National Drug Control Strategy

National Treatment Plan for Substance Use Disorder 2020

Office of National Drug Control Policy

FEBRUARY 2020

OVERVIEW

According to the National Survey on Drug Use and Health (NSDUH), in 2018 an estimated 21.2 million Americans aged 12 and older needed treatment for a substance use disorder (SUD), but only 3.7 million received any kind of treatment and only 2.4 million received treatment at a specialty facility - a disparity known as the "treatment gap".

Children and young adults have unique prevention and treatment considerations, and the treatment gap for youth and young adults ages 12-17 is greater than it is for the general public.

In 2018 an estimated 31.9 million Americans reported using an illicit drug in the past month. Furthermore, in 2018, an estimated 21.2 million Americans aged 12 and older needed treatment for a substance use disorder, approximately 20.3 million people aged 12 or older met the medical criteria for a substance use disorder, including 14.8 million people with an alcohol use disorder and 8.1 million with a drug use disorder. That year, an estimated 27.2 million Americans age 18 and older reported they experienced an alcohol or other drug use problem in their lifetime and approximately 20.2 million Americans over 18 described themselves as being in recovery from a drug or alcohol problem or having recovered from one.

Despite the number of people in recovery, nearly 89% of the estimated 20.2 million Americans who met the criteria for a substance use disorder (SUD) in 2018 did not receive specialized treatment for their condition.

That is, barely more than 1 in 10 Americans needing substance use disorder treatment actually received it. Of those who needed treatment at a specialty facility, 18 million (89%) did not feel they needed treatment; 2.36 million (11%) did receive treatment at a specialized facility; another 573,000 (3%) felt they needed treatment but did not make an effort to receive it; and 392,000 (2%) attempted to access treatment but, for a variety of reasons, failed to do so.

When examining only those Americans who suffer from drug use disorder and not including those with alcohol use disorder only, the numbers are only slightly better. An estimated 6.8 million (79%) of the 8.1 million Americans who suffer from drug use disorder did not feel they needed treatment; 1.4 million (16%) of them did receive specialty treatment; 251,000 (3%) felt they needed treatment but did not make an effort to receive it; and 218,000 (2%) felt they needed treatment and attempted to receive treatment.

Noteworthy, is that in 2018, among those aged 18 or older, 11.7% used illicit drugs in the past month and among those who were full-time employees, 12.6% used illicit drugs in the past month, as did 14.8% among part-time employees and 23.1% among the unemployed. What is being described here is a "treatment gap" between those needing treatment and those receiving it.

This "treatment gap" is one reason the United States lost over 70,000 people to a drug overdose in 2017. There is an urgent need in our nation to identify substance use problems before they develop into

substance use disorders, increase access to treatment, make treatment services and care more widely available, and ensure that the services provided are evidence-based and high quality.

As part of his larger strategy to end the addiction epidemic in this country, President Trump signed the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* in 2018. This critical legislation requires the Office of the National Drug Control Policy (ONDCP) to develop "a plan to expand treatment of substance use disorders."

Expanding Americans' access to effective evidence-based substance use disorder treatment is a key pillar of the President's *National Drug Control Strategy (Strategy)*. Treating addiction is best addressed locally when policymakers, health and provider systems and networks, and community-based support programs address addiction as a chronic illness requiring quality integrated treatment services, essential support structures, and ongoing continuing care or recovery support services. Research shows that substance use disorders can be treated, with success rates similar to those of asthma, diabetes, and other chronic illnesses. As such, the *Strategy* prioritizes increasing access to evidence-based addiction treatment, including Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) (sometimes referred to as Medications for Opioid Use Disorder (MOUDs). It also prioritizes supporting those in recovery with peer support services, access to housing, training, educational, and employment opportunities to foster a sense of stability, pride, and full engagement in the community.

Through consultations with public health experts, stakeholders and agencies across the Federal government, ONDCP has identified key elements of this treatment gap and has developed a plan to address them. ONDCP's Treatment Plan to address increasing access to treatment and closing the gap rests on three pillars that are composed of twenty-two areas of focus.

Pillar 1: Improve Efforts to Expand Early Intervention, Treatment and Recovery Support Services Infrastructure (pre-natal through adult) by:

1. Enhancing all levels of the professional, mid-level and paraprofessional addiction workforces, including in rural settings;
2. Improving services for pregnant and post-partum women, and services for infants born with neo-natal abstinence syndrome;
3. Improving access to low-threshold services, including those provided at syringe services programs (SSPs);
4. Leveraging technology, when appropriate, to increase access to care and services;
5. Improving the uniformity, quality, range, and timeliness of treatment data and expanding collection of other data to better inform treatment policy and services;
6. Addressing barriers to treatment, housing, and employment;

7. Encouraging workplace support for current employees in treatment and recovery;
8. Encouraging medically managed withdrawal services that include initiation of medication to prevent relapse, and appropriate post-stabilization service as part of a treatment program with continuing care
9. Building evidence-based recovery support services capacity;
10. Promoting quality recovery housing; and
11. Continuing Federal parity enforcement and implementation efforts regarding treatment services provided by health plans and issuers.

