Spotlight on North Carolina

Best Practices and Next Steps in the Opioid Epidemic

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About Us

About the AMA

The American Medical Association is the powerful ally and unifying voice for America's physicians and the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age in order to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden.

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About the North Carolina Medical Society

The North Carolina Medical Society (NCMS) is the oldest professional member organization in North Carolina, representing physicians and physician assistants who practice in the state. Founded in 1849, the Society seeks to provide leadership in medicine by uniting, serving and representing physicians and their health care teams to enhance the health of North Carolinians. Learn more about the NCMS at our website, www.ncmedsoc.org.

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Roadmap to Ending North Carolina's Opioid Epidemic: Medicaid and Commercial Insurance Strategies

The American Medical Association (AMA) and Manatt Health are undertaking an in-depth analysis of 4 states' Medicaid and Insurance Department responses to the opioid epidemic to identify best practices and strategies to build on accomplishments. In the Pennsylvania, Colorado and Mississippi spotlight analyses, we highlighted those states' activities related to substance use disorder (SUD) treatment, pain management and efforts to increase access to naloxone, a lifesaving medication that can reverse an opioid-related overdose. In this analysis of North Carolina, we review the state's progress in Medicaid and the commercial insurance market in these same 3 areas and identify options for further building on these gains, drawing on emerging strategies from around the country.

Key Actions Taken in North Carolina

- **Increasing access to medication-assisted treatment.** North Carolina has eliminated prior authorization for leading forms of medication-assisted treatment (MAT) in Medicaid and used federal grants to provide treatment, linkages to MAT, and training and support to providers who offer MAT services to patients.

- **Providing the full continuum of care required for SUD treatment.** Using a recently approved Medicaid waiver as a jumping off point, North Carolina's Department of Health and Human Services (DHHS) has taken steps to provide the full continuum of care recommend by the American Society for Addiction Medicine (ASAM). The waiver lifts the federal ban on treatment provided in institutions of mental disease (i.e., "the IMD exclusion"), and it also has spurred North Carolina Medicaid to review its benefit package to ensure it covers all recommended services in outpatient, inpatient and residential settings.

"Addressing this epidemic will require an ongoing, sustained effort comprised of multiple strategies and with coordination and partnership across a wide range of stakeholders including law enforcement, education, health care, policymakers, philanthropy, advocates and the business community. While we have made progress in addressing this crisis, we have much more work to do."

Mandy K. Cohen, MD, MPH
Susan M. Kansagra, MD, MBA
North Carolina Department of Health and Human Services

- **Focusing on "whole person care" in Medicaid managed care implementation.** As part of the transition to Medicaid managed care that goes into effect later in 2019, the state has established requirements for Medicaid managed care plans to provide integrated care that considers an individual's physical health, behavioral health, and related social and economic issues. This focus on whole-person care is particularly important for individuals with SUD, who often face challenges across all these domains, and who have much to gain from integrated treatment that takes into account the full array of issues affecting their health and recovery.

- **Promoting access to comprehensive pain care.** Medicaid has taken steps to increase access to non-opioid pain management alternatives. It has added or expanded coverage for some non-opioid pharmaceuticals and topical analgesics, as well as non-pharmaceutical alternatives, such as physical therapy and chiropractor services. Even as it promotes non-opioid pain treatments, Medicaid recognizes that some beneficiaries with chronic pain require opioids and has created clinical guidelines that promote individualized patient care plans.

- **Expanding naloxone access and promoting harm reduction.** North Carolina has expanded the availability of naloxone throughout the state, building on its early adoption of a naloxone standing order and Good Samaritan law. Its efforts to promote the distribution of naloxone kits to first responders, law enforcement and community coalitions have reversed more than 10,000 overdoses. As part of its commitment to harm reduction, the state legalized and publicized syringe exchange programs to reduce the spread of infectious diseases and link individuals with SUD to services.

"To truly have a positive impact on the opioid epidemic in this state, we must forge partnerships that collaboratively address the problem. That includes working together to offer waiver training and support to help providers offer MAT in their office; coordinating with community groups to provide resources to those struggling to recover from substance use disorder; and partnering with the justice system to help ensure compliance. By collaborating and coordinating these efforts, as our Project OBOT is designed to do, we serve the patient in the most comprehensive and effective manner."

North Carolina Medical Society CEO Robert W. Seligson

Where North Carolina Can Build on Its Accomplishments

- **Expand Medicaid.** North Carolina has not expanded Medicaid to low-income adults as allowed under federal law, leaving approximately 150,000 North Carolinians with an SUD without coverage. This is a major missed opportunity that could help North Carolina end the opioid epidemic within its borders. Without a solid base of coverage for its citizens, North Carolina will not have the ability to ensure that its residents are systematically screened for and treated for SUDs. Gov. Roy Cooper has called for expansion, and the legislature is debating this issue during the current 2019 legislative session.

- **Partner with Medicaid managed care plans to ensure implementation of key SUD-related policies.** North Carolina has established strong requirements for Medicaid managed care plans to provide whole-person care, offer an adequate network of providers and cover key forms of MAT without prior authorization. As managed care goes into effect, it will be critical to ensure plans are complying with these requirements and working in partnership with the state to end the epidemic.

- **Adopt cross-sector approaches to combating the epidemic.** North Carolina has established a Payers Council that brings Medicaid, Medicare and commercial insurers together to collaborate on responses to the epidemic. The Council developed concrete recommendations for health insurance payers to respond to the opioid epidemic through pain treatment, naloxone access, SUD treatment, data analytics, and patient and provider education. The state's largest insurer, Blue Cross Blue Shield of North Carolina, has eliminated prior authorization for all of its preferred buprenorphine products. Many large insurers in North Carolina have expressed support for removing prior authorization, and we encourage all of them to issue public statements that are specific as to the policies they are implementing.

- **Partner with commercial insurers to meet network adequacy and parity standards.** The network adequacy standards established for Medicaid managed care plans provide clear guidance to those plans and could be used to strengthen Department of Insurance (DOI) guidelines for ensuring that commercial insurers have adequate networks as well. The DOI also could clarify mental health and substance use disorder parity standards and use targeted market conduct exams to identify and remedy gaps in commercial insurance services.

- **Further increase access to opioid alternatives.** In Medicaid, the state already has opted to cover important forms of evidence-based non-opioid and non-pharmacological alternatives for pain management. It could build on these efforts by continuing to review whether all appropriate alternatives are covered by Medicaid. The DOI should work with commercial insurers to ensure commercially insured patients have access to timely and affordable, comprehensive, multidisciplinary, multimodal pain care.

- **Continue efforts to systematically measure the impact of opioid-related interventions.** The state has recognized the importance of evaluating its progress on combating the opioid epidemic, and has developed key metrics that are monitored and published quarterly on an opioid data dashboard. It will be important to continue evaluating the effectiveness of interventions, including working with the medical community, patient advocates, researchers and universities to identify where programs are working as well as how to more effectively use resources based on surveillance data.

