# Spotlight on Mississippi

## 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 MSMA

The Mississippi State Medical Association (MSMA) is a physician organization serving as an advocate for its members and their patients. Our vision is to be an essential part of every Mississippi physician's professional life.

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# Roadmap to Ending Mississippi'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 the first 2 spotlight analyses, we highlighted efforts by Pennsylvania and Colorado in 3 areas: substance use disorder treatment, pain management, and efforts to increase access to naloxone. In this spotlight analysis of Mississippi's response to the epidemic, we analyze the state's efforts in the same 3 areas, and supplement our analysis with examples from Pennsylvania and Colorado to show where Mississippi has accomplished less and could benefit from considering best practices from other states. Highlights from Mississippi are described below.

## Where the State Is Succeeding

- **Expanding naloxone access.** The state's efforts to expand naloxone access, including a standing order and a Good Samaritan law, have saved lives. Over 2000 lives were saved by emergency medical services using naloxone in 2017.
- **Expanding coverage of opioid alternatives.** Medicaid covers non-opioid pain management options, including some non-opioid pharmaceuticals and topical analgesics, though Medicaid also has a monthly limit on prescription drugs that reduces the impact of this coverage.
- **Community engagement.** StandUp Mississippi was designed to help reduce stigma and promote overdose prevention across multiple agencies, including the Mississippi Department of Mental Health, Department of Public Safety, Mississippi Bureau of Narcotics, Mississippi Board of Pharmacy, Federal Bureau of Investigation, Mississippi Department of Human Services, and Drug Enforcement Agency.

## Where the State Is Making Progress

- Increasing access to opioid alternatives. The University of Mississippi Medical Center's initiatives to treat pain with acupuncture, physical therapy, biofeedback, and other non-opioid alternatives could be promoted across other leading state institutions and used to expand Medicaid and commercial coverage of non-opioid pain management strategies.

- Reviewing parity compliance. The Mississippi Insurance Department (MID) is conducting a comprehensive review of health insurer policy forms to assess compliance with mental health and substance use disorder (SUD) parity laws, and is developing materials for future regulatory reviews, as well as for insurers and consumers, on parity requirements.

## Where the State Can Take Steps to End the Epidemic

- Expanding access to medication-assisted treatment (MAT) and other treatment options. Mississippi's decision not to expand Medicaid leaves many people affected by the epidemic without coverage, making it critical that the state maximize its remaining options by strategically using other sources of federal opioid funding, covering the cost of training to encourage more providers to become waivered, developing outreach programs to connect individuals to existing treatment options, and covering all clinically appropriate forms of MAT without prior authorization.

- Enforcing parity requirements. The MID will be able to use the new materials that come out of its current parity assessment work to more closely scrutinize benefit packages, prior authorization policies, and cost-sharing obligations to ensure ongoing parity compliance. Where compliance problems emerge, the MID can

**"This spotlight analysis provides us with clear opportunities to help our patients receive evidence-based treatment. There are promising initiatives already underway, and we know that there is much more work to do. Collaboration is essential for success in preventing opioid overdose deaths. Medical personnel, public safety officials, mental health and substance abuse treatment providers, and community-based organizations all bring awareness and expertise to address this complex epidemic."**

**Michael Mansour, MD, President, Mississippi State Medical Association**

use its regulatory authority to perform market conduct exams similar to the parity exams currently under way in Pennsylvania and Colorado.

- Tracking metrics to assess impacts. The data clearinghouse being established at Mississippi State University could become a forum for state agencies to track key indicators of the epidemic on a regular basis to assess whether policies, programs, and other efforts in the state are working to improve patient care and reduce opioid-related harms. Greater collaboration with the MID, Medicaid, and public health experts could be helpful.

**"Far too many Mississippi families and communities have suffered the devastating effects of opioid and heroin use disorder. . . . We hope to inspire Mississippians to work together to build healthier communities by understanding the dangers of opioids, learning the signs and symptoms of addiction, and finding out about treatment for themselves or people they know who may be suffering."**

**Diana Mikula, Executive Director, Department of Mental Health, December 6, 2017**

**Exhibit 1. AMA Priorities for Addressing the Opioid Epidemic**

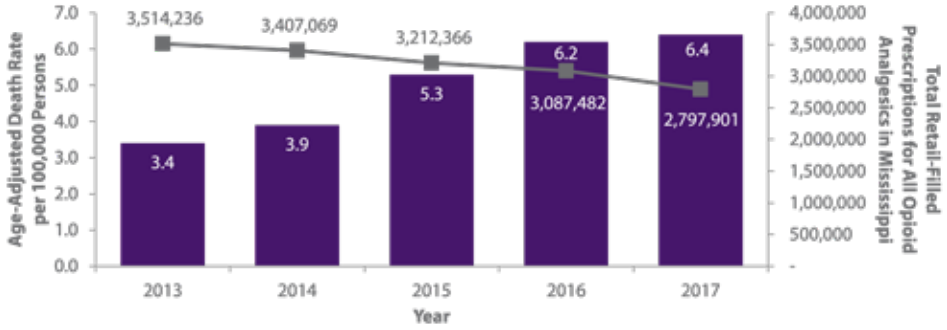
The AMA has developed a comprehensive set of recommendations aimed at ending the opioid epidemic. This spotlight analysis addresses multiple AMA priorities:

- **Increase access to high-quality, evidence-based treatment for SUD, 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 using naloxone and other methods to help save lives from overdose and link patients to treatment**

# I. Introduction

Mississippi's opioid epidemic follows national trends. Even as the number of opioid prescriptions dispensed in the state has steadily dropped, deaths due to opioid-related overdoses have continued to increase. Governor Phil Bryant has led state efforts to address the epidemic through an August 2017 executive order that encouraged the use of naloxone by law enforcement officers, and by convening an Opioid and Heroin Study Task Force comprising representatives from state agencies, medical and dental boards, providers, and county representatives. Mississippi has not been as active as some other states in expanding access to MAT and other SUD treatment, but there are potentially promising public- and private-sector initiatives that offer building blocks toward ending Mississippi's—and the nation's—opioid epidemic.

**Exhibit 2. Opioid-Related Overdose Deaths in Mississippi**




Source: National Institute of Drug Abuse, Mississippi Opioid Summary, Revised March 2019, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/mississippi-opioid-summary; IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017.

