



State Efforts to Improve the Continuum of Care for Substance Use Disorder and Opioid Use Disorder

Lessons Learned from the NGA Substance Use Disorder Learning Collaborative in Six States

March 2022

Executive Summary

In June 2020, the National Governors Association (NGA) launched the Strengthening Substance Use Disorder (SUD) Systems of Care (SUD Learning Collaborative). The purpose of the SUD Learning Collaborative was to support Governors' offices and other state officials in improving coordination across the continuum of prevention, treatment and recovery services for individuals affected by SUD and opioid use disorder (OUD). This collaborative aimed to further state efforts in developing and implementing evidence-based interventions that link individuals affected by SUD to care and treatment. States placed an emphasis on building a sustainable infrastructure so individuals can more easily access high-quality treatment and recovery supports.

The SUD Learning Collaborative was funded through a cooperative agreement grant from the Centers for Disease Control and Prevention and engaged the Technical Assistance Collaborative (TAC)¹ as a subcontracted partner to offer states specific subject matter expertise that would complement NGA expertise. Through the collaborative, state teams learned about best and promising practices from national experts, practitioners and peers from around the country. The peer-to-peer learning aspect of the collaborative is a feature of NGA learning opportunities that brings together state teams who share common challenges and provides an opportunity for peer-to-peer learning by leveraging other states' experiences and common understanding of possible and existing barriers in implementing policy solutions. Each Governor-appointed state team was multidisciplinary, with leaders spanning the health and public safety entities (e.g., Medicaid directors, drug policy analysts, behavioral health leadership, medical directors, corrections and law enforcement officials). Participation among these diverse groups of stakeholders within state teams was crucial to developing goals that were comprehensive, coordinated and collaborative in nature.

From June 2020 through March 2021, Governor-appointed teams from six states — **Kentucky, New York, Oregon, Virginia, West Virginia and Wyoming** — were competitively selected through a request for applications to engage in strategic planning analysis, with the goal of addressing their state's respective linkage to SUD care and treatment priorities. Gubernatorial support of the SUD Learning Collaborative, and the action plans state teams developed, were paramount to the successes each state achieved. Their buy-in creates a vision for the work, improves collaboration, and ensures fidelity to evidence-based SUD practices.

As part of the SUD Learning Collaborative, states discussed and identified key themes as essential to linking SUD treatment and recovery in cross-agency programs. These included:

- Improving the person-centeredness of their treatment and recovery systems;
- Improving SUD/ODU outcomes and reducing health disparities across all or some populations affected by SUD/ODU;
- Identifying and coordinating resources for SUD/ODU services across state agencies to improve the purchasing power of the state and reduce duplication and inefficiencies; and
- Restructuring community norms to reduce stigma toward those seeking services so that treatment for SUD is as accepted as treatment for any other medical condition.

The purpose of this publication is to serve as a resource for states addressing challenges related to these focus areas, especially where cross-agency collaboration is an essential element of these programs.

States participating in the SUD Learning Collaborative shared lessons learned and best practices, which are detailed in this brief. Common strategies that emerged included:

- Maximizing resources, such as federal funding, to improve prevention, treatment and recovery activities;
- Addressing racial and ethnic disparities to promote health equity;
- Using data to improve collection and use of information on racial and ethnic disparities across systems to better target state efforts;
- Addressing stigma with the goal of creating social awareness and positive contact through intentional engagement with individuals in long-term recovery; and
- Ensuring a greater connection to SUD services for those leaving criminal justice settings.

These lessons influenced the direction of later work undertaken by NGA and other groups of states in subsequent projects referenced as well.