Exhibit 1. 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, including:

- **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**

I. Introduction

North Carolina has fought the opioid epidemic with an array of public and private sector initiatives. In 2017, Gov. Cooper released an Opioid Action Plan developed in collaboration with community partners. It mobilized multiple state agencies to implement new strategies for reducing opioid prescriptions and expanding access to treatment and recovery-oriented systems of care. As part of the plan, the state established the North Carolina Payers Council to bring Medicaid, Medicare and commercial insurers together to collaborate on responses to the epidemic. While there has been a 12 percent reduction in opioid prescriptions since 2013, the death rate has not yet plateaued.[1]

Exhibit 2. Opioid-Related Overdose Deaths in North Carolina[2]

Source: 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; National Institute of Drug Abuse, North Carolina Opioid Summary, Revised February 2018, https://www.drugabuse.gov/opioid-summaries-by-state/north-carolina-opioid-summary.

This spotlight analysis primarily highlights the work of 2 agencies—North Carolina Medicaid (housed within DHHS) and the North Carolina DOI—that address issues that determine what care is available to the 18 percent of North Carolinians covered by Medicaid and the Children's Health Insurance Program (CHIP) and the 53 percent with fully insured individual or group insurance coverage.[3] This analysis also briefly reviews what the introduction of Medicaid managed care could mean for SUD treatment services and describes important work led by the Department of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) and some leading private sector institutions. It is important to highlight, however, that a full picture of the state's efforts would require the same close scrutiny of other agencies that we have given the DOI and Medicaid. Where helpful, the analysis of North Carolina's efforts has been supplemented by examples of best practices from other states.

II. Increasing Access to High-Quality, Evidence-Based Care for SUDs

With an estimated 19.4 million cases of SUDs nationwide, there is an urgent need to make treatment more widely available, starting with MAT.[4,5] Despite strong evidence that MAT is the most effective treatment option for many individuals with SUDs, barriers to MAT persist. These include stigma, a shortage of in-network providers who offer MAT, high cost-sharing, and prior authorization requirements that can impede access for patients whose willingness to seek treatment can quickly fade if they face a delay.[6]

Establishing a Strong Foundation of Coverage in Medicaid

North Carolina has worked to increase access to MAT, behavioral health care and other services, but the state faces an uphill battle because it has not expanded Medicaid, leaving many of the people affected by the epidemic without coverage. The Medicaid program currently covers pregnant women, parents/caretakers, and children and individuals with disabilities.[7] The expansion population—largely low-income parents and other adults not covered under North Carolina Medicaid—has a higher prevalence of SUDs than populations currently covered under the state's Medicaid program. It is estimated that expanding Medicaid would cover approximately 150,000 individuals with SUDs, providing them with access to treatment.[8,9] The Cooper administration is working with the legislature to pursue Medicaid expansion during the current 2019 session.[10]

Recommendation: Expand Medicaid to low-income parents and other adults, thus providing coverage to approximately 150,000 uninsured individuals with SUDs.

Expanding Coverage of MAT

For current Medicaid beneficiaries, North Carolina covers all 3 categories of MAT: buprenorphine, naltrexone and methadone, and offers the leading forms of medication within each category without prior authorization. Among buprenorphine products, Medicaid has not required prior authorization for suboxone film since November 2017, nor for Sublocade™, the extended-release injection form of buprenorphine, since March 2018.[11] Medicaid also covers Vivitrol, the long-acting injectable form of naltrexone and methadone without prior authorization.[12] Upon Medicaid managed care plans' launch in 2019, they will be required to adhere to NC Medicaid's preferred drug list and prior authorization policies, including for MAT.[13]

The NC Payers Council has brought together health care payers to increase access to MAT for the commercially insured population. The Council includes the state's largest insurer, Blue Cross and Blue Shield of North Carolina (BCBS NC), as well as many of the nation's largest for-profit insurers that offer products in the insured and self-insured commercial market. The Council facilitated data sharing among insurers and promoted alignment on best practices such as eliminating prior authorization requirements for MAT. In November 2018, BCBS NC announced that it was eliminating prior authorization for all of its preferred buprenorphine products, representing 96 percent of all buprenorphine-based MAT products, and the Council reports that "most insurers in North Carolina" are "streamlining or eliminating prior authorization."[14,15] The DOI could augment the work of the Payers Council by using its market oversight authority to monitor insurer implementation of agreements forged by the Payers Council and ensure public accountability. In Pennsylvania, for instance, the Insurance Department worked with the state's 7 leading insurers in fall 2018 to reach specific agreements on eliminating prior authorization and limiting cost-sharing for defined MAT products, and the department anticipates playing an active monitoring role in the future.[16]

Recommendation: Build on the successes in Medicaid to ensure consistent coverage of all forms of MAT without prior authorization. Encourage all payers to follow the lead of Blue Cross Blue Shield to publicly commit to removing prior authorization for MAT and monitor compliance. In commercial products where cost-sharing is an issue, require plans to limit cost-sharing to the lowest tier of the pharmacy benefit.

Enforcing Mental Health and SUD Parity in Commercial Insurance

SUD treatment is an essential health benefit under the Affordable Care Act (ACA), which applies to coverage for individuals and small groups with 1 to 50 employees. More importantly, though, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurers cover inpatient, residential and outpatient mental health services to the same extent they cover physical health services.[17]

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, parity is still a work in progress across commercial insurance in North Carolina, as in other states.

The DOI has regulatory authority to look at parity compliance and has taken steps in that direction by hiring a consultant to advise the department on parity oversight. The DOI conducted a detailed analysis of the 66 consumer complaints filed in 2018 related to mental health and concluded that they did not raise a "specific area of concern at this time."[18] The department has embarked on an outreach effort to consumers through website and printed materials, a television commercial, and participation in mental health conferences in an effort to expand consumer awareness. Enhanced awareness may lead to more consumer complaints, but parity issues are often confusing for consumers; another option for identifying consumers' problems would be to conduct targeted market conduct exams using a parity questionnaire modeled on questionnaires developed by other states. Pennsylvania and Colorado are in the process of conducting such parity examinations, and the 2 examinations published to date by Pennsylvania used parity questionnaires and found significant parity violations for SUD claims.[19]

Recommendation: Incorporate a parity questionnaire into market conduct examinations for commercial insurers to establish baseline findings of compliance with mental health and SUD parity legal obligations, including taking appropriate enforcement actions to ensure compliance with examination findings. Publish the findings to increase transparency for payers, consumers and other key stakeholders.

Exhibit 3. Parity Enforcement

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, parity is still a work in progress. In the commercial insurance market, strong market conduct examination procedures, such as those being undertaken in Pennsylvania and Colorado, can help ensure compliance with state and federal parity requirements.

