Health District

OF NORTHERN LARIMER COUNTY

2/21/2020

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

SB20-007: TREATMENT OPIOID AND OTHER SUBSTANCE USE DISORDERS

Concerning treatment for substance use disorders.

Details

Bill Sponsors: House – *Buentello (D) and Wilson (R),* Herod (D), Kennedy (D)
Senate – *Pettersen (D) and Winter (D),* Donovan (D), Priola (R)
Committee: Senate Health & Human Services
Bill History: 1/8/2020- Introduced
1/30/2020- Senate Health & Human Services Refer Amended to Appropriations
Next Action: Hearing in Senate Appropriations
Fiscal Note: 1/14/2020[1]

Bill Summary

The bill addresses a variety of policy issues related to the general topic of substance use disorder (SUD) treatment. The bill:

- Requires updated community assessments regarding the sufficiency of SUD services in the communities that managed service organizations (MSOs) serve
- Requires health insurance plans to provide coverage for SUD treatment in accordance with American Society of Addiction Medicine (ASAM) Criteria
- Requires the Colorado Health Service Corps and scholarship program for addiction counselors to consider workforce diversity and serving underserved populations when selecting participants
- The Department of Human Services (DHS) is to commission a Child Care & Treatment Study and Report
- Specific entities and programs are restricted from prohibiting the use of or access to medication assisted treatment (MAT)
- Requires the Medicaid Managed Care System must include coordination of care for SUD and mental health treatment
- Increases funding to the grant writing assistance program
- Authorizes the Division of Insurance (DOI) to promulgate rules for MAT to be included on carrier's formularies
- Requires insurance carriers to report to the DOI regarding MAT
- Requires health plans to provide coverage for at least one opiate antagonist
- Requires the Office of Behavioral Health (OBH) to provide training and outreach regarding SUD civil commitment
- Requires Medicaid to not impose an prior authorization or impose step therapy for MAT
- Consolidates part 1 of article 82 of title 27, C.R.S., into the existing part 1 of article 81 of title 27, C.R.S., in order to create a single process that includes all substances.

[1] The fiscal note is based off the bill as introduced, not as it was amended by the Senate Health & Human Services Committee. The sections 'Bill Summary' and 'This Legislation' are both based off of the bill as amended in committee.

Issue Summary

ASAM Criteria

The American Society of Addiction Medicine (ASAM) has developed and continues to monitor and revise, a set of criteria intended to provide outcome-oriented and results-based SUD treatment.[2] There are six main dimensions to the criteria to create treatment plans. The accompanying graphic delineates those dimensions.

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

DIMENSION 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
DIMENSION 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
DIMENSION 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
DIMENSION 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
DIMENSION 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
DIMENSION 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Medication-Assisted Treatment (MAT)

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines MAT as medications utilized with counseling and behavioral therapies to treat substance use disorders and to prevent opioid overdose.[3] Currently, there are three classes of medications that that have been approved by the Food and Drug Administration (FDA) to treat opioid use disorders: methadone, buprenorphine, and naltrexone.[4] Methadone is an opioid agonist that reduces the symptoms of opioid withdrawal while blocking the euphoric effects of most opioids, including heroin.[1] Methadone is required to be administered daily in an office setting for the first few years of maintenance treatment. Federal rules require methadone to be prescribed and dispensed by a certified Opioid Treatment Program. Buprenorphine is an opioid partial agonist that can reduce the effects of withdrawal but it produces effects such as euphoria or respiratory depression.[1] Since buprenorphine has these effects it is often produced in combination with naloxone to reduce the potential for misuse.[1] With naltrexone, an opioid antagonist, the medication blocks both the euphoric and sedative effects of opioids; additionally, a patient is to abstain from opioids for 7-10 days for beginning the medication.[1] Injectable naltrexone must be administered in a health care setting by a licensed provider, which includes pharmacists. The following table[5] demonstrates the regulations and effectiveness for the three FDA-approved medications.[2]

Naltrexone can also be utilized to treat alcohol use disorders (AUD). Studies have shown the effectiveness of naltrexone in decreasing cravings and improving outcomes.[6,7]

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[2] American Society of Addiction Medicine (ASAM) (n.d.)*What is the ASAM Criteria?* Retrieved from https://www.asam.org/Quality-Science/the-asam-criteria/about

[3] Substance Abuse and Mental Health Services Administration (2015). *Medication and Counseling Treatment.* Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

[4] California Health Care Foundation (Sept. 2017). *Why Health Plans Should Go to the "MAT" in the Fight Against Opioid Addiction.* Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

[5] Note that the acronym OUD included in the figure stands for opioid use disorder.