I. Introduction

As the opioid overdose epidemic continues to evolve, and with increasing challenges related to the rising prevalence of illicit opioids, stimulants, and polysubstance use, states must continue to make progress in addressing barriers to accessing high-quality substance use disorder treatment and linkages to care. In 2019, of the 21.6 million individuals 12 or over in the U.S. assessed as needing SUD treatment, only 12.2% received SUD treatment in a specialty facility.² Medicaid enrollees are disproportionately impacted by SUD and OUD, and many individuals affected by SUD continue to face barriers to high-quality treatment such as stigma, lack of coverage, and a limited provider workforce. Access to quality evidence-based treatment and recovery supports are limited, with substantial variation in state prescribing rates of medication for opioid use disorder (MOUD). An additional challenge in delivering SUD services is coordinating treatment and co-occurring physical health needs or behavioral health needs, along with wrap around or support services (e.g., housing, employment) to help individuals transition through levels of care and into recovery in the community.

Methodology

States applying for the SUD Learning Collaborative were required to submit several goals for their projects. The goals focused on identifying, developing and implementing targeted strategies that meet the unique prevention, treatment and recovery needs of their state and that strengthen statewide SUD systems of care. Given acute capacity challenges and increased needs for SUD services through the COVID-19 pandemic, the project supported states in identifying short-term strategies to bolster access to critical behavioral health interventions while supporting greater coordination and linkages across systems of care.

Once the states were accepted into the learning collaborative and set their initial goals for the project, a kick-off meeting brought state participants together virtually in July 2020 due to the COVID-19 pandemic. At the meeting, states discussed SUD prevention, treatment and recovery issues as avenues to help states accomplish their goals. National and state leaders provided an overview of key elements of a statewide vision for an SUD continuum of care and how states have responded to the COVID-19 crisis to support continuity of services for individuals affected by SUD through intervention, treatment and community-based recovery. National experts and state teams then discussed payment, policy and program strategies for addressing barriers to care and improving access to SUD treatment services throughout COVID-19, outlining a framework for assessing the impact of these changes on access, provider network stability, utilization, quality of care, and patient outcomes to support a data-informed approach for sustaining key SUD policy reforms after the pandemic subsided.

States worked with NGA and TAC staff to refine their goals and create action plans to accomplish them through a series of steps that included research, information and data gathering, cross-agency discussions, and coordination of resources. Self-identified outcome and project evaluation assessments were conducted regularly and at the conclusion of the

project, and this information was used to gather information contained in this paper, along with information gathered as part of regularly monthly assessments conducted by NGA and TAC staff who supported the states in their project goals as they progressed.

This paper begins by identifying some of the common challenges states often encounter when approaching SUD treatment and recovery. Next, the paper identifies strategies that participating states utilized when addressing cross-agency approaches to SUD and OUD treatment and recovery programs. Lastly, the paper highlights lessons learned from the project that can help inform other similar gubernatorial and state efforts related to SUD treatment and recovery.

II. State-Identified SUD Challenges

States participating in the SUD Learning Collaborative made great strides toward achieving their goals over the nine-month project period, with many facing similar — but unique — challenges throughout the course of their participation. These challenges included:

- The COVID-19 pandemic;
- Challenges with data;
- Contracting issues;
- Governance;
- Value-based purchasing; and
- Stigma.

The COVID-19 Pandemic

Given the timeframe of the project, the greatest challenge for states was the COVID-19 pandemic. Prior to the pandemic, many Governors were looking for ways to strengthen their SUD provider network capacities due to the significant service and access challenges associated with provider shortages. During the pandemic, these same Governors and their administrations were faced with additional, unanticipated challenges, including significant budget shortfalls, provider shortages, health care service disruptions, and a substantial increase in suicides and overdoses that stressed already overburdened systems. The pandemic also diverted key leadership resources and created bandwidth issues among participating states given the unprecedented competing priorities and exigent circumstances (i.e., COVID-related response). As the pandemic wore on, vaccines were developed, and state and federal funding sources were allocated for pandemic-related responses, state team members had the added constraints of designing implementation strategies for these more intensive pandemic-related workloads and, ultimately, how to best integrate existing SUD programs and strategies into newfound opportunities to accomplish broader goals.