Enhancing Network Adequacy Oversight

An important aspect of parity compliance is determining whether insurers have adequate provider networks to meet the needs of SUD patients. On the commercial side, this can be measured through market conduct examinations, but it also can be assessed as part of the "front end" rate and form review process. The DOI's parity consultant is going to provide extensive training to DOI staff on both pre-market and post-market reviews of parity. Rate and form reviews are particularly important in North Carolina since the DOI no longer receives annual network filings from all insurers and must use new procedures to identify network adequacy issues in the marketplace.

In addition to considering the DOI consultant's recommendations, the DOI could enhance its network adequacy reviews by undertaking a targeted review of insurer networks, specifically in reference to federal regulations providing that a physician may treat up to 30, 100 or 275 patients in the office with buprenorphine for SUDs. To help determine the total number of potential SUD patients who 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, and how many patients they can treat. The state could even go a step further and require health plans to affirm how many of those MAT providers are actively seeing patients with SUD. This type of quantitative analysis is not only possible, it is essential to determine the workforce capacity in a health insurance network. Identifying network gaps will

not automatically close them, but it will engage insurers in doing their part to identify what is needed and take appropriate action to fill those gaps.

The state's Medicaid program has established urban and rural network adequacy standards for SUD treatment services for its Medicaid managed care plans, beginning upon their launch in 2019. Medicaid will oversee implementation of the network adequacy standards through a system that includes:[20]

- Requiring plans to submit regular documentation, including provider network data and reports that summarize findings from plans' own network data analysis, to demonstrate network adequacy;
- Monitoring beneficiary complaints related to access to care and provider networks;
- Reviewing Consumer Assessment of Healthcare Providers and Systems survey findings related to availability and access to services and acting as needed; and
- When necessary, issuing corrective action plans when plans are identified as noncompliant with network adequacy standards and access requirements.

Medicaid also will contract with a qualified external quality review organization (EQRO) to perform an annual external quality review of each plan. This review will determine, in part, plan compliance with network adequacy and access requirements; confirm the adequacy of plan networks; and validate plan data. The EQRO will issue a public report on these findings.

Recommendation: To increase access to care for patients with an SUD, the DOI should conduct front-end reviews of network plans to ensure that consumers' health insurance coverage options will have an adequate number of addiction medicine physicians, psychiatrists, and other mental and behavioral health care professionals currently accepting new patients in a patient's health insurance network.

Encouraging More Providers to Offer MAT

North Carolina has taken steps to expand access to treatment, including MAT, primarily through the support of Medicaid and federal grants. Approximately 75 opioid treatment programs (OTPs)—which are federally certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide supervised assessment and MAT for individuals with OUD—treat 20,000 North Carolinians on an annual basis. They are reimbursed by a mixture of Medicaid, self-pay and state funds for indigent care.[21,22] While the distribution of OTPs throughout the state favors urban over rural areas, the state's Medicaid behavioral health plans are required to meet rural network adequacy standards of at least 2 OTPs within 45 minutes or 45 miles of residence.[23,24] Moreover, to increase access to MAT within the Medicaid program and as a condition of their Section 1115 Medicaid demonstration approval, the state will require residential treatment providers to provide MAT on-site or to establish referral arrangements with nearby providers.[25]

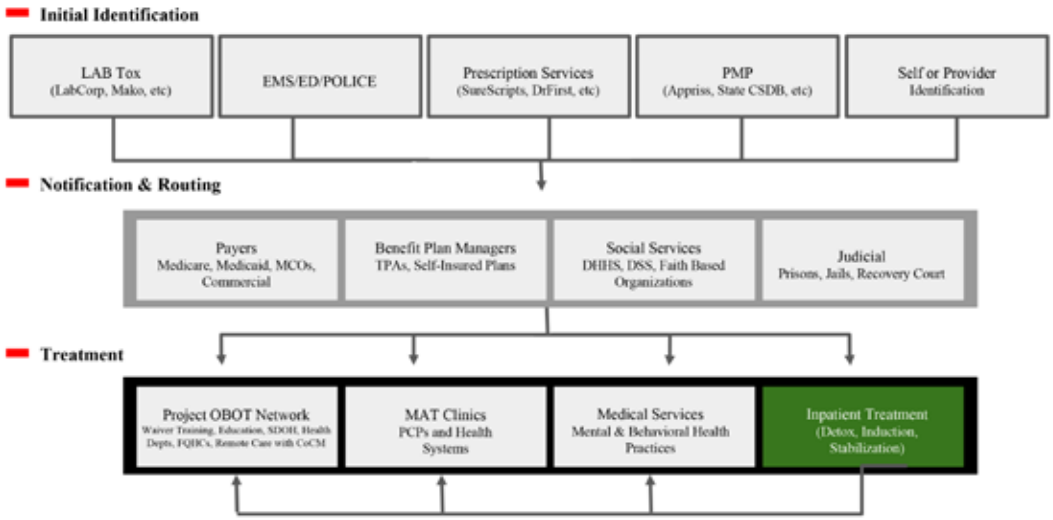
North Carolina also continues to work to increase access to office-based opioid treatment (OBOT), which is to say MAT provided by licensed clinicians outside of OTPs. Since 2016, more than 1200 physicians and other health care professionals have obtained a federal waiver to provide buprenorphine in-office to treat an OUD.[26] Yet it is estimated that less than half of these actively prescribe MAT.[27] The state is using its 21st Century Cures Act grant to expand training on MAT for providers and to address other barriers to MAT. This work is being done by the University of North Carolina (UNC) in collaboration with Project ECHO, a nationally recognized initiative used to expand access to MAT in rural and underserved areas.[28] Additionally, the state recently announced that it is using a Centers for Disease Control and Prevention (CDC) grant to partner with the Mountain Area Health Education Center (MAHEC) to provide training on prescribing MAT in medical residency programs and nurse practitioner and physician assistant training programs.[29]

In a complementary effort, the North Carolina Medical Society has developed a project that is similar to the "hub and spoke model" gaining popularity around the country. Project OBOT brought together a coalition of organizations—including the Governor's Institute, NC Association of Local Health Directors, LabCorp, The Recovery Platform, UNC School of Public Health, Project ECHO, Appriss and MAHEC—to provide training for physicians, use a network of care team collaborators to promote collaborative care coordination by ensuring treatment plans include information from all providers, and leverage technology to increase access to care.[30] Project OBOT also is working with recovery courts in an effort to include them in the collaborative care model. Project OBOT is one of the first state medical society efforts to

directly coordinate collaborative community-based care with local physicians serving as the hub, and the medical society helping build partnerships to develop the spokes.

As of December 31, 2018, SAMHSA records show about 1500 waiver-trained providers in North Carolina, with approximately 70 percent of those having the authority to treat up to 30 patients. This is short of what will provide the needed access to MAT. So while we strongly agree with continued and expanded waiver training, there also is a significant need to provide tools to encourage greater participation of waiver-trained providers. To that end, Project OBOT in North Carolina offers providers software that is specific to helping implement MAT in a practice, lower lab costs for MAT and a discounted pharmacy network for MAT. If successful, Project OBOT may provide a model for other states looking to develop community-based hub-and-spoke systems.