This spotlight analysis primarily highlights the work of 2 agencies—the Mississippi Division of Medicaid (housed within the Office of the Governor) and the MID—at the forefront of the fight. These 2 agencies address coverage issues that determine what care is accessible and affordable to the 24% of Mississippians covered by Medicaid and CHIP and the 48% with fully insured individual or group insurance coverage.[1] This analysis also describes work by the Department of Mental Health (DMH) and some leading private-sector institutions, though it is worth noting that a full picture of the state's efforts would require the same close scrutiny of other agencies that we have given the MID and Medicaid. Where helpful, the analysis of Mississippi's efforts has been supplemented by examples of best practices from Pennsylvania, Colorado, and other states.

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

With an estimated 19.4 million cases of SUDs nationwide,[2] including 121,000 cases in Mississippi,[3] there is an urgent need to make treatment, including MAT, more widely available.[4] Despite strong evidence that MAT is the most effective treatment option for many individuals with opioid use disorder (OUD), barriers to MAT persist, including stigma that keeps some patients and providers from utilizing MAT, inadequate provider networks, 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.[5]

Mississippi has taken some steps to increase access to MAT and other treatment, but the state faces more of an uphill battle than many other states because it has not expanded Medicaid, leaving many of the people affected by the epidemic without coverage. It is difficult to provide appropriate treatment to individuals who lack coverage, especially since federal grant dollars and state resources are insufficient to fill the gap. If Medicaid expansion—an issue with implications well beyond the opioid epidemic—remains off the table, Mississippi will need to maximize its remaining options by strategically using other sources of federal opioid funding to increase the SUD treatment workforce as well as developing outreach programs to connect individuals to existing treatment options.

## Expanding Access to Medication-Assisted Treatment (MAT)

Mississippi Medicaid covers naltrexone tablets and suboxone as preferred drugs. To facilitate access to MAT, requirements for prior authorization for suboxone are currently being removed (for both individuals in fee-for-services plans and those in managed care). For clinical reasons, single-agent buprenorphine is covered only for pregnant women[6] (the state believes that suboxone is the preferred treatment for those who can safely take it). In 2016, for both suboxone and buprenorphine, the state removed a 24-month maximum length of coverage and limits on the number of times an individual could restart treatment.[7] Mississippi is frequently cited as one of only 9 states that does not cover methadone in Medicaid, which may have contributed to a zero request rate for methadone as MAT in 2018.

Mississippi Medicaid officials say that Medicaid would cover methadone for MAT if appropriate diagnosis and clinical justification were given, but this type of requirement, while not appearing on the surface to be unreasonable, acts to delay and deny care to those patients

who benefit from methadone maintenance therapy for OUD. Outreach to SUD treatment providers, clarifying that methadone for MAT is a covered benefit, would help inform providers of the full array of MAT options. Physician-administered forms of MAT, including Vivitrol, Sublocade, and Probuphine are covered by Medicaid (with prior authorization requirements based on the package insert) and do not count toward the current limit of 5 prescriptions a month. Although the Mississippi Legislature has not required commercial insurers to broaden access to MAT, the MID could supplement Medicaid's efforts by working with commercial insurers, as Pennsylvania did, to secure their voluntary agreement to eliminate prior authorization requirements for MAT and cover it on the lowest cost-sharing tier of the pharmacy benefit.[8]

**Recommendation: Consider stronger efforts to promote access to MAT in both Medicaid and commercial coverage, including coverage of all clinically appropriate forms of MAT without prior authorization and with any cost-sharing limited to the lowest tier of the pharmacy benefit.**

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

Eliminating prior authorization for MAT in commercial insurance would be a good start for Mississippi, but the state would still face daunting challenges with SUD treatment facilities that do not offer MAT and a shortage of providers authorized to provide buprenorphine in-office, the most common form of MAT, for the treatment of OUD. Only one-third (34%) of SUD treatment facilities in the state offer any form of MAT.[9] In 2018, 50 physicians were newly waivered to provide buprenorphine in-office for the treatment of OUD,[10] bringing the total since 2002 to 450 waivered physicians. But it is unclear how many of these practitioners are actively treating patients with an OUD.v

The state plans to use federal grants to increase access to MAT, especially in rural areas, and the governor's Opioid and Heroin Study Task Force recommended efforts to educate the treatment workforce on MAT, expand treatment services for pregnant and parenting women, and improve evidence-based programs within treatment facilities. Legislation that died in the Mississippi house, HB 881, would have allowed treatment of SUDs through telemedicine, including MAT. This type of approach could help facilitate access to treatment in rural and underserved areas as an additional strategy for expanding the workforce of MAT prescribers and ensuring evidence-based medical care for treating OUD.

As Mississippi 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. The state also will likely need to consider new policies that may be challenging to accept, but are being proved successful in other jurisdictions. For example, some states, such as Virginia, have modernized their Medicaid payment policies to systematically award higher payment rates to providers who deliver MAT; offer greater continuity of care; and remove administrative barriers. A recent evaluation found that these efforts have greatly increased access to treatment for Medicaid patients in Virginia with OUD or other SUDs.[11] It is worth noting that some states and localities also have begun to limit the distribution of grant funding for SUD treatment to only those facilities that offer access to MAT.[12]

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 they will require significant commitment and collaboration by physicians and multiple state agencies. Medicaid officials report an interest in exactly that type of active collaboration across state agencies.

**Recommendation: Establish systematic, statewide initiatives to finance training on MAT; increase Medicaid and commercial reimbursement rates to incentivize providers to offer MAT; and consider new policies to increase access to care that will 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 coverage for individuals and small groups with 1 to 50 employees. More important, though, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurers cover medically supervised withdrawal services, residential services, and outpatient/partial hospitalization services for SUDs to the same extent these services are covered for physical health purposes.[13]

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health parity is still a work in progress across all public coverage programs and commercial insurance in Mississippi, as in other states. And while parity violations and enforcement raise complicated issues, it is essential that state regulators take increased action to ensure payers' compliance.

The MID has taken some initial steps toward addressing those complex issues in Mississippi. The MID obtained a federal grant to conduct a comprehensive review of health insurance issuer policy forms, summary plan descriptions, certificates of coverage, and other plan documents to assess their compliance with the MHPAEA. The grant was designed to accomplish several purposes:

- Establish a robust review of non-quantitative treatment limitations for medical/surgical and mental health and SUD benefits, to assure that the factors used in applying the limitation to mental health and SUD benefits in the classification are comparable to, and applied no more stringently than, those used in applying the limitation to medical/surgical benefits in the classification;
- Support MID consultation with stakeholders across the state to determine whether a universal vocabulary can be adopted among health insurance issuers to make MHPAEA compliance easier to determine; and
- Support MID efforts to establish procedures and guidance for health insurance issuers regarding MHPAEA transparency and disclosure standards.[14]

MID's grant work is ongoing with the DMH, currently drafting 3 types of new guidance. First, MID is developing a compliance assessment tool to be used by insurers to facilitate annual reviews by the MID. Second, the MID is developing a regulatory tool to be used by DMH staff in their reviews of insurer filings. Third, the MID is producing multifaceted consumer education materials designed to help consumers understand their health insurance benefits as well as what parity is and how it impacts their health benefits.