Despite the pandemic, states continued to express great interest in participating in the project and set forth to develop strategies aligned with goals established in their original applications that could also be accentuated by new avenues for coordinating and even

funding various programs. The state teams demonstrated commendable resilience by continuing their participation in this voluntary collaborative, while actively responding to the complex, evolving and pressing needs of individuals needing SUD services and rendering services throughout the pandemic.

Challenges with Data

In addition to pandemic-related challenges, there were several other challenges identified during the project. In relation to data, states experienced challenges with:

- **Missing or incomplete information and data.** The availability of data and critical information was a principal challenge for each state's initiative. Data availability varied across states, including the availability of information needed to map resources, identify underserved and under-engaged populations, and develop indicators that would measure the impact of SUD initiatives. Several states rely on Medicaid data to understand disparities in access, treatment patterns, and outcomes among racial and ethnic groups and to develop strategies to mitigate these issues. Those relying on this data were limited in their ability to use it to inform state activities as the necessary demographic data, such as race and ethnicity indicators, was not available in the enrollment files for a significant number of Medicaid enrollees. In many state Medicaid programs, enrollees provide race and ethnicity data on a voluntary basis, leading to missing or incomplete information. In addition, there are often insufficient options for self-identification (such as individuals who identify as biracial or belonging to more than one race or ethnic group), leading to low quality data or data that does not fully capture the actual composition of race and ethnicity in the state. In some instances, states relied on managed care organization (MCO) partners to provide data and reports. In many cases, however, states relying on these partners lacked the necessary provisions in their managed care organization contracts to obtain these data and reports.
- **Lack of alignment on data reporting.** Several states were interested in developing and employing performance measures across different funding streams, including Medicaid, individual or group insurance, federal block grants, and discretionary grants (portions of which may be administered at the county level). Each of these payers used different mechanisms to purchase services and required separate reporting, making it challenging to create feasible, reliable, and valid statewide measures inclusive of multiple payer sources. For instance, **Virginia** began to request and review information for its all-payer claims database to identify opportunities for reporting SUD-focused outcome measures across payers.
- **Data silos across systems.** State agency data is often siloed by agency and integrating these data sets can be challenging for many reasons. Several states lack an integrated data analytics platform that could collect encounter and claims data across state agencies and payers (e.g., public health, Medicaid and child welfare data). Combining and integrating data that could measure the performance of the SUD treatment system on key measures such as employment rates, stable housing, education and training, and incarceration rates was also a challenge.

- **Data timeliness.** Timeframes for collecting and reporting data sometimes vary. In some instances, the delay in obtaining timely information (ranging from 8-18 months) created barriers to developing reports that addressed issues as close to real-time as possible. One state chose to supplement available administrative data with real-time, anecdotal information from harm reduction organizations, street outreach programs, and law enforcement partners to enable data-guided regional overdose task force meetings, drive targeted resource coordination, and support local overdose response planning efforts.

In addition to facing data collection challenges, project states also faced hurdles around their ability to coalesce around a singular state data use plan to address SUD. These plans are necessary to identify the data and analyses that will allow a state to make policy and program decisions to address specific SUD issues, to target populations or regions for an intervention, to identify general barriers, and to influence policy makers and the public regarding actions that could be taken to address these issues. States that participated in the project focused mostly on the “how” for collecting and analyzing data, and therefore did not identify a structured process for using the findings to shape payment, policy, or programmatic interventions before beginning the analytics.

Contracting Issues

In addition to challenges regarding the use of data, some states were constrained by their purchasing and contracting practices. State procurement and contracting processes, while important to ensure program integrity, can significantly delay the implementation of an initiative, and these practices may pose barriers to potential vendors without state procurement experience. For example, one state was especially interested in meeting the specific SUD engagement and prevention needs of Black residents in the state and sought to involve trusted partners and community-based stakeholders in these efforts. The state acknowledged that the most highly qualified community-based organizations to lead this initiative did not have the institutional bandwidth to submit bids as a direct state vendor.