Exhibit 4. Government & Public Policy Determines Access and Funding for OUD



Source: North Carolina Medical Society Foundation.

Recommendation: Continue to invest in expanding the MAT workforce through training and other promising initiatives (e.g., Project ECHO), especially in rural communities. This includes enhancing incentives for primary care providers and local communities to begin providing office-based OUD treatment, and following the implementation of Project OBOT to determine whether it can be replicated in other communities and states beyond North Carolina.

Providing a Full Continuum of Care Inclusive of Residential Treatment

North Carolina historically has covered a robust array of SUD treatment and withdrawal management services, including outpatient, residential and inpatient services for those individuals who are eligible for Medicaid, including those who qualify on the basis of disability. In October 2018, the state's 1115 SUD waiver, which sought authority to use federal Medicaid matching funds for services provided in institutions for mental disease (IMD), was approved by the Centers for Medicare & Medicaid Services.[31] The IMD exclusion refers to a federal ban on using Medicaid funds to offer mental health and SUD residential treatment services for more than 15 days in a month in facilities with more than 16 beds.[32] Under the waiver, North Carolina can use Medicaid funds to finance stays delivered in IMDs for more than 15 days in a month, filling a significant gap in current treatment options. To secure its waiver, the state committed to ensuring that Medicaid covers the full continuum of care that someone with an SUD might require, including filling gaps in residential treatment and withdrawal management services.

Recommendation: Continue to move forward with implementing the elimination of the IMD exclusion and providing the full continuum of care for the treatment of SUDs under Medicaid.

Increasing Access to MAT for Justice-Involved Individuals

A priority of North Carolina's Opioid Action Plan is connecting incarcerated and formerly incarcerated individuals to SUD treatment. The state received approximately $3 million in MAT Prescription Drugs and Opioid Addiction (MAT-PDOA) funding in September 2016 to provide MAT to approximately 500 individuals on probation, as well as pre-release offenders incarcerated at Black Mountain (an SUD treatment facility for women on probation within the state prison system) and DART Cherry Correctional Center (the counterpart facility for men). The program provides Food and Drug Administration-approved OUD treatment medications, including naltrexone, buprenorphine, buprenorphine/naloxone and methadone, to these individuals.[33] Additionally, the state operates 2 pilot programs in Nash and Forsyth county jails to provide incarcerated individuals with SUDs with Vivitrol prior to release.[34]

Recommendation: Expand promising pilots to provide MAT to people on parole and to incarcerated individuals prior to release through implementing screening programs for those entering a jail or prison, continuing care for those incarcerated, and helping transition those who are released to Medicaid when appropriate, as well as additional community-based support programs.

Engaging People in Treatment

Individuals with SUDs who can benefit from MAT often require a range of supports to engage them in appropriate care, from initial assessments to care management services to referral options for complex cases. North Carolina has established the groundwork for providing this full range of supports and services in Medicaid.

Identifying Those Who Need Treatment

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based screening and early intervention strategy that can be used in any health care setting to identify people who are currently experiencing or are at risk for an SUD. North Carolina already has exercised the option in Medicaid to cover SBIRT, as well as used federal grant dollars to provide SBIRT trainings to health care workers.[35] Indeed, NC SBIRT, a 5-year SAMHSA-funded program to provide SBIRT in primary care practices throughout the northwest regions of the state, screened approximately 23,000 individuals from 2011–2016. Clinicians provided brief intervention to 718 people and brief treatment to 206, and referred 187 to more-specialized treatment.[36]

Leveraging Emergency Departments to Facilitate Warm Handoffs

Emergency departments (EDs) can play an important role in identifying people with SUDs and connecting them to treatment. The state and the North Carolina Healthcare Association provided $1.37 million in grant funding to 6 hospitals to support the integration of peer support services into their EDs. The peer support specialists connect people being seen in the ED due to an overdose to treatment with recovery and harm reduction support. To serve as a peer support specialist, an individual must have been in recovery for at least 3 years, which allows them to model the path from addiction to recovery.[37]

Recommendation: Leverage existing pilot initiatives and encourage hospitals to provide the staff and other resources that will enable more EDs to facilitate "warm handoffs" to treatment; continue to invest in training on SBIRT.

Providing Integrated Care

Beginning in 2019, North Carolina will transition most Medicaid beneficiaries from fee-for-service into managed care. The state already has established requirements that these managed care plans, known as "standard plans," provide integrated physical health services, behavioral health services, long-term services and supports, and assistance addressing social and economic issues that affect health. This focus on "integrated," or whole-person, care is particularly important for people with SUDs, who often face challenges across all these domains, and who have much to gain from treatment that takes into account the full array of issues affecting their health.

Starting in 2021, people with certain higher-intensity mental health and SUD needs, intellectual and developmental disabilities (I/DD) diagnoses, or traumatic brain injury needs will be enrolled in "tailored plans" or specialized managed care plans with additional resources and expertise to meet their complex needs. Once Medicaid beneficiaries enroll in integrated managed care plans, it will be easier for primary care providers, including those prescribing MAT, to refer their patients to and coordinate care with specialty SUD providers and social support networks. These providers will be able to work with care managers to develop care plans that encompass both physical and behavioral health needs.

Recommendation: Partner with Medicaid managed care plans to ensure they meet requirements for providing beneficiaries with integrated care that addresses the full array of barriers to recovery.

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—as well as understand issues related to workforce capacity—the state could partner with the AMA and the North Carolina Medical Society to work with SUD treatment providers to identify specific barriers to care that are facing patients and physicians and serve as a foundation for future efforts to increase access to MAT services. For example, this effort could help identify the role that stigma plays in limiting MAT services and 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, that has been shown to improve outcomes for SUD patients.

Recommendation: Partner with the medical community to assess barriers to providing care, including the role that stigma plays, and work with the medical community to address them.

