

SUPPORTING PREVENTION AND TREATMENT OF OPIOID ADDICTION

System-level Changes to Enable Integrated Behavioral Health

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Key Messages

System-level changes are needed

to realize the potential of behavioral health integration to address the opioid epidemic:

- ▶ Removal of financial and regulatory barriers to integration
- ▶ Reinforcement of behavioral health parity legislation
- ▶ Integration of data and information sharing across sectors
- ▶ Growth and appropriate distribution of the behavioral health workforce
- ▶ Reduction of stigma

Overview

The staggering increase in opioid misuse, addiction, and overdose deaths has led the President to declare the opioid crisis a national public health emergency.¹ This issue brief provides an overview of system-level changes that can support behavioral health integration in addressing this crisis, and lays out opportunities for action by policymakers, payers, and philanthropy. This is one of a three-part series on behavioral health integration and the opioid epidemic; complementary issue briefs cover the topics of prevention and treatment of opioid addiction at the individual rather than system-level.

Background

Every day, 115 Americans die of an opioid overdose; the opioid epidemic is now a more frequent cause of death than car crashes.² In 2016, approximately 11.5 million Americans misused prescription opioids, 948,000 people used heroin, and 2.1 million had an opioid use disorder, including 1.8 million people with a prescription opioid use disorder and 0.6 million people with a heroin use disorder.³ The far-reaching extent of the epidemic has touched close to half of American lives: 44% of Americans report knowing someone who is addicted to opioids, and 20% report knowing someone who has died of an overdose.⁴ The opioid epidemic cost \$504 billion in 2015, or 2.8% of the gross domestic product.⁵

Many factors led to the opioid crisis facing America today, including:

- inaccurate claims regarding the safety of opioids, fueled in large part by the pharmaceutical industry;
- pressure to fully relieve pain and measure it as the “fifth vital sign,” promoted by the American Pain Society and adopted by the Veterans Administration and the Joint Commission on Accreditation of Healthcare Organizations;
- inclusion of pain control as part of patient satisfaction scores that could affect provider and hospital reimbursement;
- inadequate healthcare professional education on treatment of pain and addiction;
- diversion of prescription opioids by distributors, pharmacies, prescribers, and patients;
- increasing availability of cheap black market heroin and fentanyl; and insufficient and isolated treatment services for addiction.¹

Behavioral health integration is a component of many key strategies to address the opioid epidemic. Behavioral health and primary care integration has been defined as patient-centered care that addresses mental health and substance use conditions, health behaviors, life stressors, and stress-related physical symptoms, provided by a team of primary care and behavioral health clinicians.⁶ Addressing whole person health requires applying this concept of integration both within and outside of the

traditional healthcare system. Therefore, behavioral health integration pertains to (1) the healthcare sector; and (2) cross sector collaborations between the healthcare sector and social services, employers, schools, and communities.

Ultimately, the underlying principle of behavioral health integration is that physical, behavioral, and social health are inextricably intertwined. Fragmented systems of care create barriers to achieving optimal whole person health. Integration of care is a solution to fragmentation. Understanding the physical, behavioral, and social determinants of health, and their relationship to one another, exposes the root causes of many health disparities. Policies advancing integration support sustainable change to achieve more equitable health outcomes.

System-level barriers to behavioral health integration include lack of trained workforce, lack of coordination across sectors, segregated funding streams and reimbursement models that do not support care coordination and psychosocial services, lack of political support, government regulations, inadequate infrastructure for support services, need for bridging across different cultures, and criminalization and stigmatization of drug use.^{7,8,9}

This issue brief was developed following a rapid review to summarize evidence, a methodology that streamlines the usual processes for systematic reviews to synthesize relevant evidence in a timely manner for decision-makers in healthcare and policy. [Detailed methods](#) are available in an online appendix.

Table 1. Strategies to address the opioid epidemic, by principal sector involved and level of prevention.