Pillar 2: Improve Delivery Systems, Provider Efforts, and Services for People with SUD, Including Special Populations, by:

12. Conducting outreach to payers, providers, health systems, States, and other stakeholders to help ensure addiction services are provided at parity with comparable medical-surgical services;
13. Improving access to specialty addiction treatment services and care in areas where it is insufficient;
14. Better integrating specialty addiction treatment services and care into mainstream health by:
    a. reducing barriers to access for patients entering treatment;
    b. promoting screening, as well as brief interventions, referral and linking to treatment, with the goal of increasing accurate diagnosis and subsequent evidence-based treatment initiation;
    c. promoting access to addiction medicine specialty consultation services for addiction disorders services in primary care, hospitals and other mainstream and general medical and healthcare settings; increasing initiation of evidence-based addiction treatment in general medical settings;
    d. increasing the number of providers with DATA 2000 waivers to provide MAT and supporting these waivered practitioners in increasing the number of patients they treat for OUD;
    e. linking specialty addiction service care with settings and providers who provide medical care to persons with SUD or injection-related infections such as endocarditis, skin infections, abscesses, or hepatitis.
15. Increasing addiction medicine specialty services in hospitals and emergency departments;

16. Exploring the potential benefits of including other substances in opioid use disorder treatment models;

17. Explore allowing opioid treatment programs to treat stimulant use disorder;

18. Expanding access to treatment by:

    a. building the capacity to provide effective services to all and particularly to special populations such as pregnant and post-partum women; pre-natal through adolescence; older adults and people with disabilities, and people from rural communities, including Native Americans and people who are homeless; and people involved in the criminal justice system;

    b. improving access to all forms of medication-assisted treatment (MAT) and behavioral counseling to include addressing co-occurring disorders; integrating peer recovery support services; identifying and expanding evidence-based linkage and low-threshold approaches to treatment engagement including interim methadone treatment;

    c. supporting Addiction Medicine and Addiction Psychiatry fellowship/residency placements in medical schools and health systems; promote workforce initiatives to support special populations;

    d. utilizing telehealth platforms to increase access to treatment, including MAT;

    e. encouraging the use of mobile treatment units (vans) by substance use treatment programs as well as the provision of MAT with buprenorphine and extended-release naltrexone by mobile health clinics.

    f. encouraging and supporting innovations in treatment delivery; and,

    g. fostering peer outreach, engagement, low threshold, syringe services and intervention efforts;

Pillar 3: Improve the Quality of Treatment by:

19. Conducting an environmental scan to identify existing standards for treatment;

20. Developing and promoting adoption of model state specialty SUD treatment licensing laws;

21. Working aggressively to eliminate fraud and abuse, reducing related patient harm; and,

22. Developing protocols, and promoting and educating about medically managed withdrawal services, optimally as part of a treatment program or with linkages to treatment, particularly among criminal justice, rural and Native American populations.

UNDERSTANDING THE TREATMENT GAP

Multiple factors contribute to the "treatment gap." For the purposes of this document, information has been organized around the following factors as contributing to the gap:

Factor 1: Individuals with SUD may not seek treatment

Factor 2: Individuals with SUD may not know how to access treatment or face financial barriers

Factor 3: Individuals with SUD may seek treatment but face provider shortages

Factor 4: Individuals with SUD may receive inadequate, clinically inappropriate, poor quality, or fraudulent treatment

Factor 5: A treatment episode is inappropriately truncated

Factor 6: Individuals may not receive treatment that is culturally competent or responsive to the individual's social determinants of health

IMPLEMENTING THE TREATMENT PLAN

Designing a plan and associated Treatment Strategy to close the treatment gap requires a detailed understanding of each of these contributing factors. The Treatment Strategy detailed below, includes Actions that respond to the areas of focus under each pillar, and will be implemented on a prioritized and tiered approach, subject to the availability of appropriations. For a holistic description of the activities taken by each NDCPA to address the National Treatment Plan's areas of focus, please refer to the *FY 2020 Budget and Performance Summary* that was published in May 2019, and to the *FY 2021 Budget and Performance Summary* that will be published after the President's proposed Budget is released.