[6] Anton, R.F. (May 3, 2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *JAMA. 295*(17). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16670409

[7] Helstrom, A.W. (Sept. 2016). Reductions in Alcohol Craving Following Naltrexone Treatment for Heavy Drinking, *Alcohol and Alcoholism 51*(5). Retrieved from https://academic.oup.com/alcalc/article/51/5/562/1740449

Table 1. Medications Used in Addiction Treatment

	WHERE IT CAN BE PROVIDED	FDA INDICATIONS	EFFECTIVENESS*	ADMINISTRATION
Methadone	**OUD.** Licensed opioid treatment programs. **Pain.** Any Drug Enforcement Agency (DEA)-licensed prescriber.	OUD and pain management	74% to 80%[12]	**OUD.** Daily pill, liquid, and wafer forms; injectable form in hospitalized patients unable to take oral medications **Pain.** Pill and injectable forms
Buprenorphine and buprenorphine/ naloxone	Prescribed by community physicians and dispensed by pharmacies; available in some opioid treatment programs. Physicians receive federal waivers after eight hours of training; nurse practitioners and physician assistants require 24 hours. Patient panels are capped at 30, 100, and 275 per provider (depending on experience and setting).[13-15] Any DEA-licensed provider can prescribe buprenorphine for pain.	OUD and pain management (depending on formulation and dose)	60% to 90%[16]	**OUD.** Daily sublingual, buccal, film, and tablet, or six-month intradermal device **Pain.** Injectable, transdermal, and buccal film
Naltrexone	No restrictions.	Opioid and alcohol use disorders	**OUD.** 10% to 21%[17]	Daily pill or monthly injectable
Naloxone (used only for overdose reversal, not addiction treatment)	Any setting: prescribed or dispensed by a clinician, furnished by a pharmacy without a prescription (legal in several states), dispensed by lay staff in community settings (by standing order), or carried by law enforcement or other first responders.	To reverse respiratory suppression in suspected opioid overdose	May require high doses for extremely high-potency illicit drug use (e.g., fentanyl and carfentanyl)	Intranasal spray, or intravenous, intramuscular, or subcutaneous injectable

*Retention in treatment at 12 months with significant reduction or elimination of illicit drug use.

Evidence has demonstrated the effectiveness of MAT, yet only 10 percent of those that seek this treatment can access it in the United States.[2] The barriers can range from a shortage of buprenorphine prescribers, to restrictive health plans, to stigma. Since methadone can only be administered by a certified Opioid Treatment Program, this places yet another barrier to treatment for patients. Insurance barriers can include dosage limits, authorization requirements, inadequate counseling coverage, cost-sharing requirements, and "fail-first" criteria.[8] Furthermore, the reimbursement rates from both public and private insurance carriers to pharmacists for administration of injectable naltrexone is less than that received by other providers for the same action. These insurance barriers can even delay an individual's care; a 2017 survey by the California Society of Addiction Medicine found that 41 percent of member providers had experienced situations where patients went without treatment due to authorization delays.[2]

Treatment in Colorado

In 2018, there were 42,604 treatment admissions for SUD in Colorado, 482 more admissions than in the previous year.[9] Alcohol is the substance with the largest number of treatment admissions, a trend that has continued since 2009. Heroin treatment admissions have increased by 89 percent since 2014 while methamphetamine admissions have increased by 39 percent.