With the new parity materials expected to be ready this year, we encourage the MID to use its full continuum of regulatory resources to follow up on any parity issues the DMH identifies, including investigating complaints from consumers and providers regarding potential parity violations. The MID already plans to perform targeted market conduct exams as the facts warrant, but could take this a step further by conducting baseline exams, focused on parity, of the less than half a dozen insurers that provide the bulk of health insurance coverage in Mississippi. Pennsylvania and Colorado are in the process of conducting broader examinations, and the 2 examinations published to date by Pennsylvania both found significant parity violations for SUD claims.[15]

**Recommendation: Use targeted market conduct examinations as warranted to thoroughly investigate parity complaints and compliance issues identified in rate and form filing reviews. Conduct parity-focused exams of all significant health insurers to establish a baseline measure of parity compliance and increase transparency for payers, consumers, and other key stakeholders on parity issues.**

**Exhibit 3. Parity Enforcement**

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health parity is still a work in progress across all public coverage programs and commercial insurance. Strong market conduct examination procedures, such as those being undertaken in Pennsylvania and Colorado, can help ensure compliance with state and federal parity requirements. The MHPAEA has been in force for more than 10 years, but meaningful enforcement actions are only now beginning to occur.

## 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. 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 MID conducts annual network adequacy reviews under a regulation that requires health carriers offering managed care plans to maintain networks that are sufficient in numbers and types of providers, to assure that all services to covered persons are accessible without unreasonable delay.[16] Health carriers are required to file an access plan by August 1 of each year, which must address network sufficiency with reference to "reasonable criteria used by the health insurer," such as provider-to-covered-person ratios for primary care and by specialty, geographic accessibility, waiting times, hours of operation, and the volume of technologic and specialty services. The MID requires the carrier's response to each criterion to include an answer statement and a reference to attached supporting documents.

The MID could enhance its network adequacy reviews by reviewing insurer filings with reference to federal regulations providing that a physician may treat up to 30, 100, or 275 patients for SUDs with buprenorphine in-office. To help determine the total number of potential SUD patients who could be cared for in a network, Mississippi 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 SUDs. Not only is this type of quantitative analysis possible, but it is essential to determine the workforce capacity in a health insurance network. As gaps are identified, the MID should require insurers to identify how their provider networks will ensure access for their enrollees. Identifying network gaps will not automatically solve them, but it will engage insurers in doing their part to take appropriate action to fill those gaps.

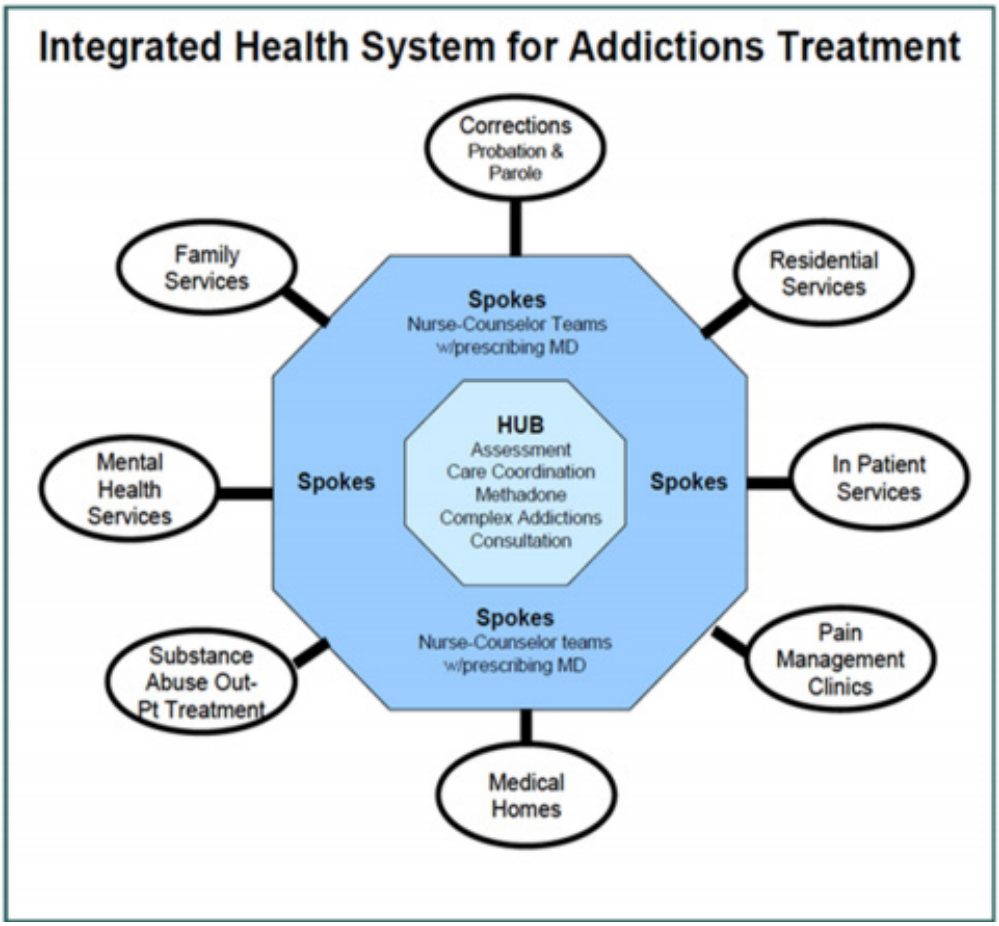
We encourage Mississippi to continue improving its ability to carefully review the adequacy of SUD treatment capacity in each insurer's products. We further encourage the MID to carefully consider how best to augment "front end" network adequacy reviews with "back end" compliance audits or market conduct examinations.