Factor 1: Individuals with SUD may not seek treatment

Many individuals with SUD do not seek treatment. A primary reason for this is lack of patient awareness: in 2018, nearly 95% of individuals who did not receive treatment for their substance use disorder did not think that they needed treatment. This is often due to patients' lack of understanding of the disease of addiction, reluctance to acknowledge an alcohol or other drug problem due to shame, concerns about social, legal, employment, or other repercussions, or denial that they have a problem. Even patients who are aware that they need SUD treatment may not seek it. Approximately 89% of Americans with SUD who recognize they should seek treatment are not ready to stop drug use. Many fear becoming 'drug sick' through the withdrawal process, which is why medically managed withdrawal during this process is so helpful and raising awareness of its availability as a service is required.

Additionally, primary care providers do not uniformly screen for SUD, much less provide more specialized services, such as assessment, diagnosis, and treatment. Even those primary care or emergency room doctors who do screen for or diagnose SUD may be unsure of where to refer a patient for treatment, or

do not refer at all due to lack of providers.

Peer workers are individuals in recovery from SUD who belong to the communities they serve and are playing a growing role, leveraging their lived experience to help bridge gaps between systems, low threshold services and engaging people with SUD who are not seeking care. For example, in both urban and rural communities, peer recovery support specialists are engaging patients in the emergency department following overdose. Peer workers are linking people who need SUD treatment directly to specialty SUD care. When it is not possible to link them to care, peer workers are providing overdose prevention and response training. They are also distributing naloxone kits, and working to remain engaged with patients who decline treatment in order to maintain the possibility of future treatment engagement. A recent study in a major urban center found that peer outreach workers were effective in engaging community members with OUD and linking them to specialty SUD treatment. Peer workers are effective in conducting naloxone distribution and training and in supporting syringe services programs.

Services that focus on reducing the risks or consequences associated with substance use can prevent people with SUD from additional health-related harms and may also help providers establish relationships that lead to patients' enrollment in treatment services. For example, syringe services programs allow providers to engage with people who inject drugs, and reduce the likelihood of infection and prevent the transmission of the human immunodeficiency virus (HIV), viral hepatitis, and other blood-borne pathogens. Continued engagement with these services may help people with SUD feel comfortable enough to seek treatment and/or engage in less risky substance use.

Also, the stigma surrounding addiction discourages many from seeking help. Nearly 15% of those who recognized they needed treatment feared that receiving it would cause their community to hold a negative opinion of them and 17% worried it would have a negative effect on their job. Many, too, are concerned about legal consequences of acknowledging a SUD use disorder (e.g. loss of custody of children). Logistics may also present a challenge: securing childcare and finding transportation to treatment may be costly or difficult, and inflexible work schedules may impose limitations on when a patient can see a treatment provider, particularly for hourly workers who do not have benefits such as paid sick leave.

Actions:

- Increase efforts to inform the healthcare and public health communities and the general public about treatment availability. (Health Resources and Services Administration (HRSA)/ Substance Abuse and Mental Health Services Administration (SAMHSA)/Indian Health Service (IHS)/ Centers for Medicaid and Medicare Services (CMS)/ Centers for Disease Control and Prevention (CDC)/Veterans Health Administration (VA))
- Promote use of mobile SUD treatment units. (HRSA/SAMHSA/IHS/treatment providers)
- Support screening for SUD in general health settings. (CMS/HRSA/IHS/VA/health systems/ health plans and issuers)

- Continue peer and paraprofessional outreach, engagement, and intervention efforts. (CDC/SAMHSA/HRSA/IHS/USDA/CMS/VA/treatment providers/health systems)
- Support efforts to reduce the impact of stigma associated with SUD. (SAMHSA/HRSA/CMS/CDC/IHS/VA/states/treatment providers/health systems/health plans and issuers)

Factor 2: Individuals with SUD may not know how to access treatment or may face financial barriers

An estimated one-in-five Americans who sought treatment in 2018 did not know where they could access it. Finding treatment is difficult even if one has public or private insurance and understands how to access SUD care through it. In addition, the majority of resources available for locating treatment do not provide information on treatment slot availability or cost. Moreover, individuals seeking treatment may not understand that the level of care they receive should be determined by an assessment and that the provider they approach may not offer the optimal level or type of care. People in need of treatment may hear of different treatment providers, or "rehabs," through their networks, but may not have the information and understanding they need to evaluate the likely appropriateness of a provider given their needs, insurance status, financial resources and employment, child-care needs, and so forth. Individuals may also imagine that treatment must include a stay in a residential setting, which is often not the case, or that residential treatment is superior to outpatient care when, in fact, the optimal level and form of care depend on individual needs and should be determined through a clinical assessment.