Best Practices and Next Steps for Increasing Access to High-Quality, Evidence-Based Care for SUDs

Best Practices	Next Steps
■ **Medicaid coverage of MAT.** Medicaid covers all forms of MAT and has eliminated prior authorization for evidence-based medical care. ■ **Promoting provider use of MAT.** The state has invested grant funds in training providers on MAT and required all residential treatment centers receiving Medicaid funds to provide or link patients to MAT. ■ **Comprehensive Medicaid coverage of SUD treatment.** The state has covered SBIRT in Medicaid, eliminated the IMD exclusion via a waiver, and ensured that Medicaid covers all recommended SUD services in the inpatient, outpatient and residential settings in accordance with ASAM standards. ■ **Focus on whole-person care.** In the transition to Medicaid managed care, DHHS has established requirements that plans provide whole-person care that addresses physical health, behavioral health, and social and economic barriers to health and recovery. ■ **Engaging a consultant to enhance parity reviews.** The DOI has engaged a consultant to make recommendations for how best to assess parity in the DOI's rate and form reviews, which require insurers to obtain prior approval for their rates and forms.	■ **Expand Medicaid.** Establish a strong foundation of coverage for addressing the epidemic by expanding Medicaid. ■ **Eliminate remaining barriers to MAT.** All commercial insurers should remove prior authorization and cost-sharing barriers to MAT; continue to remove remaining access-to-care barriers in Medicaid. ■ **Continue to invest in the MAT workforce.** Use promising programs such as Project ECHO and new initiatives such as Project OBOT; continue to expand the MAT workforce, particularly in rural and underserved areas. ■ **Expand access to treatment for individuals involved in the criminal justice system.** Build on promising pilots to screen those entering a jail or prison, provide treatment during incarceration, and ensure MAT pre- and post-release for incarcerated individuals throughout the state. ■ **Further strengthen the infrastructure for SUD treatment services.** Use a combination of incentive grants and regulatory tools, including network adequacy reviews, targeted market conduct exams and aggressive application of parity standards, to enhance the services available to treat SUDs. ■ **Expand efforts to engage people in treatment.** Promote greater use of "warm handoffs" in emergency departments and further investment in SBIRT.

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. In 2016, the latest year for which data are available, the CDC estimates that "20.4 percent (50.0 million) of U.S. adults had chronic pain and 8.0 percent of U.S. adults (19.6 million) had high-impact chronic pain."[38] North Carolina has worked to decrease patient exposure to opioid analgesics, and has been successful in reducing opioid prescriptions,[39] but also recognizes the importance of continuing to look for more ways to address chronic pain without overprescribing opioids, limiting access to non-opioid pain care, non-consensually tapering patients who benefit from opioid therapy, stigmatizing pain patients or inadvertently squeezing people toward illicit drugs.

While joining with other stakeholders to support decreasing the supply of opioids, the medical community also has championed 2 complementary public policy goals. The first is to maintain a patient-centered approach for those patients who depend on opioid therapy for pain relief—particularly those who have been long-term patients and are functional on opioid therapy. North Carolina's Medicaid program has adopted this approach in ensuring that patient differences continue to be recognized, and that those who are not misusing opioids are not adversely affected by policies designed to reduce opioid supply. The second and broader goal is that reducing opioid use must be paired with increasing access to non-opioid pain management strategies, including non-opioid medications, restorative therapies and non-pharmacologic modalities.

Exhibit 5. Does It Work, and Can We Afford It? The Cost and Effectiveness of Non-Opioid Pain Relief

Non-pharmacologic pain management strategies work just as well as opioids for many people and can be less expensive.[40] 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 nonpharmacologic 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."[41]

There also is a need to recognize that access to non-opioid pain care often requires additional resources for patients, including time off work and the time and expense of travel; and collides with the often cost-prohibitive nature of commercial insurance cost-sharing requirements. In addition, there are issues relating to insurance coverage, both in the commercial and Medicaid arena, to reimburse for a wide range of services that traditionally have not been covered, to help promote care for patients with complex and often persistent pain conditions.

Expanding Coverage of Non-opioid Pain Management Strategies

Non-opioid pain treatments range from over-the-counter medications such as ibuprofen and acetaminophen to prescription medications that do not include opioids to local anesthetics such as steroidal lidocaine patches or injections, as well as physical therapy, occupational therapy, chiropractic treatment, cognitive behavioral therapy, surgical interventions, and other medical, physical and behavioral health services. As noted by the recent U.S. Department of Health and Human Services (HHS) Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations, *"Patients with complex and persistent pain often experience barriers to care related to nonexistent or insufficient insurance coverage and reimbursement for evidence-based medical, behavioral, and complementary pain management services. Although the HHS National Pain Strategy calls for greater access and coverage for pain management services, there is a lack of uniformity in insurance coverage and lack of coverage alignment with current practice guidelines for pain management. This is particularly true for the coverage of nonpharmacologic and behavioral health interventions."*[42]

North Carolina's Medicaid program has taken steps to expand coverage of non-opioid pharmaceuticals and alternative treatment. It covers non-opioid prescription medications to treat pain, such as anticonvulsants and antidepressants, topical analgesics, and injectable treatment, as listed in Exhibit 6 below, though prior authorization requirements vary. In addition to covering pharmacologic non-opioid alternatives, North Carolina Medicaid covers physical therapy, which can be used to treat chronic pain. Indeed, it recently raised the cap to a total of 27 visits for adults.[43] Medicaid is developing a clinical coverage policy for acupuncture, which also covers chiropractic services as well as certain forms of behavioral health treatment (e.g., cognitive behavioral therapy) that can be used to treat pain. When they launch in 2019, Medicaid managed care plans will be required to cover these services, and will not be allowed to impose limits that are more restrictive than these Medicaid fee-for-service policies.[44]

Exhibit 6. Examples of Treatment Options for Acute and Chronic Pain

Opioids	Non-opioid Pharmaceuticals	Non-opioid Topical and Injectable Treatments	Alternative Treatments
Vicodin	NSAIDs (Diclofenac, Meloxicam, etc.)	Sympathetic Nerve Blocks	Acupuncture
Oxycodone	Acetaminophen	Lidocaine Patches	Massage, Chiropractic, Physical Therapy
Tramadol	Anti-Epileptics (Lyrica and Neurontin)	Transcutaneous Electrical Nerve Stimulation (TENS) Unit	Mindfulness Meditation
Percocet	Anti-Depressants (Amitriptyline and Cymbalta)	Steroid Injections	Yoga

On the commercial insurance side, ensuring the availability of comprehensive and alternative pain management options requires DOI regulatory review of benefit design and utilization management requirements to understand the level of coverage for modalities such as neuromodulation, cognitive behavioral therapy aimed at managing pain, physical and rehabilitative therapies, and other therapies such as acupuncture, massage therapy and mindfulness. While we recognize that such services may not be readily available, access to these modalities is key both to treating acute and chronic pain and to treating common co-morbidities such as depression, anxiety and sleep disturbances.

Similar to Medicaid, commercial insurance regulators should work closely with payers in the commercial market to identify pain management physicians, anesthesiologists, physiatrists, interventional pain management specialists, neurosurgeons, osteopathic physicians and other physician specialists, as well as non-physician health care professionals who are important components of a health care team. Knowing the potential network is an important first step in better designing an adequate pain care network.

Recommendation: The DOI should look more closely at commercial insurance benefits and formulary design to ensure coverage of non-opioid options for pain care, including pain management specialists in their networks. This should be a central component of any action by the NC Payers Council. Evaluate Medicaid's efforts to promote non-opioid pain care in order to provide commercial payers with a framework in the private market.