**Recommendation: Combine annual network adequacy reviews, including quantitative details of MAT provider access, with market conduct examinations, to produce in-depth analyses of insurers' compliance with network adequacy and mental health and SUD parity legal obligations. Pursue appropriate enforcement actions, including requiring corrective action plans and parity reexaminations, 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. As it looks for ways to increase access to treatment, Mississippi should consider the "hub and spoke" model, which continues to gain popularity nationwide as a means to encourage physicians to offer MAT as well as help patients access a wide range of medical, social, and other behavioral care services. A key feature of the model is that providers can receive backup support from addiction medicine specialists and other health care professional services as well as specialized care for more complex patients. For example, Medicaid officials report that their newly formed Innovation Initiatives program is exploring federal funding through the Maternal Opioid Misuse (MOM) Model to improve coverage for pregnant women and babies on Medicaid who are born with neonatal abstinence syndrome (NAS). The federal government released the funding notice for the MOM Model in February 2019 and applications are due in May 2019.[17]

### Exhibit 4. Hub and Spoke Model



## Facilitating Warm Handoffs by Emergency Departments


Emergency departments (EDs) present opportunities to support frontline providers and connect people to treatment at times of acute need, including when patients have overdosed or are seeking prescription opioids in response to an addiction. For example, Pennsylvania agencies have partnered with the Pennsylvania chapter of the College of Emergency Physicians to release guidelines for ED physicians to implement "warm handoffs." Instead of simply providing patients with a handout that lists resources, warm handoff protocols call for a more substantive connection. This includes linking patients to treatment (e.g., having a peer counselor or social worker help make a patient's appointment before leaving the ED) as well as support personnel to identify addiction medicine physicians and other health care professionals in the local area who are in the patient's insurance network and are accepting new patients.[18] Having the ED serve as a point of entry for patients to receive MAT, moreover, has produced promising results.

A recent study in the *Annals of Emergency Medicine* found that "emergency department-facilitated transition to outpatient care is more likely to lead to healthier patient outcomes when it begins with Medication-Assisted Treatment (MAT) in the emergency department."[19] Efforts to expand access to MAT through the ED have shown promise in large cities such as Chicago and Denver, which rely on having multiple waivered physicians on staff as well as peer counselors or addiction recovery coaches within the hospital setting. As physicians in these locations report, the counselors and coaches serve to help identify addiction medicine physicians who are in a patient's health insurance network and are accepting new patients. That information is critical to helping ensure the patient goes to the first appointment and is proving beneficial to support follow-up visits and prolonged recovery. We encourage the MID and Medicaid to consider how to advance this type of innovation/referral to treatment from the ED.

**Recommendation: The MID and Medicaid should work closely with the emergency medicine community to identify how to use the emergency department as a way to help refer patients to care for an OUD, including additional use of peer recovery coaches and other support services to help identify providers accepting new patients.**

## Expanding Access to Residential Treatment; Supporting Additional Screening Efforts

Mississippi has not covered residential treatment services for Medicaid beneficiaries with SUDs. To the extent that policy was 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"—Mississippi now has an opportunity to revisit that policy. Due to a recent change in federal law, the state may be able to cover IMD services for a limited period of time through a simple process, though fully waiving the IMD exclusion would still require a more complex waiver process and coverage of a full spectrum of mental health and SUD services. Medicaid officials report that they are considering coverage of residential services, which would require providers to be certified through the DMH. Coverage of residential treatment also raises issues of how to monitor and license residential treatment facilities, as well as how to ensure that people still are treated in the community when that is the more appropriate setting.[20]

Mississippi obtained a state-plan amendment in 2017 to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) for pregnant women in Medicaid, a step toward strengthening screening and referral to treatment for SUDs. While this benefit expansion will help steer pregnant women to treatment earlier and may reduce incidence of NAS, Mississippi has not extended SBIRT to other Medicaid beneficiaries in the state. We urge Mississippi Medicaid to consider building on its SBIRT program. For example, Colorado established a $1.5 million competitive grant program, and a new Medicaid behavioral health benefit provides up to 6 behavioral health visits in a primary care setting, which can be used by those identified as needing SUD treatment through SBIRT.[21]

**Recommendation: Increase coverage of residential treatment under new federal rules governing IMDs, with appropriate oversight and credentialing of qualified treatment centers to ensure facilities offer all forms of MAT and linkages to community-based care. Further enhance care through support of expanding SBIRT and other screening tools.**

## Reducing Stigma and Encouraging Individuals to Enter Treatment, Through Public Education

Stigma against individuals with SUDs is an issue nationwide, but is particularly strong in Mississippi, as illustrated by attitudes tying individuals with an SUD to crime and opposing MAT as merely substituting one drug for another.[22] The state has taken initial steps to address stigma through the StandUp Mississippi initiative, which works to destigmatize substance abuse and connect individuals with SUD to treatment. The DMH hosted 19 public town hall meetings across the state, attended by over 3000 people; developed a campaign website; and runs a hotline for those seeking treatment.[23] It is not clear whether lessons learned and insights provided during the meetings, campaign efforts, and hotline experience are shared across agencies to identify opportunities to reduce stigma and better connect individuals with care. Community involvement and outreach are important elements in fighting against stigma, but they must be evaluated and better incorporated into community- and statewide efforts. Given that state funds need to be available for this type of effort, it will require specific leadership and attention from state officials to work with the medical and patient communities in a more coordinated manner.

**Recommendation: Evaluate community and statewide efforts to reduce stigma and enhance overdose prevention efforts to identify best practices. Seek to build on the campaign efforts of StandUp Mississippi beyond the limited scope of federal grant resources.**

## Partnering With the Medical and Patient Communities to Further Support Screening, Remove Stigma, and Understand 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 Mississippi State Medical Association 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 could serve as a foundation for future efforts to increase 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 being unable to afford care or having to go without additional care, including behavioral health care, which has been shown to improve outcomes for SUD patients.

**Recommendation: Work with the medical and health care community to better understand barriers to providing care, including the role that stigma plays, and evaluate the most successful efforts to support providers and share screening resources for potential replication throughout the state.**

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

| Best Practices | Next Steps |
|---|---|
| ■ **Increased Medicaid coverage of MAT.** As of March 2019, Medicaid will cover both naltrexone and suboxone without prior authorization. Injectable forms of MAT are available with prior authorization, and do not count toward the prescription limit.<br><br>■ **Assessment of parity compliance.** The MID is has taken steps to assess insurer compliance with parity in policy filings, and is in the process of developing regulatory materials, as well as insurer and consumer education materials, to facilitate closer scrutiny of parity issues.<br><br>■ **Initial steps to address stigma.** The state's StandUp Mississippi campaign seeks to make inroads against stigma.<br><br>■ **Added SBIRT for pregnant women in Medicaid.** The new benefit of SBIRT for pregnant women may help connect beneficiaries to treatment and reduce incidence of NAS. | ■ **Expand access to all clinically appropriate forms of MAT.** Remove barriers to MAT access in commercial insurance. Educate providers about methadone being a covered Medicaid benefit for MAT. Encourage SUD providers to provide or facilitate access to MAT.<br><br>■ **Expand mental health and SUD parity enforcement.** Perform market conduct exams to identify and correct parity problems, and consider targeted exams to identify any gaps in mental health and SUD parity compliance.<br><br>■ **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 in-network providers who deliver MAT and mental health care—and who are accepting new patients.<br><br>■ **Continue working to address stigma.** Conduct education efforts on SUDs as a medical disease, to reduce stigma.<br><br>■ **Promote "warm handoffs."** Support innovations such as emergency department initiation of MAT, to actively connect those who overdose to treatment services in the community.<br><br>■ **Assess barriers among patients and physicians to providing SUD services.** Further evaluate StandUp's outcomes, and partner with the AMA and the Mississippi State Medical Association on outreach to physicians to identify barriers to providing SUD services, including the role that stigma plays and the potential for telemedicine to expand access to services. |

# 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 Centers for Disease Control and Prevention (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."[24] Mississippi, like all states, has worked to decrease patient exposure to opioid analgesics, and has been successful in reducing opioid prescriptions,[25] but it is not clear whether this reduction in opioid supply has led to improved patient pain outcomes, including access to non-opioid forms of pain care.