[8] "Fail-First" can require detox before medication coverage or failure of another medication before coverage is allowed.
[9] Substance Abuse Trend and Response Task Force (Jan. 2020) *Annual Report.* Retrieved from https://coag.gov/app/uploads/2020/01/SATF_2020_ANNUAL_REPORT_FINAL_V_FINAL_BB2020-1.pdf

The Colorado Health Institute's (CHI) 2017 report for the Colorado Department of Health Care Policy and Financing (HCPF) detailed many aspects about the landscape of residential and inpatient treatment for substance use disorders (SUDs) within the state.[10] From 2010 to 2014, approximately 10.9 percent of Coloradans who needed treatment for an alcohol use disorder (AUD) received it while 15.7 percent of those with an illicit SUD received needed treatment. Approximately 67,000 Coloradans needed treatment for a substance use disorder but did not receive it, with the rates being higher among Medicaid recipients than privately insured individuals. More than half of respondents (54.1 percent) to CHI's Community Health Access Survey (CHAS) reported not getting the treatment they need due to cost. Similarly, 52.8 percent responded that they did not think their insurance would cover the treatment services. The 2017 report illustrated the number of beds for SUD treatment as of 2015. Twenty-eight counties do not have licensed residential and inpatient SUD treatment facilities, community mental health centers, opioid treatment programs (OTPs), medication-assisted treatment (MAT) providers or Special Connections[11] providers. These counties include areas of the San Luis Valley, southeast Colorado and northern Colorado.

Table 3. Number of Beds for Substance Use Treatment, 2015

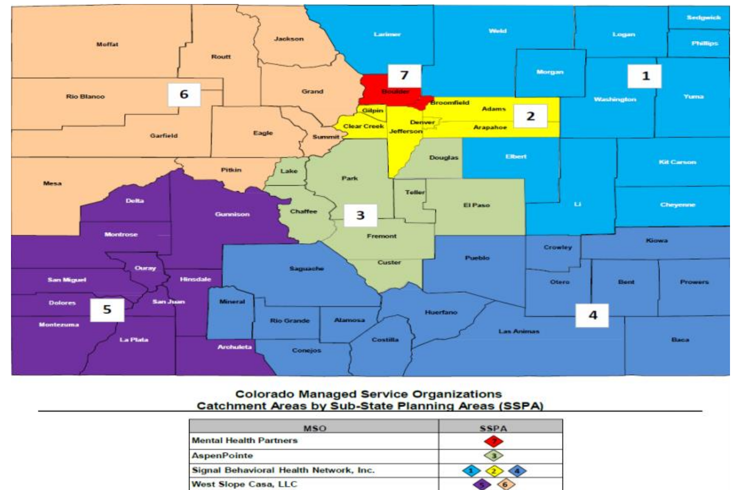
Residential		Inpatient	
Number of Facilities	Range of Beds Reported	Number of Facilities	Range of Beds Reported
15	0 to 12	5	0 to 10
9	13 to 18	3	16 to 21
13	19 to 28	2	22 to 34
6	29 to 47	1	35+
6	48+	Min to Max Range	127 to 216
Min to Max Range	826 to 1,276		

Source: N-SSATS, 2015

An analysis of MAT in Colorado found that 31 of the 64 counties within the state do not have an entity that provides methadone or buprenorphine.[12] Of these 31 counties, 10 had opioid overdose rates above the state average.[12] More than half a million Coloradans have little or no access to MAT in the counties where they reside.[12] The Keystone Policy Center report noted that broad access to MAT is developing slowly in Colorado due to inability to pay for the treatment, provider discomfort, and lack of information about administration.[13] A suggestion made in the report included expanding the payment methodology for MAT.

Managed Service Organizations (MSOs)

OBH contracts with four MSOs for the provision of SUD treatment and withdrawal management services within the seven regions for those individuals who are not eligible for Medicaid and to provide services that are not covered by Medicaid. The MSOs then subcontract with local treatment providers to deliver those services. The map demonstrates the geographic areas that the MSOs serve.[14] Specific priorities for funding vary across MSO regions, but there are statewide themes to address care coordination, continuity of



[10] Colorado Health Institute (2017). *Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf .

[11] The Special Connections program provides case management, counseling and health education to pregnant Medicaid enrollees with substance use problems.

[12] Colorado Health Institute (May 2017). *Miles Away from Help: The Opioid Epidemic and Medication-Assisted Treatment in Colorado.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20MAT%20report.pdf

[13] Keystone Policy Center (Feb 2017). *Bridging the Divide: Addressing Colorado's Substance Use Disorder Needs.* Retrieved from http://leg.colorado.gov/sites/default/files/17opioid0801attachh.pdf

[14] OBH (2018). *Overview of Colorado OBH & the State Behavioral Health System.* Retrieved from https://denverchamber.org/wp-content/uploads/2018/05/Denver-Chamber-of-Commerce-Overview-of-Behavioral-Health_Patrick-Fox.pdf

care, workforce, residential treatment, withdrawal management services, sustainability, transportation, and others.[15]

This Legislation

Managed Service Organization (MSO) Community Assessments

The bill requires updated community assessments from managed service organizations (MSO). By September 1, 2021, and every 3 years after, each MSO is to assess the sufficiency of SUD services for youth 17 and under, young adults 18-25, pregnant women, postpartum and parenting women, other adults, and individuals with co-occurring or complex conditions within its geographic region. Beginning with the 2021 assessment the MSO is to contract with an independent entity to compile the assessment. The Department of Human Services (DHS) can require the assessments to be standardized and must disseminate the requirement in a timely manner. The General Assembly is to appropriate funds to the MSOs to contract. The assessment must include:

- Review and analysis of existing assessments and other reports identifying needed resources and gaps using qualitative and quantitative data
- Review of the adequacy of the continuum of SUD services for youth 17 and younger, young adults 18-25, pregnant women, postpartum and parenting women, and other adults, including those with co-occurring or complex conditions

The assessment must include input, including review and comment, from appropriate entities. These include people with lived experience, community mental health centers, regional accountable entities, county departments of human or social services, local public health agencies, probation departments, schools, tribal leaders, and other relevant stakeholders. The contractor and MSO are to use best practices to ensure feedback from underserved populations and communities and to identify and address health inequities.

By February 1, 2022, and every 3 years after, each MSO is to develop and disseminate for feedback the community assessment and a draft community action plan. At least 30 days are to be provided for stakeholder comment on the documents.

By May 1, 2022, and every 3 years after, each MSO is to electronically submit to DHS and the Department of Health Care Policy and Financing (HCPF) the community assessment and community action plan. DHS is to post on its website the updated community action plans from each MSO.

Each MSO currently has to submit an annual report to DHS. The bill requires that the report includes the amount and purpose of actual expenditures utilize funds from the Marijuana Tax Cash Fund in the previous state fiscal year. DHS and the MSO are to develop a communications plan together for the report, including a process for disseminating it to county governments.

DHS, in collaboration with the MSOs, are currently required to submit a report to the Joint Budget Committee (JBC) and Joint Health and Human Services Committee by November 1, 2020. The bill requires that the report also detail how the money given to the MSOs was used to increase the network of providers in the region.

Health Plan Coverage

At a minimum, all health benefit plans[16] are to provide coverage for SUD treatment in accordance with ASAM criteria for placement, medical necessity, and utilization management. The Commissioner of

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[15] Keystone Policy Center. (Feb. 2017). *Bridging the Divide: Addressing Colorado's Substance Use Disorder Needs.* Retrieved from https://www.keystone.org/wp-content/uploads/2017/03/Keystone-SUD-final.pdf

[16] Does not include plans that are solely under Federal regulation (i.e. Medicare, Tricare, etc.) or others like accident only, dental, vision, and others listed at C.R.S. 10-16-102 (32)(b).

Insurance, in consultation with HCPF and OBH, can identify an alternative nationally recognized and evidence based SUD criteria if ASAM is no longer available, relevant, or adhering to best practices.