Governance

Other states experienced challenges in developing their governance structures for oversight of the SUD continuum. As efforts to address the opioid and other addiction crises — such as stimulant use and polysubstance use — expanded to include new partners across state government, many states identified the need to clarify the roles of each state agency. Lack of organization and coordination across various state agencies led to the potential for duplication of efforts and ineffective use of limited resources. States also reported a need to improve communication across agencies and increase understanding of each agency’s programs, funding streams, authorities, and responsibilities. In addition to navigating the involvement of multiple state agencies, some states were required to respond to legislative actions that had parallel or even conflicting mandates related to oversight of the SUD continuum of care. States had to reexamine their plans for

coordination and oversight to ensure compliance with the requirements of new legislation and align their plans with the intent of the new laws.

Value-Based Purchasing

A broader challenge recognized during the SUD Learning Collaborative centers on the limited number of value-based purchasing approaches to SUD treatment that states can reference as examples. One state was interested in developing a next-generation value-based payment for SUD. Specifically, the state was interested in developing an approach that would incorporate SUD services and providers within total cost of care payment models, which include all costs associated with a defined population and their specific clinical conditions. These models provide care coordination across the healthcare needs of individuals affected by SUD within the payment system utilized by the individual. A state may allocate a per member per month capitation rate for everyone in such a program and the Medicaid MCO would assume responsibility for full care as a result. The MCO then coordinates fee-for-service or other payments to all involved providers the individual touches across physical and behavioral health needs. Typically, at the end of the year, any leftover funds would be redistributed to all medical partners, reinvested in efforts to provide coordinated services, or returned to states.³ The state was particularly interested in exploring options to re-attribute individuals from primary care providers to SUD providers, develop an attribution approach across multiple providers, or expand total cost of care models to include SUD provider network criteria and performance measures. The challenge for this state was that, although it had more experience than most other states with value-based payment approaches in their Medicaid program, a comprehensive scan of new and existing approaches netted little information to advance their approach further or help them identify ways to save valuable resources if redistributed under such a program as a cost savings measure.

Stigma

Stigma around the use of medications to treat SUD, especially agonists and partial agonists like methadone and buprenorphine, remained a challenge for some states despite their best efforts to address this concern. Some states indicated that stigma regarding MOUD was prevalent in their criminal justice systems. The perception that MOUD involves “substituting one drug for another” persists in the field of criminal justice and across many other communities and stakeholder groups. Some state correctional facilities are only offering injectable naltrexone to inmates, citing concerns that other forms of medication could be diverted for alternative uses. Other states indicated limited benefit in the use of injectable naltrexone for OUD in the criminal justice system, with little interest and uptake in the population, poor follow-through in the community, and funding challenges for continued medication. This analysis ultimately helped inform other projects funded by CDC that NGA conducted during 2021, focused especially on justice-involved individuals under community supervision. The outcomes from that project are forthcoming from NGA in early 2022.

III. Common Strategies Across States

As states implemented their governors' visions for stronger treatment infrastructures and linkages to care, some common implementation paths emerged, including:

- Maximizing resources, such as federal funding, to improve prevention, treatment, and recovery activities;
- Addressing racial and ethnic disparities to promote health equity;
- Using data to improve collection and use of information on racial and ethnic disparities across systems to better target state efforts;
- Addressing stigma with the goal of creating social awareness and positive contact through intentional engagement with individuals in long-term recovery; and
- Ensuring a greater connection to SUD services for those leaving criminal justice settings.

Maximizing Resources

As states worked to improve their SUD systems of care, all of them recognized the need to maximize federal, state and private resources to harmonize existing efforts and build on successes. Over the past ten years, Medicaid has played an important role in financing SUD services for many low-income individuals and families. In some states, Medicaid is projected to be the major payer of these services, surpassing the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment federal block grant, and commercial insurance. States also have major investments in state general revenues for SUD services and rely on local monies (i.e., county-based funds) that support important services and local treatment and prevention initiatives. An influx of funds from the federal government over the past several years to assist states in addressing the opioid overdose epidemic and the COVID-19 pandemic highlighted the need for better coordination of resources.