Financial barriers are a major impediment to treatment access. The actual or perceived cost of treatment can be an enormous deterrent as approximately a third of individuals who recognized the need for treatment stated that they could not afford it. Publicly funded treatment systems make care available, regardless of ability to pay. However, the public is often not aware of this and limited capacity in these systems can result in wait lists. This makes services difficult to access for some individuals. The SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant provides funding to all the States to address SUD services, and prioritizes pregnant and parenting women, injection drug users, individuals with HIV/AIDS, and individuals with tuberculosis. States may also give priority access for publicly funded treatment to additional populations, such as individuals involved in the criminal justice or child welfare system. Finally, health plans, issuers and health systems do not uniformly provide the coverage and services required for comprehensive evidence-based substance use treatment.

Even for those with private insurance, treatment can take weeks or longer to access and can be financially burdensome, as many private insurance providers still do not cover SUD treatment on par with treatment for other chronic conditions. Additionally, there may be fewer providers who are willing to accept private insurance for such treatment.

How states administer Medicaid is not uniform. For example, 11 States do not currently provide Medicaid coverage for MAT when dispensed through an opioid treatment program (OTP). In these states, utilization of opioid agonist therapy, the standard of care for OUD, is significantly lower than

in states where Medicaid covers methadone maintenance (30.1 percent versus 45 percent). However, note that the SUPPORT Act, enacted in October 2018, requires state Medicaid programs to cover MAT for OUD, including all FDA-approved drugs, counseling services, and behavioral therapy, from October 2020 through September 2025. According to a study sponsored by the National Institute of Health, in states that offered neither Medicaid nor SAPT block grant coverage of care in an OTP, fewer than one-in-five individuals with OUD received this care. Additionally, while Medicaid requires coverage of "medically-necessary" behavioral health services, states have some flexibility in defining what qualifies as a "medically necessary" intervention—and therefore must be covered. Lastly, to manage costs, some states may opt to consider medication management an optional form of care.

Historically, private insurance coverage of mental health and substance use (MH/SU) disorder treatments was not comparable to coverage for medical/surgical benefits (physical health). The terrain began to shift in 1996, with the passage of the Mental Health Parity Act (MHPA), which required that annual or lifetime dollar limits on mental health benefits be no lower than those for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. While this law did not apply to SUD care, it was an important milestone.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) went further than the 1996 law by including SUD care and by mandating that covered plans and issuers provide comparable coverage for MH/SU services and medical-surgical benefits. The law also prohibits imposition of copayments, deductibles, or other costs for MH/SU care that are greater than those that apply to substantially all medical-surgical benefits in the same classification. While MHPAEA does not specify which treatments or procedures should be covered as a mental health condition or substance use disorder, MHPAEA regulations provide guidance on how one determines which MH/SU and medical-surgical services should be deemed comparable for purposes of determining compliance with the law. Although MHPAEA only applied to health plans offered by large employers, the Affordable Care Act extended the application of the law to apply to issuers selling individual and small group health insurance coverage, both on and off the Exchange.

The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments), which are jointly responsible for implementing MHPAEA and ensuring compliance with it, have developed extensive training and informational resources to address unresolved issues and continue to work with states, health plans and issuers, health systems, providers, and other stakeholders to provide clarity and consistency regarding the interpretation and implementation of MHPAEA. The Departments periodically issue additional guidance and other resources to help employers comply with the law and consumers understand their rights. Additionally, the Departments annually report enforcement and investigative statistics. The Department of Labor also works very closely with state regulators and the National Association of Insurance Commissioners to help foster a consistent application of MHPAEA. While substantial progress has been made, ambiguity and inequities remain.

Many consumers do not understand what does and does not constitute a parity violation, nor do many know how to appeal a denial of benefits or lodge a complaint with state or Federal agencies. Moreover,

when individuals are consumed with accessing the care they feel they or a loved one need, they may feel that they do not have time to appeal or make a complaint and they may believe that any favorable resolution of a complaint could come too late to help them or a loved one because the appeals process can be costly and time consuming.