Principal Sector Involved	Primary/Universal Prevention	Secondary (Selective and Indicated) Prevention	Tertiary Prevention/ Treatment
Healthcare	Health care professional education on chronic pain and opioid prescribing*	Coverage of non-pharmacologic treatments for chronic pain* Use of Prescription Drug Monitoring Programs Limits on opioid dosage or duration Coverage of non-opioid medications for chronic pain	Medication-Assisted Treatment in primary care* Health care professional education on treatment of opioid use disorder* Naloxone prescribing Coverage of inpatient and residential treatment programs
Education	School-based youth prevention programs*	School-based youth early intervention programs*	
Community	Public education campaigns Community-based youth prevention programs* Stigma reduction campaigns	Drug “Take Back” Events Community-based youth early intervention programs*	Stigma reduction campaigns Naloxone availability Good Samaritan immunity laws Safe injection facilities Clean needle exchange programs
Criminal Justice	Interventions targeted at drug trafficking	Identification and prosecution of “pill mills”	Drug courts and other diversion programs* Medication-Assisted Treatment in criminal justice settings* Naloxone availability

Strategies integrating behavioral health are denoted with an asterisk. Primary, or universal, prevention refers to interventions that can be applied to the general population, before any evidence of a disease is present. Secondary prevention is targeted at individuals or populations with identifiable risk factors for a condition (selective intervention) or early signs of a problem (indicated intervention). Tertiary prevention, or treatment, seeks to reduce harm and consequences once a disease is already present.¹⁰

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individuals would have access to substance use disorder treatment

Stigma

The bottom line

Behavioral health integration helps address stigma by normalizing and facilitating access to treatment for addiction through co-location with other medical or social services. Public education campaigns are an additional mechanism to reduce stigma.

Stigmatization and criminalization of opioid addiction contribute to inaction and use of ineffective strategies to address the epidemic. People of color addicted to opioids are more likely to be viewed as criminal than white individuals addicted to opioids.¹¹ More than half of Americans (62%) believe reducing stigma around addiction would be an effective strategy to address the opioid epidemic.⁴ Integrated services increase access not only by decreasing investment in transportation and time required through receiving treatments at one site, but also by decreasing stigma of receiving behavioral health services through their inclusion in general medical care. Stigma regarding treatment of opioid use disorder has been propelled by the media; news coverage of the opioid epidemic has largely framed opioid use disorder as a criminal justice issue rather than a treatable health condition.¹² Stigma reduction campaigns have been included in some regional and state efforts to address the opioid epidemic, including the State without StigMA campaign in Massachusetts.¹³

Payment

The bottom line

Individuals with opioid addiction need insurance coverage to access appropriate services; Medicaid expansion is an important facilitator in this regard. Payers can support integration by carving in behavioral health services as part of the medical benefit and enhancing payment through the use of additional billing codes to reimburse integrated services, or more optimally, through non-fee-for-service solutions such as global budgets that cover both behavioral and physical healthcare. Better enforcement of parity laws would ensure that behavioral health services are covered equally to physical health services as intended by legislation.

Insurance Coverage

Lack of insurance coverage poses a significant barrier to obtaining behavioral health services. Individuals with opioid use disorder are more likely to be uninsured than the general population.¹⁴ Among people with a substance use disorder, those with Medicaid coverage are more than two times as likely to receive treatment as uninsured individuals.¹⁵ Medicaid is the single largest source of coverage for behavioral health services, including substance use disorder treatment. Medicaid expansion in 31 states has provided coverage for an additional 1.2 million people with substance use disorders. Another 1.1 million individuals would be eligible for coverage if Medicaid were expanded in all states.¹⁶ Notably, state restrictions on Medicaid eligibility based on drug tests would bar individuals with opioid use disorder from the primary means of accessing treatment for addiction.¹⁷

Carve-Outs

Many payers carve out behavioral health services, meaning these services are administered and paid for through a separate contractual arrangement from physical health services. In Medicaid there has been a shift in the past few decades towards more managed care contracts to decrease costs, and many states opted to carve out their behavioral health services under a separate managed care contract or sometimes fee-for-service arrangement. This separation of funding streams can create barriers to reimbursement for treatment of behavioral health diagnoses in primary care.¹⁸ More recently some states are returning to carving in behavioral health services; in 2016, Medicaid programs in 24 states included substance use disorder services in comprehensive managed care contracts that include physical health services.¹⁵ Integrating funding streams rather than employing behavioral health carve-outs is one strategy payers can employ to support integration.