Diversity of funding brought many new partners to support issues affecting the SUD continuum, and strategies to establish effective coordination of such efforts became crucial. States such as **Oregon** sought to increase collaboration within the Oregon Health Authority and the Alcohol and Drug Policy Commission (ADPC) with other external agencies to build on existing and new strategies for maximizing resources, aligning efforts with the state strategic plan, and monitoring progress toward established goals. Engaged state agencies participated in a mapping exercise that identified existing initiatives, funding streams, responsible persons, and relevant authorities to reduce the likelihood of service duplication and to create better alignment. In addition, the state created the foundation for a governance structure tasked with overseeing implementation of the ADPC's newly created strategic plan to address substance use prevention and treatment services. The Oregon team identified concrete measures, key stakeholders and responsible entities for each of the goals set forth in the plan. The state was able to report improved connections and collaboration between ADPC, the Public Health Division, and the Health Systems Division — which works with partners statewide to build and advance a system of care to

create a healthy Oregon including the Oregon Health Plan (OHP), Oregon's Medicaid, and Children's Health Insurance Program. **West Virginia** sought to enhance its planning to implement landmark legislation, the Family First Prevention Services Act (Family First), that seeks to expand services for families (including SUD services) to help children remain in their homes, reduce unnecessary use of congregate care, and build the capacity of communities to support children and families. As a result of the project, the state was able to identify stakeholders and next steps for collaboration toward a statewide plan for pregnant and parenting women to help achieve this goal.

Addressing Disparities

With the disproportionate illness and health care outcomes highlighted by the COVID-19 pandemic, state leaders are actively pursuing strategies to improve health systems to better serve racially and ethnically diverse communities that have experienced challenges in accessing care. Within the broader concerns surrounding health disparities, inequities in access to prevention and treatment for individuals affected by SUD are of particular concern. Racial disparities regarding access to SUD care remain a significant public health issue, and many states participating in this collaborative focused on addressing these disparities within an effort to improve health equity more broadly. **Kentucky** sought to reduce disparities in access to SUD treatment — in particular medications for opioid use disorder — among racial and ethnic groups, especially among Black Kentuckians. Additionally, **Oregon** sought to create a multi-sector plan to address fragmentation and segmentation of services occurring in communities of color by tracking the demographics of providers and working to build a workforce that can meet the linguistic and cultural needs of all Oregonians. **West Virginia** sought to mature its system of care for pregnant and parenting women and their families, improve their life trajectories, and reduce the number of children placed into foster care due to parental substance use. **Wyoming** sought to engage high-risk populations who were involved with the child welfare system and the criminal justice system.

Using Data to Understand Need

Perhaps the most common focus across states was their interest in improving the collection and use of data across systems to better target their efforts to advance their vision for SUD service delivery systems. For example, **Kentucky** added contractual language into their U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response contracts to require grantees to disaggregate their data by race and ethnicity and identify activities that would improve equitable access to OUD-related services. The state sought to collect and review quantitative and qualitative data that identify racial disparities and improve the availability, accessibility, acceptability, and quality in the SUD system of care for communities of color. **Oregon** recently completed a “deep dive” review of their data system and began modernizing these sources to meet the needs of their SUD strategic plan. To support these efforts, **Oregon** prioritized its participation in the collaborative on developing a clear governance structure to monitor demonstrated progress toward established goals and outcomes. As a result of this focus,

the state was able to gain access to a mapping tool that will assist with the synchronicity of an integrated governance model so data can be better understood across agencies.

Virginia sought additional assistance to provide ongoing support for data sharing across executive agencies and inform real-time intervention strategies.⁴

Addressing Stigma

States also focused on addressing stigma in their project goals and efforts. **West Virginia** sought to reduce the stigma of SUD treatment, particularly MOUD, among pregnant and parenting individuals. States that were looking to increase access to MOUD in correctional systems recognized the need to address negative perceptions and bias toward the use of medications, especially agonists and partial agonists, as critical to successfully implementing this approach in all state and county-based facilities. **Kentucky** leveraged SAMHSA's State Opioid Response grant to fund minority-led organizations in the development and dissemination of anti-stigma campaigns.