Actions:

- In collaboration with States, local governments, health systems, specialty treatment provider associations, and private payers, explore the development of mobile and online applications/ platforms providing up-to-date information on treatment slot availability, information on providers and types of treatment, and online appointment scheduling. (States, local governments, health systems, specialty treatment provider associations, and private payers, SAMHSA, CMS, HRSA/local FQHCs)

- Increase public awareness on how to access treatment, public and private insurance coverage, services for the uninsured, and payment and financing options for individuals without coverage who are unable to cover the cost of care out of pocket. Accomplish this effort by leveraging health plans, employee assistance programs, employers, social workers, advice lines, the medical community, homeless shelters, jails and local television, radio, and public health networks as messengers. (SAMHSA/HRSA/USDA/CDC/IHS/VA/CMS/Labor; health plans, advice lines, medical community, homeless shelters, jails staff and local public health networks)

- Engage and encourage public and private insurers to cover comprehensive services while working to reduce patient cost. (HHS/States/health plans and issuers)

- Continue efforts to facilitate parity compliance and improve parity enforcement. (Labor/Internal Revenue Service (IRS)/Treasury/HHS/Center for Consumer Insurance Information Oversight (CCIIO)/ CMS)

- Encourage more treatment providers to subsidize and/or provide treatment scholarships and raise awareness of the availability to people in need of treatment. (Treatment providers/SAMHSA/IHS)

Factor 3: Individuals with SUD may seek treatment but face access barriers and provider shortages

Ensuring network adequacy remains a challenge in the SUD treatment arena. In some cases, inadequate payment rates may discourage providers from joining health plan networks, resulting in a paucity of in-network resources and forcing plan members to wait extended periods of time or to access out-of-network care at significantly higher cost. In addition, some cities and the majority of rural communities have no detox facilities or MAT providers. Many jails allow people to “detox” without medical management, which can be life-threatening.

There is a substantial shortage of clinicians qualified to treat substance use disorder. Data from the HRSA’s National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-

2025 indicates that 77% of US counties had a shortage of psychiatrists who could prescribe medication and that one-in-five counties had an unmet need for psychologists, advanced-practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. Only approximately 5,000 medical doctors have addiction medicine or addiction psychiatry credentials, and most only practice addiction medicine part-time.

This shortage of specialized providers is especially acute in relation to the treatment of opioid use disorder. Only 10% of treatment facilities include opioid treatment programs. According to HHS in 2017, 38% of clients in a one day census of treatment facilitates had access to MAT. Thanks to recent efforts to provide training and support, including SAMHSA's Providers' Clinical Support System (PCSS), more primary care clinicians are providing MAT. The number of physicians in other practice areas and specialties providing MAT are increasing as well. These include emergency medicine, pediatrics (a form of primary care), and obstetrics and gynecology. Clinicians who complete the required training and obtain a waiver from the Drug Enforcement Administration are permitted to prescribe buprenorphine for the treatment of OUD.

The number of patients a provider can treat concurrently is limited to 30 during the first year of practice. Subsequently prescribers can request permission to serve up to 100 patients concurrently, and in some cases, are permitted to service up to 275. Most buprenorphine prescribers serve far fewer patients than their patient cap would allow and frequently have months in which they see no MAT patients.

A survey of all rural physicians with a DATA 2000 waiver in 2016 found that 11 percent had not prescribed buprenorphine for the treatment of OUD, and only 56.2% were currently accepting new patients for treatment. Physicians with a 30-patient cap were treating an average of 8.8 patients while those with a 100-patient cap service an average of 56.9 patients. More than half of the physicians with a 30 patient cap (53 percent) were not treating any patients for OUD.

Key reasons cited for not obtaining a waiver included a lack of confidence addressing drug problems and lack of access to addiction experts. A 2017 survey of both waivered and non-waivered physicians found that the majority of waivered physicians (55 percent) were not interested in prescribing to more patients while over a third (36 percent) indicated that they did not have time for more patients. Nearly a third of physicians who did not have a waiver (30 percent), expressed concern about too many requests for treatment with buprenorphine while 26 percent were concerned about potential diversion. Other research identifies the following key reasons for provider reluctance to prescribe buprenorphine for the treatment of OUD: insufficient training and education on opioid use disorder treatment; lack of institutional and clinician peer support; poor care coordination; provider stigma; inadequate reimbursement from private and public insurers; and, regulatory hurdles to obtain the waiver. These and other studies point the way to actions that can be taken to address key barriers to expanding access to office-based opioid treatment.

Addiction often requires multiple rounds of specialty treatment and ongoing recovery support services. Ensuring that those struggling with addiction are supported in their recovery is an important step to

treating their addiction. Peer workers are people in recovery who help others achieve and sustain recovery. Peers can conduct outreach, work to engage individuals in need of care who may not want it, and play a crucial role in connecting people to services. They can also connect individuals to supports in the community, including mutual aid, faith groups, alcohol- and other drug-free social and recreational activities, recovery housing, job training, and specialized services.

Treatment availability varies greatly by geography. Those who live in rural areas, for example, often have to travel much farther than their urban counterparts to access treatment, and some regulations prevent providers from using technology such as telemedicine to treat these populations. A lack of residential treatment services and residential financing options often prevent people from moving to another location to receive treatment.