Colorado Health Service Corps & Scholarship Diversity

The bill requires that when reviewing applications and selecting participants for the health service corps, the Primary Care Office and Advisory Council are to consider the goal of creating a diverse health workforce that is able to address the needs of underserved populations and communities. Upon request, the Office is to provide non-identifying demographic information concerning all applicants and participants.

Additionally, when administering the scholarship program for addiction counselors, the Office is to use best practices for increasing diversity in applicants, including those in recovery and underrepresented populations. When selecting the participants for the program, the needs of the communities being served by those individuals should be considered. Upon request, the Office is to provide non-identifying demographic information concerning all applicants and participants.

The bill increases the annual appropriation by $1 million to $3.5 million for state fiscal year 2020-2021, and each state fiscal year thereafter.

Pharmacy Reimbursement

The bill clarifies that a pharmacy that has entered into a collaborative pharmacy agreement with one or more physicians to receive an enhanced dispensing fee for the administration of all FDA-approved injectable MAT medications. Current law only allows for the enhanced dispensing fee for injectable antagonist medication.

Child Care & Treatment Study

The Executive Director DHS, in consultation with the Executive Director of HCPF, is to commission a state child care and treatment study and report. At a minimum the study and report are to:

- Make findings and recommendations concerning the needs and gaps in family-centered SUD treatment
- Identify alternative payment structures for funding child care and children's services alongside a parent's SUD treatment

A request for proposals should be issued to conduct the study and report by an entity independent of DHS. The final report must be provided by March 31, 2021, to the General Assembly, the Office of Early Childhood within DHS, and the Executive Director of HCPF. DHS is to include the findings and recommendations in its annual SMART Act Hearing during the 2022 regular legislative session.[17]

Prohibition on Denying MAT

Contracts between OBH and MSOs must include terms and conditions prohibiting MSO contracted providers from prohibiting or denying access to MAT. Entities providing withdrawal management services purchased by OBH cannot deny or prohibit access to medical services or SUD treatment and services to individuals that receive prescribed MAT. Recovery residences that receive state funds or provide services that are paid through state programs cannot deny admission to people participating in prescribed MAT. A court cannot condition participation in a drug or problem-solving court/program or enter into orders relating to probation, parole, or community corrections based on the requirement that the individual cease prescribed MAT. The sole exception is if the person or prescriber determines that MAT is no longer necessary or an effective treatment for the person. Community corrections programs cannot reject any offender referred for

[17] Enacted in 2010 and extensively revised in 2013, Colorado's SMART Government Act includes requirements for state departments to create publicly-available annual strategic/performance plans and present them to the General Assembly.

placement based on their participation in MAT. Further, the program cannot establish any rule, condition, or guideline that prohibits or significantly impairs the person's ability to participate in MAT.

Medicaid Coverage of Care Coordination

The bill requires that the statewide managed care system under Colorado's Medicaid program must provide care coordination for the full continuum of SUD and mental health treatment and recovery, including support for transitioning between levels of care.

Grant Writing Assistance

The bill adds to current law, requiring the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies' ('the Center') grant writing assistance program to consider addressing the needs of underserved communities and populations when reviewing applications to the program. The bill allocates $250,000 for fiscal years 2020-2021 through 2024-2025 from the Marijuana Tax Cash Fund to support the program, including hiring employees as well as direct and indirect program costs.

Health Insurance, MAT & Naloxone

The Commissioner of Insurance, in consultation with CDPHE, can promulgate rules or seek a revision to the prescription drug benefits required under the essential health benefits package in order for MAT to be on insurance carrier's formularies.

The bill requires carriers to report to the Commissioner:

- The number of in-network providers who are federally licensed to prescribe MAT, including buprenorphine
- The number of prescriptions written by the identified in-network providers for MAT during a specified reporting period that are paid for or denied by the carrier.

Rulemaking is to occur regarding the reporting period, the frequency of reporting, and any other provisions necessary to implement the required reporting.

The bill requires health plans to provide coverage for naloxone, or a similar FDA-approved drug for drug overdose, without prior authorization and without imposing any cost sharing requirement (i.e. deductible, copayment, or coinsurance).