While joining with nearly all 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 chronic pain patients and are functional on opioid therapy (even if it includes a high dose). As Mississippi monitors and continues to see reductions in opioid prescribing, it is critical that patient differences continue to be recognized; those who are functional and not misusing opioids must not be adversely affected by policies designed to reduce opioid supply.

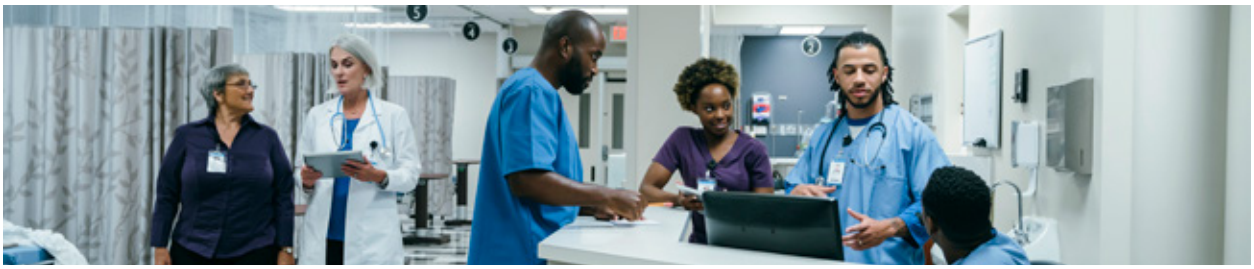
The second and broader goal is that reducing opioid use must be paired with increasing access to non-opioid pain management strategies, including both non-opioid medications and alternative therapies. Mississippi Medicaid and the MID have been strong participants in reducing opioid prescriptions, and that effort is ongoing as regulatory bodies such as the Mississippi State Board of Medical Licensure wrestle with setting limits on the dose and quantity of opioid prescriptions. As those trends continue, it is imperative that pain management specialists, ED physicians, and other medical personnel do not face the dilemma of having no available or affordable option other than opioids to offer pain patients, in cases where opioids are not the best option. Access to comprehensive care raises challenges in a state where there may not be a large supply of pain management specialists, interventional pain physicians, psychiatrists, and other highly specialized physicians. Moreover, given Mississippi's large rural population, there are additional complexities due to travel if such specialists practice only in the state's large, urban areas and academic medical centers.

Ensuring the availability of options requires regulatory review of benefit design and utilization management requirements to understand the level of coverage for modalities such as neuromodulation; cognitive behavioral therapy; mental health care; 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 comorbidities such as depression, anxiety, and sleep disturbances.[26]

**Recommendation: Regulators need to work closely with payers in the commercial market and Medicaid to identify pain management specialists, including anesthesiologists, psychiatrists, interventional pain management specialists, other physician specialists as well as non-physician health care professionals who are important components of a health care team. Without an adequate pain care network, it will be incredibly difficult to provide appropriate pain care services to patients.**

**Exhibit 5. 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 as opioids for many people and can be less expensive.[27] 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."[28]



## Expanding Coverage of Alternative Pain Management Strategies

Non-opioid pain treatments include a wide of options, ranging 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; cognitive behavioral therapy; and other medical, physical, and mental health services. Mississippi's Medicaid program covers some non-opioid prescription medications to treat pain, such as anticonvulsants and antidepressants, as well as steroid injections, chiropractic care, physical therapy, and topical analgesics such as those with lidocaine.

Adult Medicaid beneficiaries, however, are subject to a cap of 5 prescription drugs a month and 16 physician visits a year (increased from 12 in January 2019),[29] which can present serious barriers to treatment both for pain and for SUD. During its 2018 session, the Mississippi Legislature gave the Medicaid program new flexibility to remove these caps, and Medicaid's EASE Initiative is currently working to expand benefits, with plans to increase the number of prescriptions later in 2019. While the increases in the number of prescriptions and physician visits allowed are welcome reforms, for Medicaid beneficiaries with serious or multiple chronic conditions the adjusted caps will likely still present barriers to care. Lifting these limits when necessary would remove a barrier to accessing the full range of available treatment for individuals with SUDs and chronic pain—conditions that do not fit neatly into a specific number-of-visits paradigm. In addition, Medicaid could look to coverage innovations in other states, such as Colorado's action raising rates for physical therapy to encourage more PT providers to participate in Medicaid and more services to be delivered.[30] Given Mississippi's challenges in building adequate access to pain management specialists, we recommend particular attention be paid to ensuring access to non-opioid pharmacologic pain care alternatives.

**Recommendation: Ensure that caps on the number of prescriptions Medicaid patients can obtain per month do not adversely affect patients with SUD or chronic pain, and consider innovations from other states in non-opioid pain management. This includes a close review of formulary and benefit design to ensure access to a broad range of non-opioid pharmacologic and non-pharmacologic alternatives.**

**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 | Antidepressants (amitriptyline and Cymbalta) | Steroid injections | Yoga |

## Identifying Best Practices and Extending Them to Medicaid and Commercial Coverage

There is a broad array of new strategies that both Medicaid and the MID can look to in expanding coverage for innovative pain management strategies. The University of Mississippi Medical Center (UMMC) is working to reduce a patient's post-surgery pain through Enhanced Recovery After Surgery (ERAS).[31] The program calls for a multidisciplinary team of providers to adopt a culture of reducing a patient's stress response to surgery as a way to help the patient recover more quickly. Additionally, UMMC pain management providers are treating pain with alternative therapies such as acupuncture; PT and OT; biofeedback; and non-opiate medications such as local anesthetics, epidural analgesia, and nerve blocks.[32] Medicaid officials have partnered with UMMC in the past and have recently reached out again. Ideally, state officials could work with UMMC to share lessons learned from these efforts with other hospital systems throughout the state.