Promoting SUD Linkages through Criminal Justice Involvement

Most states also highlighted the importance of the criminal justice system in providing effective SUD treatment and intervention services for the individuals they reach and supported the need for SUD crisis intervention services more broadly. At each point of contact with the criminal justice system, states highlighted the need to have a greater connection to SUD services. **New York** expressed a desire to establish mechanisms to divert individuals with SUD away from jails and emergency departments. **New York** also incarceration as an important opportunity to initiate access to treatment and has been successful in providing access to MOUD in state- and county-run correctional facilities. Along with **Virginia**, **Wyoming** identified a need to create effective transitions of care for treatment continuation post-incarceration. Several states also focused on the need to promote effective transitions between health care settings. For instance, **Virginia's** data indicated that unsuccessful transitions from emergency departments to community-based care were a weakness in their approach to addressing the issue and sought to enhance emergency department-based MOUD and peer interventions.

IV. Lessons Learned for State Leaders

The work of the SUD Learning Collaborative provided valuable lessons learned that can inform other states' efforts to examine and re-energize their efforts to address the opioid epidemic as well as address new and perennial issues with individuals affected by other SUDs and co-occurring conditions. The lessons learned from this project were varied but focused generally on the following areas:

Ensure Consistent Leadership

As with any initiative, leadership is necessary to organize, strategize and implement key activities that help a state meet the goals of a project. Consistent leadership and clearly expressed goals are key to success. The SUD Learning Collaborative underscored what is paramount for many state improvement efforts: leadership buy-in and project champions are necessary for states to improve their approaches. Consistent with this lesson learned is the importance of the creation of partnerships across agencies or divisions among leadership to ensure long-term buy-in from all perspectives involved in cross-agency collaboration.

Address Racial and Ethnic Disparities to Improve Health Equity

Across the country, some of the largest increases in drug overdose deaths in recent years occurred among Black residents, yet these residents affected by OUD are less likely than white individuals to receive evidence-based treatment in office-based settings, such as buprenorphine.⁵⁶⁷ Thus, developing approaches to examine disparities and gaps in access to evidence-based care is an important component to strengthening SUD systems and improving health equity. For instance, **Kentucky's** efforts provided a roadmap for developing strategies to reduce racial and ethnic disparities in access to SUD treatment services. The state was able to use data-informed approaches to identify populations and geographies facing the most significant disparities in accessing and utilizing SUD services.

One participating state developed a comprehensive data analytics approach to examine gaps in access to evidence-based care that Black residents experienced compared to other racial and ethnic groups in the state. Such findings are foundational and instructive for other states interested in developing targeted payment, policy and programmatic approaches to narrow gaps among racial and ethnic groups and make progress on ensuring equitable access to care.

As a starting point, states could collaboratively engage key partners, including community stakeholders, MCOs, and researchers with the requisite expertise, to discuss the value, implications, opportunities and potential methods for improving the completeness and usability of racial and ethnic data in Medicaid files.⁸

Develop a Data Use Plan

Most states had existing data or created new data sets to support their goals for the project. States that had the most successes were clear about how they were going to use the data and then pursued data collection and analysis to comport with their data use plan. Therefore, it is critical that states initially develop an internal consensus and establish a structured approach for collecting, analyzing and using this information. A helpful method for developing the data use plan can include articulating essential questions for key components of the process, such as the following:

- Determining what data collection and analysis efforts already exist (i.e., What initiatives are already underway and who leads these efforts?)
- Designing analyses to focus on key questions and capacity (i.e., What are the data needs and what are the right questions we want to ask? How do we build capacity to analyze, where needed?)
- Identifying ways to collect and produce data (i.e., What are these data sources, who owns these data, and what are the metrics that can answer our questions?)
- Identifying data gaps and strategies to address these gaps (i.e., If we do not already have the data, where can we get it? Does the state already have partnerships? Will it require outreach and facilitating relationships?)
- Deciding how to use data once collected and analyzed (i.e., What will we do with the answers to our questions?)