Individualized Approaches to Long-term Opioid Use and Pain Management

Even as it promotes non-opioid pain treatments, Medicaid recognizes that some beneficiaries with chronic pain require opioids. Others can be tapered, but only over time and with a careful plan that does not abruptly terminate their access to legally prescribed opioids. Accordingly, Medicaid developed guidelines to assist providers in tapering opioids when appropriate.[45] Circumstances under which it is appropriate to taper opioids may include when patients request dosage reductions, do not have clinically meaningful improvement in pain and function, or show signs of SUD. Prescribers are advised to have patients return frequently in order to monitor their opioid use, and to develop individualized tapering plans that are focused on maximizing pain treatment with non-pharmacologic alternatives and non-opioid medications. In particular, prescribers are advised to "go slow," ensure that patients receive appropriate psychosocial support and offer encouragement.

Ensuring Commercial Prescription Drug Formularies Are Non-Discriminatory

The DOI has prior approval authority over insurer formularies through the rate and form review process, which means that DOI must approve the formularies before they are used in the marketplace. This gives DOI the opportunity to ensure that drug formularies cover a broad range of medications and restorative and behavioral health options in a non-discriminatory manner. The DOI also has authority over non-pharmacological benefits, such as physical therapy, provided in health plans, though alternative therapies are typically not subject to the same rigorous standards as new drugs, making it more difficult to regulate when alternative therapies should be covered. Regulation of formularies can raise difficult issues as well, since formularies are an important tool for insurers to manage their pharmacy benefit in the face of escalating drug prices. Nevertheless, formularies should meet 2 basic consumer access tests with respect to pain management: non-opioid alternatives should be available on the

formulary; and formulary tiers, prior authorization and other utilization management tools, if used, should be used sparingly to make access affordable and timely. Exhibit 9 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. For example, in the Proposed Notice of Benefit and Payment Parameters for 2020, the U.S. Department of Health and Human Services (HHS) noted that formularies which exclude MAT drugs for the treatment of OUDs are discriminatory if they cover the same drugs for other medically necessary purposes, such as analgesia or alcohol use disorder.[46] Similarly, the Colorado DOI has long offered guidance to insurers on how certain medications (including medications related to pain) should be placed on formulary tiers, and recently turned that guidance into a June 2018 regulation that could be applicable to how certain pain medications are placed on formulary tiers. The regulation states that the Colorado 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.[47] We encourage the North Carolina DOI to consider a similar regulation.

Exhibit 7. HHS Guidance on Discriminatory Formularies

In recently proposed guidance for ACA-qualified health plans, HHS noted that formularies which exclude MAT drugs for the treatment of OUDs are discriminatory if they cover the same drugs for other medically necessary purposes, such as analgesia or alcohol use disorder.

Exhibit 8. Coverage of Non-opioid Alternatives

In addition to focusing on opioid prescribing patterns, the DOI has the data, collected through rate and form review, to shine a light (and encourage action) on whether the most common non-opioid pharmaceuticals for treating pain are covered and on their cost-sharing and utilization management requirements.

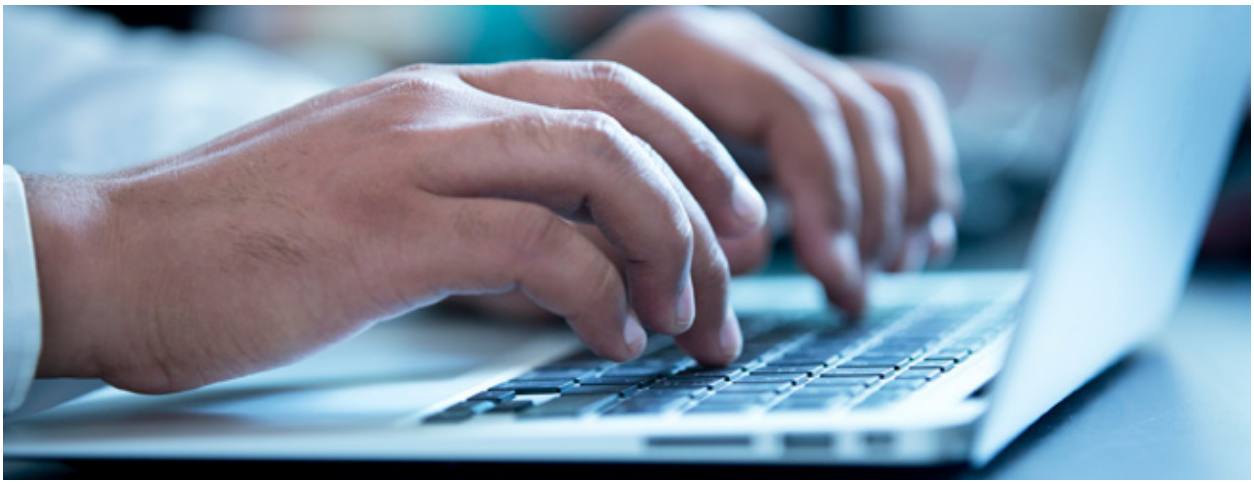


Exhibit 9. Common Utilization Management Techniques

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 on higher tiers. Drugs on the higher cost-sharing tiers can have prohibitive out-of-pocket costs.
Prior Authorization	Requires insurer approval before a drug listed on the formulary will be covered for the specific patient.
Step Therapy	Requires a patient to try a drug that is typically on a lower cost-sharing tier before covering a higher-cost drug.

Recommendation: Require commercial insurers to post and regularly update their formularies online, with clear designation of commonly used non-opioid pain alternatives, utilization management requirements and cost-sharing.

Recommendation: Ensure that commercial insurance formularies do not violate benefit design discrimination standards by, for example, limiting the availability of non-opioid alternatives on low cost-sharing tiers or applying unreasonable prior authorization and step therapy requirements that will delay, deny or deter access to them.

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

To help further identify barriers to pain management faced by physicians and patients, North Carolina could partner with the AMA and the North Carolina Medical Society to gain a ground-level view of patient access to pain care, including barriers to non-opioid alternatives on the part of specific payers, with the goal of guiding further initiatives as necessary. This effort could include analysis of payment and benefit design aimed at enhancing access to comprehensive pain care services—for example, ensuring that behavioral health and medical care services can be provided on the same day, or that certain services are available in terms of time and distance standards.

Recommendation: Build on existing relationships with the medical and patient communities to assess access to comprehensive pain care services, including formulary and benefit design and provider and patient experiences.