Mississippi could also look to the Colorado Opioid Safety Pilot, run by the Colorado Hospital Association, which was a 6-month pilot in 8 Colorado hospital EDs and 2 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% reduction in opioid administrations during the pilot period compared with 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 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%. Ketamine use was up 144%.[33,34] Based on the success of the pilot, the Colorado Hospital Association is working to implement the program in EDs statewide.

There also are many examples of insurer-led innovations in pain management that focus on improving pain outcomes rather than simply reducing exposure to opioid analgesics. This includes a Kaiser program for patients in Colorado and Geisinger innovations in Pennsylvania. In addition, many states are taking advantage of Project ECHO—a program run out of the University of New Mexico that connects pain management experts in academic medical centers to locations throughout a state.[35] These programs are most prevalent among insurers that are integrated with delivery systems in ways that are not common in Mississippi, though some of the innovations may nevertheless be replicable.

**Recommendation: Identify comprehensive, multidisciplinary, multimodal pain care innovations in Mississippi's academic medical centers—and best practices from other states (e.g., ERAS, Project ECHO)—and scale them to rural and other areas in the state.**

## Ensuring Prescription Drug Formularies Are Non-discriminatory

The MID has prior approval authority over insurer formularies through the rate and form review process, which means that the MID must approve the commercial formularies before they are used in the marketplace. This gives MID the opportunity to ensure that drug formularies cover a range of medications in a non-discriminatory manner. The MID also has authority over commercial coverage of non-pharmacological benefits (such as physical therapy) provided in health plans, though restorative and behavioral therapies are typically not subject to the same rigorous standards as pharmacologic options, making it more difficult to regulate when these therapies should be covered. This type of formulary review, moreover, is focused on ensuring patients have access to the medications in different drug classes that can help alleviate pain and pain symptoms and can serve as an alternative to opioid therapy when the risks of opioid therapy outweigh the benefits. Although controlling costs through formulary and benefit design is understandable, if policies simply act to restrict access to opioid analgesics without increasing access to affordable, non-opioid alternatives, the inevitable result will only be an increase in patient suffering.

We therefore encourage the MID to consider 2 basic consumer access tests with respect to pain management: first, non-opioid alternatives should be available on the formulary; second, formulary tiers, prior authorization, and other utilization management tools should be used sparingly (if at all) in order to make access affordable and timely. Formularies that are overly restrictive may constitute benefit design discrimination, which is prohibited by the ACA. For example, as noted by the Department of Health and Human Services in the Proposed Notice of Benefit and Payment Parameters for 2020, formularies that 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.[36]

As a point of reference, the Colorado Division of Insurance (DOI) has long offered guidance to insurers on how certain medications (including medications related to pain) should be placed on formulary tiers, and it 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% 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. We encourage the Mississippi Insurance Department to consider a similar regulation.

We also encourage the MID to enhance transparency by working with payers to ensure that formularies are posted online and regularly updated so patients can clearly see whether their health insurance plan covers non-opioid alternatives.

**Exhibit 7. Coverage of Non-opioid Alternatives**

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

### Exhibit 8. 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. |

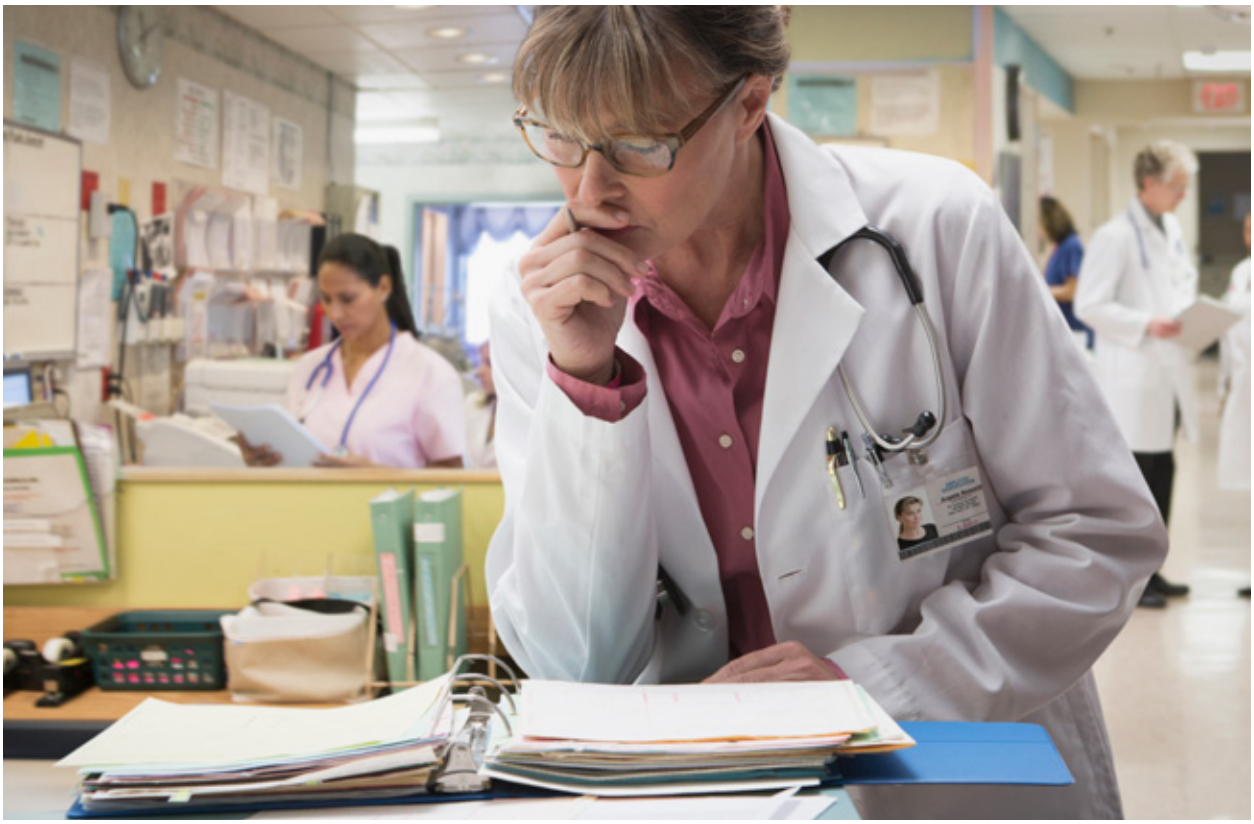
**Recommendation:** Require commercial insurers to post their complete formulary and benefit design packages online, with clear designation of commonly used non-opioid pain alternatives, including non-pharmacologic options. Insurers should update this monthly and clearly state the utilization management requirements and cost-sharing for these options.