Parity

Parity laws support equal insurance coverage of behavioral health services commensurate with physical health services, but many have cited concerns about enforcement of these regulations. The Behavioral Health Coverage Transparency Act, which was introduced in Congress in 2016 but not enacted, would have required insurers to disclose their analysis of parity determinations and reasons for mental health claims denials. It also would have allowed the Department of Health and Human Services and the Department of Labor to audit health plans regarding their compliance with parity laws.¹⁹

Federal Parity Legislation

- Mental Health Parity Act (MHPA; 1996) – Prohibits large group plans from imposing lifetime or annual dollar limits for mental health benefits less favorable than physical health benefits (mental health benefits do not include substance use disorders).
- Mental Health Parity and Addiction Equity Act (MHPAEA; 2008) – Requires group market and government plans covering behavioral health services to cover them at least as favorably as physical health benefits, including treatment limits, cost sharing, and in- and out-of-network coverage. Expands the parity requirement from the MHPA to substance use disorders.
- Patient Protection and Affordable Care Act (ACA; 2010) – Increases access to services through expanded insurance coverage (Medicaid expansion, employer and individual mandates). Includes behavioral health services in required Essential Health Benefits for individual and small employer markets. Extends parity requirements of MHPAEA to individual market insurance plans.²⁰

Payment Models

In fee-for-service payment models, coverage of services needs to be specified in billable codes. There is often inadequate coverage through fee-for-service codes for integrated behavioral health services in primary care or case management, though codes supporting some integrated services have been created and adopted by some payers.^{21,22} Global payment models present an opportunity to allow healthcare providers to more proactively and flexibly use funds to meet patients' needs as they see fit.²³

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Workforce, Education, and Training

The bottom line

More behavioral health providers trained in integrated care are needed, particularly in rural settings. Knowledge gaps should be addressed through enhanced education for all health professionals on pain management and treatment of opioid addiction.

Expert groups and providers themselves have voiced a need for enhanced education regarding chronic pain and opioid use disorder for primary care providers, ancillary clinic staff, and behavioral health providers.^{24,25} As integrated care brings together disciplines that have traditionally worked separately with different cultures, training is also needed for healthcare providers to learn how to best work together as a team. Addressing stigma around use of medications for addiction and towards patients with substance use disorders should be included in educational efforts.²⁴ Similar needs for education apply to other social service sectors as well.

Improvements in education will support current efforts; however, there is also a lack of sufficient workforce of both behavioral health providers and primary care providers prescribing medication-assisted treatment (MAT). Because workforce shortages are particularly an issue in rural areas, strategies for expansion must take geographic distribution into account.

Data Integration

The bottom line

Integration of care delivery and coordination of initiatives across sectors require integration of data sources, real-time data sharing, and consensus on measures of integrated outcomes.

Behavioral health providers are not able to access controlled substance prescription data in 30 of 49 states that have a prescription drug monitoring program (PDMP). Furthermore, 42 CFR Part 2 prohibits the inclusion of data from substance use disorder programs in PDMPs; methadone administration from opioid treatment programs is excluded.²⁶ This regulation applies confidentiality rules to any federally-assisted substance use disorder program and mandates that prior written patient consent is required for each disclosure of information unless it is part of mandatory abuse and neglect reporting or a medical emergency disclosure to another healthcare provider.²⁷