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

Key Best Practices	Key Next Steps
■ **Medicaid coverage of non-opioid pain relief.** Medicaid covers a number of non-opioid prescription drugs that can be used for pain, as well as services such as physical therapy. ■ **Medicaid calls for individualized approaches to address pain.** Medicaid developed guidelines to assist providers in tapering opioids when appropriate and devising individual treatment plans that "go slow" and include frequent visits.	■ **Expand commercial coverage of alternative pain management.** Require commercial insurers to offer a full array of alternative pain management options that are available with minimal cost-sharing and without prior authorization or other utilization management requirements. ■ **Identify strategies to increase use of alternative pain management among providers.** Partner with the AMA and the North Carolina Medical Society to identify barriers to non-opioid medications and services. ■ **Assess patient access to comprehensive pain care.** Build on existing relationships with the medical and patient communities to better assess patient access to comprehensive pain care services, including formulary and benefit design and provider and patient experiences.

IV. Enhancing Access to Naloxone

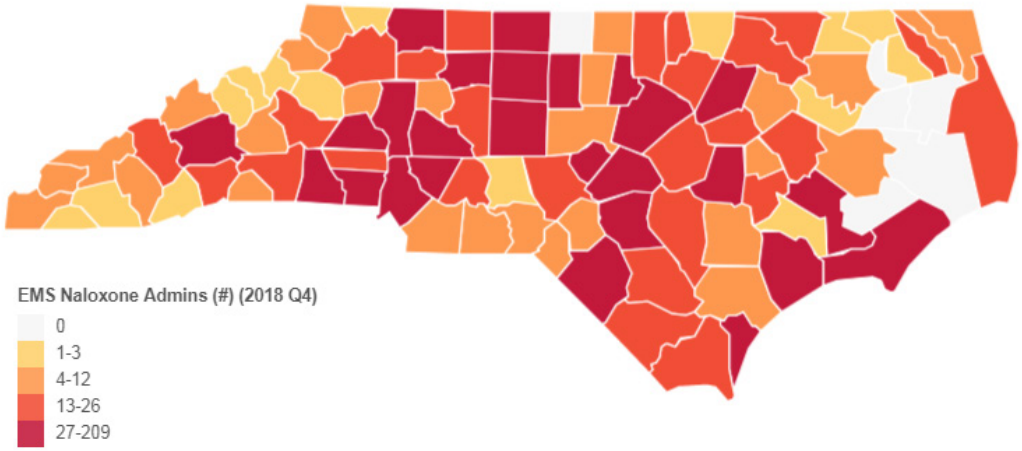
Through numerous measures, North Carolina has promoted access to naloxone, a prescription medication that can reverse an opioid overdose. Indeed, making naloxone widely available is a key focus of the state's Opioid Action Plan.[48] Accomplishments to date include early adoption of a Good Samaritan law that allows individuals to access, carry and administer naloxone, and provides criminal immunity and protection from civil liability for people who do so. In June 2016, the state adopted legislation authorizing the state health director to issue a standing order for naloxone dispensing in North Carolina, the third state to establish such an order.[49] The Division of Public Health (DPH) lists on its website all pharmacies, health departments and syringe exchange programs that offer naloxone.[50]

North Carolina also has played a role in directly purchasing and distributing naloxone. In October 2017, the state purchased nearly 40,000 units of nasal naloxone to make the overdose reversal drug more widely available and thus help reduce the number of unintentional opioid-related deaths. In 2018, an additional 20,000 kits were purchased. The naloxone has been distributed to partners across the state, including opioid treatment programs (OTPs), Emergency Medical Services (EMS) agencies, Oxford House and other community partners.[51] Additionally, the NC Harm Reduction Coalition has distributed over 60,000 naloxone rescue kits across the state since August 2013, and tracks the number of opioid reversals using those kits by community members (not including reversals by first responders, presented separately below). There were more than 4000 community naloxone reversals in 2018.[52]

Finally, the state also is committed to creating and adopting strategies that promote naloxone co-prescribing by clinicians. To that end, in November 2017, the DPH issued guidance to clinicians on prescribing naloxone for people on opioids who are at risk of overdose and for patients discharged from hospitals after an opioid overdose.[53]

The state has also legalized safe syringe programs to reduce the rates of hepatitis C and other infectious diseases, which have increased as a result of the opioid epidemic, and publishes a list of syringe exchange programs on its website.[54] The state recognizes that safe syringe programs can help link people to treatment, social supports and naloxone. There are currently 29 programs operating in the state, which serve over 5000 people annually. These programs tested over 3000 people for HIV and 1400 people for hepatitis C and made over 1000 referrals to treatment. The state is seeking to increase the number of counties that have syringe exchange programs and build the capacity of these programs.[55]

Exhibit 10. Fourth Quarter 2018 EMS Naloxone Reversals by County



Source: North Carolina Office of Emergency Medical Services (OEMS), EMSpic-UNC Emergency Medicine Department, 2012–present, https://injuryfreenc.shinyapps.io/OpioidActionPlan/.

Recommendation: Continue naloxone outreach and access efforts to save lives from overdose. Add other evidence-based harm reduction efforts, including expansion of safe syringe programs to other sites, in supporting wide-ranging public health approaches to reducing transmission of infectious diseases and saving lives.

Best Practices and Next Steps for Naloxone

Best Practices	Next Steps
■ **Issuing a standing order.** Issued standing order for naloxone prescriptions and enacted Good Samaritan protections. ■ **Distributing naloxone.** In October 2017, the state purchased nearly 40,000 units of nasal naloxone to make the overdose reversal drug more widely available and thus help reduce the number of unintentional opioid-related deaths. ■ **Disseminating information on where to find naloxone.** Developed a statewide map of pharmacies that actively stock naloxone. ■ **Promoting naloxone co-prescribing.** Issued guidelines to encourage co-prescribing of naloxone to patients who recently overdosed and those at risk of overdose. ■ **Establishing syringe exchange programs.** Legalized syringe exchange programs to reduce the spread of infectious diseases and link individuals with SUDs to services, and published a list of syringe exchange programs throughout the state.	■ **Eliminating prior authorization.** Eliminate prior authorization and quantity limits for naloxone in commercial plans. ■ **Promote co-prescribing in Medicaid and the commercial market.** The AMA and the North Carolina Medical Society are interested in continuing to work with the state to educate physicians about co-prescribing naloxone to patients at risk of overdose.

V. Evaluation

As North Carolina has highlighted in its Opioid Action Plan, it is important to evaluate initiatives aimed at addressing the epidemic. The epidemic is far from over in any state, and it is critical to evaluate which state policies are working as intended, any unintended consequences of policies and what additional action may be required.