Another concern is that outside of a small number of pilot projects and individual programs, existing data systems do not provide real-time data on treatment slot availability. Scalable platforms should be utilized, that can be customized to identify in real time available providers, treatment and housing slots locally.

Actions:

- Provide training, consultation, and other support to increase the number of healthcare providers screening for and addressing all forms of SUD in general healthcare settings, including potential co-location of, consultation with, or telehealth services from addiction medicine specialists and other addiction professionals and paraprofessionals. (Medical field/HRSA/CMS/SAMHSA/VA/IHS)
- Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists. (HRSA/DOL/health systems/insurance groups)
- Educate healthcare professionals in Primary Care, Emergency Departments, Acute Care Hospitals, Mental Health clinics and other clinical settings with an enriched SUD population on how to make a “clinical assessment” and to engage in shared decision-making on the range of appropriate SUD treatment options, similar to how they would for other chronic diseases. (HRSA/CMS/health systems/hospitals/medical schools)
- Increase addiction medicine hospital services and integrated care. (hospitals/health systems)
- Increase addiction consultation services and integrated care. (hospitals/health systems)
- Adopt hub and spoke, health home, accountable care organization, and other innovative models to improve SUD treatment and care. (States, health plans and issuers, health systems treatment providers)
- Increase access to treatment programs, especially for stimulants, benzodiazepines, and other non-opioid substances requiring management during the acute withdrawal process. (health systems)

- Improve reimbursement in areas where needed, particularly where out of network usage rates are higher. (health plans and issuers/heath systems/medical field/VA)
- Support peer recovery support services. (CMS/SAMHSA/HRSA/VA/IHS/FQHCs/health systems, treatment providers)
- Expand access to employment opportunities and support for people in treatment and recovery. (DOL/DOJ/SBA/state and local governments/local education agencies/community colleges/public health providers)
- Expand and improve uniformity of treatment data and other mechanisms to inform treatment policy and services delivery. (CMS/SAMHSA/HRSA/NHTSA/VA/IHS/treatment providers/health systems)

Factor 4: Individuals with SUD may receive clinically inappropriate, poor quality, or fraudulent treatment

Those who are struggling with SUD are often not provided with the right treatment due to a lack of standardization in treatment offerings. For example, as mentioned earlier, fewer than half of privately-funded SUD treatment facilities offer MAT, meaning that most treatment facilities are not providing the most effective treatment for opioid use disorder. Moreover, in 2016, 47.5 percent of U.S. counties, including 60.1 percent of rural counties did not have a prescriber with a DATA 2000 waiver to provide MAT. This mismatch between patient needs and provider offerings is especially present in SUD withdrawal/detoxification units. Many communities do not have medication management withdrawal programs, particularly as part of a treatment program or linking to a treatment program; many that do often only provide it for alcohol and opioids but not for other drugs like cocaine or methamphetamine. Increased outreach, engagement, screening, early intervention, and expanded access to both medically managed and medically monitored withdrawal programs and centers associated with treatment programs could play an important role in increasing the percentage of Americans with SUD who seek treatment.

For treatment to be effective, it must be comprehensive. Individuals who are battling substance use disorder often use more than one drug and qualify for more than one SUD. A significant portion have co-occurring mental illnesses and medical conditions, as well as complex psychosocial needs including, for example: family challenges, law enforcement/criminal justice involvement or child welfare system involvement, child custody concerns, threat to or loss of employment, homelessness. Treatment providers are ideally staffed by addiction medicine specialists and addiction psychiatrists (MDs), nurse practitioners and physician assistants, addiction counselors, peer workers, community health workers, mental health care specialists, nutritionists, and social workers. However, requirements can vary widely between states, which can limit the level and number of staff providers are able to employ. Furthermore, the country's physical health and SU providers operate under different confidentiality standards, which can impede the sharing of medical records that is necessary for comprehensive care. This lack of integration creates barriers to providing comprehensive care to patients.

Unfortunately, patients and their families may not know how to identify high-quality treatment

providers, or may not be able to afford such high-quality treatment options, including individuals who may have private insurance, and may opt to solicit the services of:

- treatment programs that do not meet basic quality standards;
- programs which use untested methods, rather than evidence-based approaches; and
- entities posing as recovery residences that are operated by individuals seeking to defraud residents and insurers for profit.