Training & Community Outreach

By September 1, 2020, OBH is to implement a program for training and community outreach relating to SUD treatment. At a minimum, the program must include the availability and process for civil commitment for those individuals with a SUD. The program can also include information about the statewide care navigation program, the 24-hour phone crisis services, and other resources for the community, family members, and individuals with a SUD. Program must provide training and outreach to first responders, law enforcement, criminal justice agencies, emergency departments, hospitals, treatment facilities, primary care providers, behavioral health providers, county departments of human or social services, individuals with SUD, family members of an individual with a SUD, and organizations working with those with SUD.

Medicaid & MAT

By August 1, 2020, the Medical Services Board is to ensure that its rules do not impose any prior authorization requirements on or step therapy requirements as a prerequisite for a prescription for FDA-approved MAT. Additionally, the rules cannot exclude coverage for any FDA-approved MAT and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

Consolidation of Articles Related to Emergency Treatment & Commitment Processes for Drugs & Alcohol

The bill consolidates part 1 of article 82 of title 27, C.R.S., relating to emergency treatment and voluntary and involuntary commitment of persons for treatment of drugs into the existing part 1 of article 81 of title 27, C.R.S., which relates to the processes for alcohol use disorders, in order to create a single process that includes all substances. The new scope of part 1 of article 81 of title 27, C.R.S., includes both alcohol use disorder and substance use disorder under the term "substance use disorder."

The bill also amends some of the current language included in statute. The bill extends the definition of "administrator"[18] to include an administrator's designee. It adds the definition of "incapacitated by substances" to include a person who is incapacitated by alcohol or incapacitated by substances. Throughout the bill terminology is amended to refer to "substances" to include both alcohol and drugs. The duration of the initial involuntary commitment is increased from 30 days to up to 90 days. The bill allows a person to enter into a stipulated order for committed treatment, which would expedite placement into treatment. In accordance, the bill removes the mandatory hearing for the initial involuntary commitment but allows a person to request a hearing if the person does not want to enter into a stipulated order for committed treatment. Codifies the "patient's rights" relating to civil commitment, which must be provided to the individual in writing and orally. The rights are:

- To be evaluated to determine behavioral health treatment needs relating to the use of substances
- If under an emergency commitment, to refuse to be examined by a licensed physician for certification. The refusal may be alleged in a petition for involuntary commitment. A person can request to be examined by their physician, or a court can order the person be evaluated by a licensed physician
- To receive timely medical and behavioral health care and treatment that is determined based on needs and delivered in least restrictive setting possible
- To be treated fairly and receive the same consideration and access to appropriate services as others, regardless of race, color, national origin, age, gender identity, sexual orientation, political affiliation, religious beliefs, financial status, or disability
- To contest a commitment proceeding or to enter into a stipulated order of the court for committed treatment
- To retain and consult with an attorney at any time and to have an attorney appointed by or provided by the court in a timely manner, if the person wants the assistance of an attorney and is unable to obtain one
- To, at any time, seek to be discharged from commitment by an order in the nature of habeas corpus
- Once no longer under the influence of drugs or intoxicated by alcohol, sign in and seek voluntary SUD treatment, unless the administrator determines that reasonable grounds exist to believe that the person will not remain in voluntary treatment or that they are a clear danger to the health and safety of themselves or others
- If in committed treatment, to receive 24-hour notice prior to being transferred to another facility
- To have reasonable opportunities for visitation and communication with family and friends, consistent with an effective treatment program and determined by DHS rules. Each person can meet with their attorney, clergyperson, or health care provider at any time
- To have reasonable access to mail and writing materials, including postage, and assistance from staff if the person is unable to write, prepare, or mail correspondence
- Subject to DHS rules, to have reasonable access to phone or other communication devices and to make calls/communications in privacy. Staff shall not open, delay, intercept, read, or censor communications or utilize communications as a method to enforce compliance with staff

[18] C.R.S. § 27-81-102(1) "administrator" means the administrator of an approved treatment facility or an individual authorized in writing to act as the administrator's designee

- To wear their own clothes, keep and use personal possessions, and keep/spend a reasonable sum of their own money
- To have access to medical records
- To have treatment records remain confidential, except as required by law
- To not be fingerprinted, unless required by law
- To refuse to be photographed, except for facility identification purposes
- To have the opportunity to register and vote by absentee ballot, with the assistance of facility staff
- To have appropriate access to adequate food, water, and hygiene products
- To have physical privacy in showering, changing, and using the restroom
- To be free of restraints and solitary confinement

The bill incorporates person-centered language throughout by replacing "her or she" with language like "the person" or "the administrator."