**Recommendation:** Ensure that 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, Mississippi could partner with the AMA and the Mississippi State Medical Association to identify a ground-level view of how patients access pain care, including barriers to non-opioid alternatives by specific payers, 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—for example, ensuring that behavioral health and medical care services could be provided on the same day, or that certain services are available in terms of time and distance standards.

**Recommendation: Conduct a thorough review of how patients access comprehensive pain care services, including formulary and benefit design and provider experiences. This will require Mississippi to work closely with the medical and health professional community as well as with insurers and employers.**



### 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 treatments.** Medicaid covers many non-opioid pain care options, including antidepressants, anticonvulsants, steroid injections, chiropractic care, physical therapy, and topical analgesics.<br>■ **Postsurgical pain care.** The University of Mississippi Medical Center uses an evidence-based, multidisciplinary approach to reducing postsurgery pain: ERAS (Enhanced Recovery After Surgery). | ■ **Expand coverage of alternative pain management.** Work with commercial insurers to offer a full array of alternative pain management options, including non-opioid medications, behavioral health, and other alternative services. Ensure that these options are readily available and affordable, by eliminating or easing prior authorization requirements and reducing cost-sharing.<br>■ **Increase benefit caps in Medicaid.** Eliminate the monthly cap on prescription drugs when appropriate, and continue to raise the cap on physician visits. Evaluate the effect on patients' access to care.<br>■ **Identify strategies to increase use of alternative pain management among providers.** Partner with the AMA and the Mississippi State Medical Association to identify barriers to non-opioid medications and services.<br>■ **Evaluate how payers' and other policies focused on non-opioid pain alternatives have affected patients' pain care.** It is vital that regulators and others evaluate policies by health insurance companies, pharmacy benefit managers, and corporate pharmacy chains to determine whether those policies have improved patient outcomes or unintentionally caused increased patient harm. |

# IV. Enhancing Access to Naloxone

Mississippi has taken a number of steps to promote access to naloxone, a prescription medication that can reverse an opioid-related overdose. These include a standing order established through legislation and signed by State Health Officer Dr. Mary Currier,[37] which makes naloxone available without a prescription to individuals with an SUD, their families, friends, and other third parties. Mississippi also has adopted a Good Samaritan law to protect third parties who help treat overdose victims with naloxone.[38] The Mississippi State Medical Association and the AMA strongly supported the naloxone and Good Samaritan laws. Medicaid covers nasal naloxone, and each fill of a naloxone script counts toward the 5-prescription limit. The MID could go further, as Pennsylvania did, in securing the voluntary agreement of commercial insurers to cover multiple forms of naloxone without quantity limits.

The DMH is using funds from federal grants for education and distribution of naloxone to law enforcement officers in high-risk areas to combat overdose deaths. As of December 2017, the DMH has distributed 5892 doses of naloxone and provided education to more than 3950 law enforcement officers in 104 different agencies in 49 counties. To expand on existing efforts, the state could follow the example of other states that have distributed naloxone to schools, community centers, and other public settings where individuals may experience overdoses. This includes creating an interactive state map, as Colorado has done, showing the location of pharmacies that carry naloxone, though there can be issues with pharmacies not having the product in stock. State officials report that they are considering a similar map in Mississippi.

### Exhibit 9. Naloxone Administration by EMS: Number of Cases, MS, 2017


Source: The Mississippi Opioid and Heroin Data Collaborative, 2017 Provisional Data Report, https://www.mbp.ms.gov/Documents/2017_Interagency_Report_PMP.pdf, April 6, 2018.

**Recommendation: Continue naloxone outreach and access efforts to save lives in cases of overdose. Identify programs and other efforts under way that seek to link overdose events with referrals to treatment by an addiction medicine professional.**

### Best Practices and Next Steps for Naloxone

| Best Practices | Next Steps |
|---|---|
| ■ **Standing order.** Issued standing order for naloxone, to enable individuals to obtain naloxone for themselves or a loved one without a patient-specific prescription.<br>■ **Use naloxone to save lives.** Saved over 2000 lives in 2017 through distribution and use of naloxone. | ■ **Eliminate prior authorization.** Eliminate prior authorization and quantity limits for naloxone in commercial plans.<br>■ **Help patients identify where to find naloxone.** Develop a statewide map of pharmacies that actively stock naloxone; engage retail chain and community pharmacy support for public education.<br>■ **Link people saved by naloxone to treatment.** Identify where the state is working to link those who experience an overdose event with referral to treatment; evaluate whether such efforts are working.<br>■ **Promote co-prescribing in Medicaid and the commercial market.** The AMA and the Mississippi State Medical Association are eager to work with the state to continue to educate physicians about co-prescribing naloxone to patients at risk of overdose. |

# V. Evaluation

It is important to evaluate the impact of existing initiatives to increase access to SUD treatment, comprehensive pain care, and naloxone in order to help determine what is working to improve patient care and reduce death and other opioid-related harms. However, given the number of Mississippians still needing high-quality, evidence-based care, it is clear that much more work remains. This makes it critical to evaluate on an ongoing basis which state policies are working as intended, how the policies work together, their impacts on patients, and what additional action may be required, including reevaluating policies that may be having unintended consequences.

Mississippi has made initial efforts to gather and report data on the size and scope of the epidemic. The Board of Pharmacy, Bureau of Narcotics, Department of Health, and DMH created the Mississippi Opioid and Heroin Data Collaborative. The collaborative has produced 2 recent reports with detailed statistics on opioid prescriptions, overdose deaths, treatments for opioid-related disorders, naloxone administrations, and drug-related arrests. Data from these reports is also available in a dashboard format, but the data is not frequently updated, and it is not clear how well these reports inform MID, Medicaid, or public health efforts to increase access to SUD treatment, pain care, or overdose prevention efforts. Medicaid has recently introduced an online dashboard with summary statistics on the Medicaid program, such as the number of enrollees, total expenditures, and the number of providers. State officials indicate they are exploring adding opioid-related data.[39]

The National Strategic Planning and Analysis Research Center (NSPARC) at Mississippi State University plans to establish a statewide clearinghouse where data from multiple entities can be collected, integrated, and aligned. Funded through a $200,000 grant from the Health Resources and Services Administration (HRSA), the project includes the formation of a statewide consortium of agencies with a role in fighting the epidemic, which includes the Mississippi Board of Pharmacy, Mississippi Department of Human Services, Mississippi Public Health Institute, and Mississippi Department of Employment Security. NSPARC intends to use data to prevent opioid misuse and abuse, to treat those with a substance use disorder, and to help enforce federal and state regulations on prescription and illicit forms of the drugs. Establishment of the clearinghouse is a response to a major objective outlined in the Opioid and Heroin Study Task Force final report.