Actions:

- Improve integrated care for physical and SUD services. (HRSA/SAMHSA/IHS/CMS)
- Increase public education efforts on effective treatment approaches including medically managed detoxification followed by evidence-based treatment such as MAT. (treatment providers, health systems, SAMHSA, local public health organizations)
- Increase awareness of SAMHSA standards for Recovery Residences. (SAMHSA/HUD/ONDCP/IHS/VA/treatment providers/health systems/state substance use authorities)
- Increase awareness of how affordable housing models can support recovery. (SAMHSA/HUD/ONDCP/IHS/VA/treatment providers/health systems/state and local housing authorities/nongovernmental groups)
- Explore development of National Consensus Standards for addiction treatment programs to consolidate various treatment quality standards developed by different Federal and nongovernmental groups. (National Institute for Standards and Technology (NIST)/Federal partners/nongovernmental groups)
- Support development and promote adoption of model state laws. (SAMHSA)
- Eliminate or reduce fraud and abuse. (CMS/SAMHSA/Labor/IRS/Department of Justice(DOJ))

Factor 5: A treatment episode is inappropriately truncated

SUD care admission, continuing stay, discharge, and medical necessity criteria can vary greatly from payer-to-payer and from State-to-State. Consequently, the coverage that the same individual would receive under different payers can vary substantially. In some cases, service caps may limit coverage to a specific number of days or hours. Additionally, medical necessity criteria, the standards that need to be met to initiate or continue care, can vary greatly. Arbitrary service caps or more stringent medical necessity applied to MH/SU services can be shown to be MHPAEA violations when comparable limitations, including medical necessity criteria, do not apply to coverage for comparable medical-surgical benefits under a health plan. MHPAEA requires group health plans and individual health insurance coverage to ensure that the financial requirements and treatment limitations that are applicable to mental health

or substance use benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. MHPAEA does not require plans to cover mental health and SUD services. Therefore, plans that elect not to offer these services and that are not required to do so under law, are not in violation of MHPAEA.

Additionally, some private and public insurance plans are not governed by MHPAEA, so that these plans are not in violation in MHPAEA even when such plans place greater limitations on substance use disorder or mental health services coverage than apply to medical-surgical benefits under the plan.

Generally, there are two categories of MHPAEA violations. The first category consists of financial requirements and quantitative treatment limitations (FR/QTLs) that are more restrictive than the predominant FR/QTLs that apply to substantially all medical/surgical benefits. Financial requirements include deductibles, copayments, coinsurance and out of pocket limitations. Quantitative treatment limitations include annual, episode, and lifetime day and visit limits. For example, a plan cannot apply a copayment for SUD care unless it applies a copayment for substantially all medical-surgical benefits in the same classification. The second category consists of non-quantitative treatment limitations (NQTLs) where the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SU benefits in the classification are either not comparable to, or are applied more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.. Examples of NQTLs include medical necessity criteria, standards for provider admission to a network, reimbursement rates, and requirements for using lower-cost therapies before a plan will cover a more expensive therapy.

Were admission, continuing stay, discharge, and quality standards more consistent, disparities in care could be reduced across public and private plans that must comply with MHPAEA, those that are not covered by the law, and publicly funded SUD treatment services, which receive a combination of SAPT block grant, state, and local funding.

Actions:

- Continue to conduct outreach to, engage, and solicit input from health plans and issuers, providers, benefit managers, health systems, people who received treatment and are in recovery, their families, and those with members with active SUD regarding parity implementation. (HHS, Labor, Treasury, ONDCP)
- Continue to implement more efficient and effective parity compliance and enforcement programs. (HHS, Labor, Treasury, ONDCP)
- Conduct an environmental scan to identify existing national voluntary quality standards and other widely adopted quality standards as well as widely adopted admission, continuing stay, and discharge criteria. (HHS, ONDCP/NIST)

Factor 6: Individuals may not receive treatment that is responsive to unique social and cultural requirements

Addiction is a disease that affects people of all races, ages, genders, and socioeconomic levels. A comprehensive strategy to close the treatment gap must include targeted interventions and treatment and recovery support services for communities with special needs. Many social determinants impact access to healthcare and are often critical factors when addressing vulnerable populations.

The incidence of neonatal abstinence syndrome (NAS) has been steadily rising since the 1970s. Addressing this issue remains difficult for many reasons. Many mothers do not discuss this issue with their doctor for various reasons, such as fear of punitive repercussions, which vary from state to state, including fear of arrest and/or loss of custody of their children. Moreover, pregnant women with OUD may avoid prenatal care altogether due to these concerns. MAT with opioid agonists (methadone or buprenorphine) is the recommended treatment for pregnant women with opioid dependence and is preferable to medically supervised withdrawal due to the high relapse rates associated with withdrawal and worse maternal and fetal outcomes associated with a return to illicit opioid use. The American College of Obstetrics Gynecology (ACOG) guidelines recommend screening every pregnant woman for SUDs, offering brief interventions, and providing a referral for treatment, as needed.