Law enforcement has identified lack of real-time data sharing across sectors as a barrier to a coordinated response, particularly with regard to identifying batches of fentanyl-adulterated heroin leading to overdose deaths. One district in Pennsylvania developed a regional clearinghouse to receive reports of heroin overdoses and seizures from first responders, which has led to new leads and enhanced investigation.²⁸

The need for standardized measures to better assess the response to the opioid epidemic has been recognized,^{17,29} and experts have called for broad outcomes measures to include polysubstance use, physical and psychological health, mortality, criminal activity, self-efficacy, and quality of life.³⁰ Specific measures have been proposed to assess behavioral health integration in criminal justice settings,³¹

treatment of pain,³² care by addiction specialists,³³ and to monitor the opioid epidemic at a state level, including overdose data, receipt of treatment, and use of measures from the National Behavioral Health Quality Framework (such as metrics on abstinence, patient satisfaction, and continuity of care).¹³ Vermont has developed a statewide dashboard to help policymakers track trends related to addiction prevalence and treatment capacity.¹³ At the practice level, electronic health record dashboards with integrated physical and behavioral health data increase adherence to guidelines and behavioral health visits.³⁴

Policy Levers

Policy levers to address the opioid epidemic specifically through system-level changes that support behavioral health integration are highlighted in Table 2. The listed opportunities for payers and philanthropy also apply to policymakers as they relate to state Medicaid policy and research funding. Additional policy opportunities for prevention and treatment of opioid addiction are listed in complementary briefs in this series.

Table 2. Policy levers to prevent opioid addiction that incorporate behavioral health integration.

Decision maker	General Approach to Policy Opportunities	Specific Policy Opportunities
Policymakers	<p>Potential policy levers for policymakers include:</p> <ul style="list-style-type: none"> • enforcement of parity laws, • Medicaid expansion, • support for behavioral health workforce growth, and • addressing regulatory barriers to data sharing 	<p>Strengthen enforcement of behavioral health parity laws, such as allowing the Department of Labor to levy penalties and launch investigations for violations.¹</p> <p>In states that have not already done so, expand Medicaid to enable access to treatment services.</p> <p>Increase behavioral health provider training and recruitment programs, particularly in rural areas, such as through scholarships and loan repayment from the National Health Service Corps.</p> <p>Remove regulatory barriers, including through 42 CFR Part 2, to information exchange for physical and behavioral health providers caring for the same patient.</p>
Payers and Policymakers	<p>Potential policy levers for payers include:</p> <ul style="list-style-type: none"> • carving in behavioral health services, • use of global budgets, and • additional reimbursement of integrated services 	<p>Eliminate carve-outs of behavioral health services.</p> <p>Employ global budgets that include both behavioral and physical health services for comprehensive, whole-person healthcare.</p> <p>Where global budgets are not used, reimburse additional billing codes for integrated services.</p>
Philanthropy and Policymakers	<p>Potential levers for philanthropic organizations include funding support to train providers and practices to integrate care.</p>	<p>Fund training programs for behavioral health providers in integrated settings and practice transformation support for behavioral health integration.</p>

Additional recommendations are relevant to integrating efforts across social service sectors. The President’s Commission on Combating Drug Addiction and the Opioid Crisis has called for block granting federal funding to states for all activities related to the opioid epidemic to streamline the process of obtaining funding between agencies and reduce administrative burden and logistic barriers to states.¹ The National Academies of Medicine recommends the development of a systems model for addressing the opioid epidemic, establishment of the data infrastructure needed to support it, and assigning responsibility to a lead agency for developing and implementing a national strategy.²⁶

Conclusion

Opioid addiction is both preventable and treatable, and behavioral health integration plays a key role in many effective strategies for prevention and treatment alike. System-level changes to support behavioral health integration, however, are needed to fully realize its potential in addressing the opioid epidemic. The current insufficient availability and isolation of addiction services are driven by inadequate and ill-distributed integrated workforce capacity, lack of insurance coverage, fragmentation of data, and separated funding streams. Policies that integrate underlying system infrastructure will enable integrated healthcare services and efforts across sectors.

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