Fundamentally, data use plans are most effective when developed at the inception of a project or directive and can serve as a beacon to guide the work. For example, in response to 2018 legislation requiring a pilot project to demonstrate the value of data sharing and analytics, **Virginia** developed the Framework for Addiction Analysis and Community Transformation. This regional data-sharing platform analyzed data from federal, state, local and private organizations such as local corrections, state and local police, community service boards, the Virginia Department of Forensic Sciences, the private health care system, and the U.S. Census Bureau. The success of this program led to its expansion into other regions, as well as continued expansion efforts for using real-time data sharing to facilitate responsive, evidence-based decision making to improve outcomes.

Collection and analysis of data will often require sharing information across state agencies, managed care providers, health care providers and other organizations. In some instances, this information sharing may require data use agreements between these parties to comport with requirements from the Health Insurance Portability and Accountability Act (HIPAA) and more stringent protections regarding data sharing of information on individuals with a SUD required under 42 CFR Part II. Data use agreements are common and contain various provisions that set forth limitations on how the data will be used, requirements for release of information by the beneficiary and outline processes and

safeguards to ensure data is safely stored and transmitted. There are helpful tools and examples of data sharing agreements that can guide state's efforts to determine if they need such agreements and help them develop the content of these agreements.

Implement Creative Purchasing Approaches

In recent years, states and other payers have made strides in moving toward a value-based approach to health care. While there is significant interest in exploring similar approaches for behavioral health conditions, including SUD, the SUD Learning Collaborative highlighted the continued challenges in designing and implementing value-based care models for behavioral health conditions. Some of the challenges highlighted in the project include:

- Limited focus on substance use disorder — most of the existing measures focus on process improvements, more broadly. While these are reasonable proxy measures for outcomes, there are no nationally vetted patient outcome determinants.
- Lack of agreement across states, payers and provider communities on which measures could be included in a value-based purchasing arrangement. Providers have raised concerns regarding the validity of information collected for measurement reporting and have also expressed concerns on whether punitive action will be taken by payers and states based on performance.
- Challenges in the development of methodologies to attribute patients to specific providers. Process measures (such as Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence) assess the effectiveness of emergency department's referral efforts and community providers (physical health and SUD) to engage individuals based on these referrals. These attribution methodologies must be well thought out and negotiated across plans and providers, especially as individuals' engagement with substance use disorder providers may be short-term and episodic.

Even in the absence of alternative payment models specific to SUD treatment services, states can explore incorporating expectations for additional ways to meet the needs of individuals affected by SUD into existing value-based care models, including fully capitated arrangements or other risk-bearing arrangements. One **New York** Medicaid Managed Care Organization has entered into a value-based payment arrangement with opioid treatment programs. The outcome of this contracting arrangement may help inform the state on the development of future initiatives related to value-based purchasing within the SUD system.

Leverage Federal Initiatives

States participating in the SUD Learning Collaborative were actively engaged in reviewing federal initiatives that were considered and, in some cases, integrated into state programs where possible. One such example is the recent American Rescue Plan Act (ARPA) with funds available to states for various SUD-related purposes. This law and other legislation

can provide additional opportunities for states to enhance their delivery system for individuals with SUD.

In recent years, opioid overdose has become a significant cause of maternal death in the United States, with rates highest in the immediate postpartum year. Currently, states must cover pregnancy-related services (e.g., prenatal care, labor and delivery, and postpartum care) and “conditions that might complicate the pregnancy” for this eligibility category under Medicaid programs through the end of the month in which the sixty-day postpartum period ends. The provisions set forth in ARPA allow states the option to provide continuous Medicaid and Children's Health Insurance Program coverage under this eligibility category for women who are not otherwise eligible for Medicaid through twelve months postpartum. This option may also support states in achieving related aims for their family- and child-serving agencies and systems.