The existing opioid crisis recovery funds advisory committee is relocated from article 82 to article 81 in title 27, C.R.S. In addition, the bill makes conforming amendments, including in the professional licensing statutes in title 12 to remove references to both alcohol use disorder and substance use disorder as grounds for professional discipline, and replaces those terms with the single term "substance use disorder." The bill also makes conforming amendments to remove statutory references to the old provisions and replaces those references with a new reference to the relevant provisions in article 81 of title 27, C.R.S.

Reasons to Support

The bill helps to solidify MAT across the state as a standard of care and it closes a remaining loophole in our community with agencies that still prohibit MAT and ensures that entities receiving state funding or participating in state programs will be adhering to treatment best practices. The triennial MSO community assessment will assist in the MSO and the community in identifying continuing SUD treatment and service gaps in the community. It will ensure that the MSO is continuing to fund the most pressing needs. The requirement that all health benefit plans provide coverage for SUD treatment in accordance with ASAM criteria may increase access to treatment. Additionally, it could increase the number of payers in the behavioral health care system, which may improve the sustainability of providers and all levels of care. Expanding the grant writing assistance from the Center may help more small organizations that do not have a dedicated grant writer or the knowledge of how to apply for complex grants the ability to create or grow programs that may be essential to their communities.

Supporters

- Colorado Association of Local Public Health Officials (CALPHO)
- Colorado Behavioral Healthcare Council (CBHC)
- Colorado Center on Law & Policy (CCLP)
- Colorado Coalition for the Homeless
- Colorado Community Health Network
- Colorado Cross-Disability Coalition
- Colorado Medical Society
- Colorado Nonprofit Association
- Colorado Occupational Therapist Association
- Colorado Pharmacists Society
- Colorado Providers Association (COPA)
- Colorado Psychiatric Society
- Colorado Rural Health Center
- Emergent Biosolutions
- Healthier Colorado
- Mental Health Colorado
- RxPlus Pharmacies
- SCL Health
- Sober AF Entertainment

Reasons to Oppose

The requirement that all health benefit plans provide coverage for SUD treatment in accordance with ASAM criteria has the potential to increase premiums, as it requires plans to increase the number of services that it will reimburse providers for. Expanding the grant writing assistance from the Center may not be appropriate until the current program has completed its first cycle and can be evaluated for effectiveness. The reporting requirements for insurance carriers could increase administrative burden for those entities.

Opponents

- Biotechnology Innovation Organization

Other Considerations

It is important to assess and ensure that Medicaid provides coverage for SUD treatment in accordance with ASAM criteria for placement, medical necessity, and utilization management.

In Colorado, there are not adequate services along all of the ASAM continuum of care; therefore, to ensure access for individuals it will be important to begin to provide funding to aid in the development of those services. Additionally, as these services begin to develop, it will be essential to ensure that there is a trained workforce.

As MAT utilization increases, it will be important to continue to maintain and expand efforts to recruit providers that are qualified by federal law to prescribe buprenorphine.

The bill intends to ensure “person centered” language throughout; however, the following represent instances where the preamended version of bill, which reflects how it was amended in Senate Health and Human Services, continues to use “he or she”/ “his or her” language.

- Page 31, Line 2
- Page 32, Lines 14/15/21/27
- Page 33, Line 11
- Page 35, Line 27
- Page 36, Lines 1/2
- Page 44, Lines 2/3/25
- Page 46, Line 27
- Page 53, Line 22
- Page 57, Line 11
- Page 59, Lines 3/23

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.