## Best Practices and Next Steps for Evaluation

| Best Practices | Next Steps |
|---|---|
| ■ **Data collaborative.** Developed a cross-agency collaborative to collect and publish key statistics on the opioid epidemic. | ■ **Dashboard.** Work to develop a regularly updated dashboard that presents key statistics on the opioid epidemic; convene MID, Medicaid, and public health and medical experts to build a plan on how to more effectively use the data.<br>■ **Perform systematic review of the effectiveness of policy interventions.** Work with public and private institutions to systematically evaluate which policies are working, their impact on patients, and what additional action may be required, including reevaluating policies that may be having unintended consequences.<br>■ **Turning data into action.** Transform data surveillance into public health interventions (e.g., areas of high mortality may need greater coordination between pharmacies, payers, and providers to expand naloxone access). |

# Postscript

In February 2019, after reviewing a draft version of this spotlight, Mississippi Medicaid officials provided additional information on some steps they have recently taken or plan to take in fighting the state's opioid epidemic. We have highlighted some of these steps in the text, but also want to highlight key steps here because this is exactly the kind of response we welcome.

## Institutional Infrastructure and Collaboration

- Mississippi Medicaid recently went from a part-time to a full-time medical director, and expects the expansion of this role will enhance Medicaid's ability to address a range of issues on the epidemic, including coordinating on opioid-related issues with internal and external stakeholders.
- Medicaid's newly formed Innovation Initiatives program is currently pursuing federal funding through the Maternal Opioid Misuse Model.
- Medicaid held 2 conversations with UMMC regarding pain management initiatives.

## Access to Treatment

- Mississippi Medicaid noted that it actively collaborates with organizations such as the Mississippi State Medical Association, DMH, the State Health Department, the State Boards of Medical Licensure and Pharmacy, and other professional organizations. Medicaid recommends that this group of partners work together to expand access to MAT.
- Medicaid indicated that it is considering coverage of residential services. Providers of these services would be required to be certified through the DMH in order to be reimbursed by Medicaid.
- Medicaid contacted the Mississippi Pharmacists Association (MPhA) to suggest partnering with the Mississippi Board of Pharmacy to explore making a map of pharmacies that have naloxone. MPhA indicated that this would be explored.

## Analysis and Evaluation

- Medicaid and UMMC are in discussions regarding an analysis of NAS babies.
- Medicaid is open to collaborating with NSPARC on expanding data analysis to prevent opioid abuse and treat patients with an SUD.

# Endnotes


1 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%22mississippi%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.

2 "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.

3 Mississippi Prescription Monitoring Program, Statistics, https://pmp.mbp.ms.gov/statistics/#stat-7.

4 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.

5 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," September 4, 2003, http://www.ncbi.nlm.nih.gov/pubmed/12954743.

6 Mississippi Division of Medicaid, "Buprenorphine/Naloxone and Buprenorphine Therapy Coverage Provider Sheet," https://www.medicaid.ms.gov/wp-content/uploads/2014/04/BuprenorphineNaloxoneBuprenorphineSummaryProviders.pdf.

7 Mississippi Division of Medicaid, "MS Medicaid Provider Bulletin," December 2016, Volume 22, Issue 4.

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

9 Opioid & Health Indicators Dataset, AMFAR, http://opioid.amfar.org/indicator/AMAT_fac.

10 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=MS.

11 http://hac.virginia.gov/committee/files/2017/10-16-17/V_a%20-%20DMAS%20Handout.pdf.

12 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/healthshots/2018/09/12/644685850/many-recovery-houses-wont-let-residents-use-medicine-toquit-opioids.

[13] 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/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/ms-cpg.html.

[15] 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.

[16] https://www.mid.ms.gov/legal/regulations/20141reg.pdf.

[17] https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/.

[18] https://www.ddap.pa.gov/Pages/Warm-Hand-Off.aspx.

[19] "Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department," Duber H, et al. *Annals of Emergency Medicine*, October 2018. Available at https://www.annemergmed.com/article/S0196-0644(18)30352-4/fulltext.

[20] On October 24, 2018, the president signed into law the federal 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 are, however, some limitations on the state option, which states must evaluate.

[21] https://www.manatt.com/Insights/White-Papers/2019/Spotlight-on-Colorado-Ending-the-Opioid-Epidemic.

[22] https://www.sunherald.com/news/local/article215583990.html.

[23] https://standupms.org/treatment/.

[24] "CDC: Morbidity and Mortality Weekly Report," September 14, 2018, https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6736a2-H.pdf.

[25] IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017.

[26] Dahan A, van Velzen M, Niesters M. "Comorbidities and the Complexities of Chronic Pain," *Anesthesiology* 10, 2014, Vol.121: http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1921542.

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[29] https://medicaid.ms.gov/medicaid-ease-initiative-aims-to-improve-access-to-needed-services/.

[30] https://www.manatt.com/Insights/White-Papers/2019/Spotlight-on-Colorado-Ending-the-Opioid-Epidemic.

[31] Ljungqvist O, Scott M, Fearon KC. "Enhanced Recovery After Surgery: A Review." *JAMA Surg.* 2017;152(3):292–298. doi:10.1001/jamasurg.2016.4952. https://jamanetwork.com/journals/jamasurgery/article-abstract/2595921.

[32] The University of Mississippi Medical Center, "UMMC Physicians Creating Opioid Use Alternatives Model," https://www.umc.edu/news/News_Articles/2018/02/ummc-physicians-creating-model-for-opioid-use-alternatives.html.

[33] Colorado Hospital Association, "Colorado Hospitals Achieve 36 Percent Reduction in Opioid Administration," January 25, 2018, https://cha.com/colorado-hospitals-achieve-36-percent-reduction-in-opioid-administration.

[34] https://cha.com/wp-content/uploads/2018/06/CHA-Opioid-Pilot-Results-Report-May-2018.pdf.

[35] See, for example, how Project ECHO in New Mexico connects with locations throughout the state as well as with partners in other states; https://echo.unm.edu/wp-content/uploads/2014/10/clinic-pain-map.pdf. This type of "train the trainer" innovation could be of particular benefit in Mississippi, where academic medical centers could help family practice and other locations throughout the more rural parts of Mississippi that do not have ready access to pain management specialists.

[36] 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.

[37] https://www.mbp.ms.gov/Documents/Naloxone_Statewide_Standing_Order_5_31_2018.pdf.

[38] https://standupms.org/learn/policy/.

[39] https://medicaid.ms.gov/medicaids-november-vital-signs/.