The impact of the opioid crisis on American Indian and Alaska Native (AI/AN) population is immense. Between 1999-2015, while the opioid epidemic resulted in an overall increase in drug overdose deaths in the U.S., within this time, the AI/AN population experienced the largest increase in the number of deaths compared to all other racial and ethnic groups. In fact, the role of historical trauma defined here as the cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma, has been linked to significant health disparities related to substance use disorder, including access to treatment for SUD or MH disorders. The rate of drug overdose deaths among AI/AN is above the national average and in 2017, CDC reported that the AI/AN population had the second highest overdose rates from all opioids (15.7 deaths/100,000 population) among all racial/ethnic groups in the U.S. In addition, due to racial misclassification on death certificates, these numbers may be underestimating overdose mortality counts for the AI/AN population, resulting in inaccurate public health data for the AI/AN population.

An especially vulnerable population are homeless individuals. By some estimates, two-thirds of homeless Americans struggle with substance use disorder, and overdose has surpassed HIV/AIDS as the leading cause of death for homeless people in America. The relationship between SUD and homelessness is complex with studies suggesting that each can be the cause or an effect of the other. There are a number of factors that make accessing treatment and achieving recovery especially challenging for people that are homeless, including: lack of social supports such as family and friends and the need to focus on day-to-day survival, including ensuring one's safety, locating food, and finding shelter from the elements. There is also a high rate of co-occurring mental illness among homeless individuals with SUD, which further limits their ability to seek and utilize care and also requires care from a provider that is equipped to address co-occurring MH and SU disorders.

Another vulnerable population are criminal associated populations. Untreated addiction coupled with untreated mental disorders make up a significant proportion of the people who move in and out of the criminal justice system. The majority of people in jails, state prisons, and Federal prisons meets the criteria for SUD as do one-in-five Americans on probation. Of particular importance in the first two weeks following release, formerly incarcerated people are nearly 13 times more likely to die of an overdose than the general population. Reentrants with SUD are faced with readjusting to life in community and the need to find housing and employment while trying to manage their addiction and other co-occurring medical issues. Jails and prisons cite budgetary constraints, space limitations, and a lack of qualified counselors as the top three reasons they cannot provide adequate treatment to inmates.

In addition, and no less important veterans, rural populations, racial and ethnic minorities, older adults, people with disabilities, and members of the LGBTQ community require focused attention, outreach, and targeted services to improve treatment engagement and outcomes.

Actions:

- Educate and support services for infants who develop NAS or neonatal opioid withdrawal syndrome (NOWS) due to prenatal substance exposure (SAMHSA/HRSA/CDC/VA/ED/IHS/health systems/health plans and issuers/local public health)
- Promote MAT and family-based treatment for pregnant and post-partum women with the goal of supporting family unification. (SAMHSA/HRSA/CDC/VA/IHS/health systems/health plans and issuers/local public health)
- Increase access to treatment for homeless populations with increased outreach, mobile units. (HUD/SAMHSA/HRSA/IHS/VA/treatment providers/health systems/local public health)
- Increase criminal justice population's access to treatment, including MAT, while incarcerated and upon reentry. (DOJ/SAMHSA/HRSA/VA/treatment providers/health systems/local public health providers)
- Support recovery efforts in tribal communities to include sober/transitional living facilities, residential treatment facilities, medically managed withdrawal services integrated into treatment program, case management services, employment, food assistance, and transportation.
- Expand awareness among, and support outreach to, and services for veterans, rural populations, ethnic and racial minorities, and LGBTQ groups. (USDA/SAMHSA/HRSA/CDC/VA/IHS/health systems/health plans and issuers/local public health)
- Increase rural access to evidence-based SUD care through outreach, primary care screening, telehealth, distance learning, and mobile units. (USDA/SAMHSA/HRSA/VHA/health systems/health plans and issuers/local public health)
- Educate and expand services and support implementation of Trauma Informed Care across all agency activities including direct care, grants, policy, and trainings. (IHS)

- Expand efforts to build the peer workforce within these special populations. (USDA/VA/IHS/SAMHSA/HRSA/health systems/health plans and issuers/local public health)
- Ensure access to treatment facilities for older adults and people with disabilities. (Treatment Providers/Health Systems/CMS/IHS/VA)

CONCLUSION

The Actions described in this plan will help increase access to treatment and reduce the treatment gap. The Actions will be implemented by the organizations, agencies, and offices with the policies, programs and authorities to accomplish them. ONDCP will coordinate with Federal partners on a regular basis to monitor implementation status of these actions on a tiered and prioritized basis. ONDCP and Federal partners will coordinate with non–federal partners to monitor collaboration where Actions require.