In addition, ARPA incentivizes states to provide crisis services for mental health and substance use disorders through Medicaid and substantially increased SAMHSA block grant funding to address mental health and substance use issues. Specifically, ARPA provides enhanced federal Medicaid match rates for states implementing mobile crisis responses for Medicaid beneficiaries experiencing a crisis. States can begin to receive this additional match in April 2022. While crisis services are often considered a mental health service, several states are demonstrating success with SUD by integrating the three core services described in the SAMHSA Crisis Toolkit: crisis call centers, mobile crisis response services, and crisis stabilization services.⁹ States that are pursuing this enhanced match could incorporate SUD into their approach.

ARPA funding is only one example of federal legislative initiatives, but it is used here as an example of how such initiatives can be utilized for several SUD-related programs in the states.

Develop Processes to Support Cross-Agency Collaboration

Between April 2020–April 2021, provisional data from CDC indicated opioid overdoses were 28.5% higher than the preceding 12-month period.¹⁰ Multiple new federal and state funding streams focused on supporting the SUD linkage to services,¹¹ treatment, prevention and recovery services continuum —combined with increased national attention on the overdose crisis — has led new stakeholders to become involved in work that has traditionally been left to state directors for behavioral health and state Medicaid directors.

The involvement of new stakeholders calls for strong governance and oversight models to improve efficiency, maximize resources, ensure alignment and avoid duplication of effort. To support future progress in this area, **Virginia, Wyoming and West Virginia** participated in resource mapping exercises, as well as efforts to develop possible governance structures, models and charters for steering committees. It is critical that states also consider involving stakeholders, community-based organizations, and agencies that will implement and own the work in the action phases of these planning efforts.

Review State Policies and Regulations for Potential Barriers

States identified existing state and federal laws, policies and regulations that created barriers to achieving goals set forth to improve their SUD continuum of care. While states may not have control of federal laws and regulations, they can examine their own state policies for conflicts to help eliminate barriers as well as work with federal partners to clarify and/or request waivers or variances for specific programs. As part of this project, **Virginia** identified state-level policies that were perceived to be barriers to community-based naloxone distribution (i.e., harm reduction) and clarified these policies to increase access to this life saving medication. **New York** was interested in licensing and geographic requirements for MOUD programs in corrections to reduce burden and ease facilitation of access (i.e., for opioid treatment program medication units), as well as restrictions around emergency transport for individuals in SUD crisis to non-emergency department settings. Most states struggled with insufficient demographic data (i.e., race and ethnicity data) in Medicaid enrollment and grant-funded databases. States may wish to consider examining their own requirements, policies and criteria to identify policy barriers that may be addressed to support the progress of strategic priorities and solutions.

V. Conclusions

Through this learning collaborative, states determined they had several policy and program options for supporting continued access to evidence-based SUD treatment. Whether these are improving governance structures that inform collaboration and participation among diverse stakeholders, innovating data analysis and evaluation, or addressing racial and ethnic disparities in the continuum of care, Governors and their staff are at the forefront of confronting state SUD challenges. Their efforts are critical to ensuring access to quality substance use disorder services throughout an effective and equitable continuum of care.

As states and their leaders continue working to improve OUD care, many are confronting new challenges with illicit stimulant and polysubstance use that present new hurdles, including a lack of medications to treat stimulant use and ongoing challenges related to the treatment of co-occurring and polysubstance use disorders. Using the infrastructure and evidence-based strategies employed during the opioid overdose crisis may help states pivot to effectively address polysubstance use more broadly — to save lives and improve the long-term health of states and their communities — even if specific challenges continue to emerge. In 2022, NGA is focusing its efforts in this area through the convening of the Policy Academy on State Strategies to Improve Care for Stimulant and Polysubstance Use, intended to help state leaders identify and implement best practices to improve care and reduce overdoses among people who use opioids and stimulants. The policy academy includes intensive work with three states and one territory on strategies for meeting the challenges identified by the increase in stimulant and polysubstance use through specific action plans developed when the project began in October 2021 and will continue through the Fall of 2022.

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