participate and adds to the program reporting requirements specific information regarding the utilization of the program by pharmacists. The Colorado Pharmacists Society is added to the MAT Expansion Advisory Board.

Medicaid Reentry Services

The bill requires the Department of Health Care Policy and Financing (HCPF) to seek federal authorization to provide screening for physical and behavioral health needs, brief intervention, MAT, other needed prescription medications immediately before release from the Division of Youth Services (DYS), a Department of Corrections (DOC) facility, or a participating county jail.

Pending federal authorization, HCPF will implement the new benefit on July 1, 2025, for people in a DYS or a DOC facility and July 1, 2026, for people in county jail, except for MAT, which will be provided without federal authorization. The BHA will approve county jails for participation based on their commitment to diversion efforts and issue licenses to provide these services to the incarcerated Medicaid members. HCPF will produce an annual report which will require tracking participants following release and assessing the system.

Telemedicine Reimbursement

The bill mandates adding substance use disorder treatment to the list of health care or mental health-care services that are required to be reimbursed at the same rate for telemedicine as a comparable in-person service.

SUD Partial Hospitalization

The bill requires HCPF to seek a federal authorization to provide partial hospitalization for SUD treatment with full federal financial participation by July 1, 2026.

Medicaid Coverage of MAT

Requires each regional accountable entity (RAE) that covers methadone administration for the treatment of SUDs to:

- Not impose any prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders, regardless of the dosage amount.
- Set the reimbursement rate for take-home methadone treatment and office-administered methadone treatment at the same rate.

Withdrawal Management Data Collection

The bill requires the BHA to begin to collect data from each withdrawal management facility by July 1, 2025, on the total number of individuals who were denied admittance or treatment for withdrawal management and the reason for the denial. This data must be shared with each Behavioral Health Administrative Services Organization (BHASO). Beginning on January 1, 2025, the BHA must review and approve any admission criteria established by a withdrawal management facility.

RAE Reimbursement

The bill requires each RAE to disclose the aggregated average and lowest rates of reimbursement for a set of behavioral health services determined by HCPF.

Child Abuse Prevention Trust Fund

Appropriates $150,000 from the General Fund to the Colorado Child Abuse Prevention Trust Fund for programs to reduce the occurrence of prenatal substance exposure annually. It also appropriates $50,000 from the General Fund to the Child Abuse Prevention Trust Fund for state fiscal years 2024-2025 and 2025-2026 to convene a stakeholder group to identify strategies to increase access to childcare for families seeking SUD treatment and recovery services.

Support of Behavioral Health Safety Net

The bill requires the BHA to contract with an independent third-party by July 1, 2025, to support providers seeking to become approved BHA safety net providers, with the goal for the provider to become self-sustaining. This party will help the providers in accessing alternative payment models and enhanced reimbursement rates through the BHA and Medicaid.

Contingency Management Grant Program

The bill creates the Contingency Management Grant Program in the BHA to support selected SUD treatment programs. A contingency management program is an evidence-based treatment program that provides motivational incentives to treat individuals with a stimulant use disorder. Grant recipients may use the funds

for staffing, training, supplies, administrative costs, the costs of vouchers/incentives up to $599, and other related expenses approved by the BHA.

Opioid Treatment Program Working Group

This section requires the BHA, in collaboration with HCPF, to convene a working group to study and identify barriers to opening and operating an opioid treatment program (OTP), including satellite units and mobile clinics. This must be convened by October 1, 2024. The group must complete its work and make recommendations to the BHA by October 1, 2025. The working group must be composed of at least the following individuals:

- Addiction counselor
- Medical director of an OTP
- Director or clinical manager of an OTP
- Physician who is board certified in addiction medicine or addiction psychiatry
- Individual who resides in a rural community who has lived experience or a family member with lived experience
- Individual who resides in an urban community who has lived experience or a family member with lived experience

Fiscal Note

For state fiscal year 2024-25, the bill requires an appropriation of $6.1 million to multiple state agencies.