North Carolina has taken multiple steps to measure the impact of its strategies, including gathering and disseminating information on the size and scope of the opioid epidemic throughout the state. The DPH regularly tracks and monitors opioid overdose data and issues monthly surveillance reports for ED visits, deaths and naloxone distribution. In addition, the division manages the opioid data dashboard, created in 2017, to track the multiple data metrics developed to measure the state's progress against its Opioid Action Plan. Metrics are divided into 5 strategy areas, updated on a quarterly basis and displayed in a summary table (Exhibit 11 below):

- Reduce death/ED outcomes
- Reduce oversupply of prescription opioids
- Reduce diversion/flow of illicit drugs
- Increase access to naloxone
- Treatment and recovery

The dashboard also displays trends over time in graphs of each metric for the state and all 100 counties.[56]

Exhibit 11. Metric Summary Table[57]

Metric Summary Table: NC (Population: 10,273,419)

Metrics	Most Current Provisional Data		
	Time	Quarter	Year-To-Date
Reduce Death/ED Outcomes			
Number of unintentional opioid-related deaths to NC Residents (ICD-10)	2018 - Q2	343	708
Number of ED visits that received an opioid overdose diagnosis (all intents)	2018 - Q4	1,527	6,769
Reduce Oversupply of Prescription Opioids			
Average rate of multiple provider episodes for prescription opioids, per 100,000 residents	2018 - Q2	9	9
Number of opioid pills dispensed	2018 - Q2	107,088,000	217,709,000
Percent of patients with an opioid prescription receiving more than an average daily dose of 90+ MME of opioid analgesics	2018 - Q2	6	6
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day	2018 - Q2	23	22
Reduce Diversion/Flow of Illicit Drugs			
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	2018 - Q4	86	82
Number of acute hepatitis C cases	2018 - Q3	42	137
Increase Access to Naloxone			
Number of EMS naloxone administrations	2018 - Q4	2,680	11,633
Number of community naloxone reversals	2018 - Q4	1,051	3,943
Treatment and Recovery			
Number of buprenorphine prescriptions dispensed	2018 - Q2	160,091	314,721
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	2018 - Q3	19,655	57,493
Number of certified peer support specialists (CPSS)	2018 - Q4	3,350	3,350

Additionally, the state has begun to analyze more intensively some of the measures included in the opioid data dashboard to evaluate its interventions. For example, the DPH is assessing whether increasing naloxone distribution reduces ED overdose visits.[58] The state is also working with researchers and universities to develop a research agenda that focuses on evaluating current interventions and informing the design of new ones.[59] As a condition of its 1115 SUD waiver, the state also will be monitoring the effectiveness of its SUD waiver and collecting data on specified metrics and measures.

Best Practices and Next Steps for Evaluation

Best Practices	Next Steps
■ **Dashboard.** Established a dashboard that provides county- and state-level data on 13 key opioid metrics to measure the state's progress against its Opioid Action Plan. ■ **Systematic review of the effectiveness of policy interventions.** The state is working to systematically evaluate which policies are working, their impact on patients and what additional action may be required.	■ **Deepen use of data and evaluation to inform future interventions.** Build on the dashboard and evaluation efforts to identify how to transform the data surveillance into public health interventions.

Endnotes

1 Multiple Cause of Death 1999–2017 on CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). Atlanta, GA: CDC, National Center for Health Statistics. 2018. Available at http://wonder.cdc.gov.

2 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; National Institute on Drug Abuse, North Carolina Opioid Summary, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/north-carolina-opioid-summary.

3 Henry J. Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2016, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22pennsylvania%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.

4 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.

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8 https://files.nc.gov/ncdma/documents/Reports/Legislative_Reports/SL2016-94-Sec12F-10-and-SL2017-57-Sect11F-6_2018_01.pdf.

9 https://files.nc.gov/governor/documents/files/Governor%20Cooper%20HELP%20Committee%20opioids%20letter%201.17.18.pdf?PJ3G3v56ApMTLkYXHef8YtAPjV_0I1BX.

10 HB662, introduced in 2017, would have created the Carolina Cares program to expand Medicaid to individuals earning below 133% of the federal poverty level and who met work requirements and paid a monthly premium, but did not pass. https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H662v0.pdf.

[11] NC Medicaid staff explained that utilization for the other buprenorphine products was very low, which is why the prior authorization requirements were not removed. https://files.nc.gov/ncdma/documents/Providers/Programs_Services/Pharmacy/Pharm_Newsletter_2018_02.pdf; https://files.nc.gov/ncdma/documents/files/PDL_2018-2019_DEC-27-2018.pdf.

[12] North Carolina Medicaid covers methadone without prior authorization, although it is not listed on its preferred drug list. Source: Interviews with NC Medicaid staff. https://files.nc.gov/ncdma/documents/files/PDL_2018-2019_DEC-27-2018.pdf.

[13] https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf.

[14] Specifically, BCBS removed prior authorization requirements for suboxone film, buprenorphine/naloxone tablets and buprenorphine. This announcement followed the addition of Subloclade as a covered opioid dependency drug in March 2018. Source: http://blog.bcbsnc.com/2018/11/opioid-epidemic-access-expands-medication-assisted-treatment/; https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/medicalpolicy/sublocade.pdf.

[15] https://files.nc.gov/ncdhhs/documents/files/NC-Payers-Council-Report-WEB-FINAL-9.5.18.pdf.

[16] https://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=344.

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[18] Email communication from DOI on February 1, 2019.

[19] https://www.insurance.pa.gov/Regulations/Regulatory%20Actions/Documents/Current%20Market%20Conduct/Aetna_FinalExamReport_01042019.pdf; https://www.insurance.pa.gov/Regulations/Regulatory%20Actions/Documents/Current%20Market%20Conduct/First%20Priority%20Life%20Insurance%20Co.%2018.pdf.

[20] https://files.nc.gov/ncdhhs/documents/NetworkAdequacy_ConceptPaper_Final_20180215.pdf.

[21] https://files.nc.gov/ncdma/documents/files/1A-41_4.pdf.

[22] Of the 75 OTPs, ten to 15 of them do not accept Medicaid and are self-pay only. Source: NC DMH/DD/SAS interviews.

[23] Currently, 7 prepaid inpatient health plans deliver behavioral health and I/DD services to Medicaid beneficiaries throughout the state. Physical health services, pharmacy services and long-term services and supports are delivered through Medicaid fee-for-service.

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[27] Analysis of SAMHSA data by the North Carolina Medical Society, January 18, 2019, http://www.ncmedsoc.org/tag/project-obot/.

[28] https://sph.unc.edu/files/2017/03/Opioid-ECHO-Program-Press-Release.pdf.

[29] https://www.ncdhhs.gov/news/press-releases/dhhs-mountain-area-health-education-center-train-next-generation-nc-doctors.

[30] https://projectobot.com.

[31] Medicaid https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf.

[32] 42 U.S.C. § 1396d (a)(29)(B).

[33] https://files.nc.gov/ncdhhs/NC%20Opioid%20STR%20Final%20Narrative.pdf.

[34] Interviews with DHHS staff.

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[36] Information provided by DMH/DD/SAS.

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[44] https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf.

[45] https://files.nc.gov/ncdhhs/documents/Provider_Considerations_for_Tapering_of_Opioids.pdf.

[46] https://www.federalregister.gov/documents/2019/01/24/2019-00077/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.

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[58] Interviews with DHHS staff.

[59] http://www.ncmedicaljournal.com/content/79/3/157.full.