Reasons to Support

There is a shift toward viewing substance use disorders as a community health problem, emphasizing a more person-centered approach. This approach recognizes that individuals with SUDs need access to health care services rather than punitive measures. This bill aims to increase access to SUD treatment by changing prior authorization requirements and allowing pharmacists to prescribe, dispense, and administer these treatment options. It provides a mechanism for these providers to be reimbursed for these services, which increases the likelihood of uptake.

By allowing LCSWs and LPCs to supervise those seeking certification, this bill seeks to address one of the biggest threats to behavioral health care access in Colorado today- the workforce shortage. Those seeking certification in these fields are required to meet a certain number of post-degree experience under supervision. This process is not without imposing challenges to the capacity of the existing workforce and reducing the barriers to allow more professionals who are qualified to participate in facilitating candidates through certification thus helping the workforce grow in volume and skills.

Adding SUD treatment to telemedicine services that are required to be reimbursed also helps address gaps caused by the workforce shortage. Telehealth will allow these professionals to reach people in larger service areas.

This bill funds the expansion of MAT Expansion Pilot Program including grants to provide training to pharmacists. To implement the provision of reimbursement for MAT administered by pharmacists to the highest level of quality, access to workforce skill development is necessary. This would create a funding

mechanism to do so. It might also serve as an incentive for more pharmacists to provide MAT, reducing barriers to treatment such as travel distance.

Funding approaches to address prenatal substance exposure has both benefits for newborns, pregnant people, and families.

Supporters

- ACLU of Colorado
- Colorado Community Health Network
- Colorado Coalition for the Homeless
- Colorado Hospital Association
- Colorado Pharmacists Society
- Colorado Psychiatric Society
- Colorado Retail Council
- Indivior
- Mental Health Colorado
- RxPlus Pharmacies
- Colorado Providers Association

Reasons to Oppose

The provision that allows pharmacies or pharmacists the authority to prescribe MAT is a possible critical divergence in schools of thought for the harm reduction framework. The difference lies in that some argue that medication only treatment without the accompanying counseling and behavioral health treatment is not effective. The premise being that pharmacies or pharmacists prescribing medication for the treatment of SUD would not be accountable to assuring that patients receive those parts of the overall treatment. While an optimal approach for many individuals with OUD involves a blend of medical and behavioral health interventions, some argue that the necessity of the latter should never hinder access to the former.[11] Many health care facilities have already implemented strategies to broaden the pool of providers capable of prescribing SUD treatment medications, improving access to care, and patient-centered health care in which both patients and doctors share the responsibility for making decisions together.[12]

Studies show a distinct form of stigma attached to MAT termed "intervention stigma."[13] This stigma, separate from the stigma associated with the condition of SUD itself, encompasses public, self-imposed, and structural biases. Misguided fears regarding medication diversion have particularly impeded office-based MAT.[14]

Opponents

- Any opposition has not been reported.

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[11] Rachel P. Winograd, Ned Presnall, Erin Stringfellow, Claire Wood, Phil Horn, Alex Duello, Lauren Green & Tim Rudder. (2019) The case for a medication first approach to the treatment of opioid use disorder, The American Journal of Drug and Alcohol Abuse, 45:4, 333-340, DOI: 10.1080/00952990.2019.1605372

[12] Sunggeun (Ethan) Park, Jennifer E. Mosley, Colleen M. Grogan, Harold A. Pollack, Keith Humphreys, Thomas D'Aunno, Peter D. Friedmann. 2020. Patient-centered care's relationship with substance use disorder treatment utilization. Journal of Substance Abuse Treatment. Volume 118, 108125, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2020.108125.

[13] Madden, E. F. (2019). Intervention stigma: How medication-assisted treatment marginalizes patients and providers. Social Science & Medicine, 232, 324-331.

[14] Dickson-Gomez J, Spector A, Weeks M, Galletly C, McDonald M, Green Montaque HD. (2022) “You’re Not Supposed to be on it Forever”: Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids. Substance Abuse: Research and Treatment. Volume 16. doi:10.1177/11782218221103859

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides behavioral health, dental care, preventive, and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact David Navas, Policy Analyst, at (970) 530-2736, or e-mail at dnavas@healthdistrict.org.