POLICY BRIEF

# Combatting the Opioid Crisis in Arizona

## Introduction

Across the nation, states are experiencing an opioid epidemic. Once-vibrant communities have been infiltrated by prescription narcotics and, when those have become too expensive, cheap heroin from Mexico.

In 2012, 259 million prescriptions were written for opioids—more than enough to give every American adult their own bottle of pills. According to the American Society of Addiction Medicine, "four in five new heroin users started out misusing prescription painkillers; 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were 'far more expensive and harder to obtain.'" [1]

Drug overdose is now the leading cause of accidental death in the United States. In 2015 alone, there were more than 52,000 lethal drug overdoses. Opioid addiction is driving this epidemic, with more than 20,000 overdose deaths related to prescription pain relievers in 2015 and another 13,000 overdose deaths related to heroin that same year. [2]

These troubling statistics paint a grim picture. While the federal government shares responsibility for tackling this problem, it is incumbent upon the states to take action to protect the health and safety of their citizens as well as the future of their own economies. This paper explores ways in which Arizona can tackle head on its own opioid epidemic, including legislative and policy recommendations as well as best practices employers can implement to ensure their employees receive the prevention and treatment support they need.

## I. Background: The Making of an Epidemic

Opioids are a class of drugs that include the illicit drug heroin as well as prescription pain relievers like oxycodone, hydrocodone, codeine, morphine, and fentanyl. Opioids interact with receptors in the brain and nervous system to produce pleasurable effects (the "high") and relieve pain.

The use of heroin and opium derivatives has a long history in the medical community dating back hundreds of years.[3] In modern times, up until the late twentieth century narcotic painkillers were used very conservatively and almost exclusively in an inpatient context to treat severe and acute pain associated with cancer and other terminal illness. [4]

The 1990s were a turning point in the growing opioid problem as prescribing behaviors began to change. Pharmaceutical companies used a limited observation of opioid pain relievers to treat patients in a hospital setting as evidence that opioids were safe and non-addictive. Based on limited data, pharmaceutical companies launched aggressive marketing and physician education campaigns to change doctors' attitudes and willingness to prescribe opioid painkillers. For the first time, doctors became willing to explore the use of opioids in an ongoing, outpatient context to treat pain that was not due to terminal illness. With new tools for treating pain available, clinicians and pain societies successfully lobbied for the increased use of opioids for all types of pain. This, in turn, led to new and reformulated prescription opioids, including those with extended release technology such as morphine, fentanyl, and others, to feed the growing market demand.

In the early 2000s, a major shift took place within the medical community when new standards for pain management were widely adopted. Those standards incorporated pain as a "fifth vital sign," thereby changing the approach to pain management by doctors, and the expectation of pain eradication by patients: the new standard for pain management transformed the treatment of pain into the elimination of pain. "These developments had a gradual but dramatic effect on the culture of American medicine. Soon, clinicians were giving an entire month's worth of Percocet or Lortab to patients with only minor injuries or post-surgical pain that required only a few days of opioid analgesia." [5]

Unsurprisingly, this led to a steep rise throughout the 2000s in the prescription of opioids; in tandem, the rates of abuse rose, too. From 1998 to 2008, the abuse and misuse of prescription opioids doubled. And those rates continue to rise. According to the national Centers for Disease Control and Prevention, the number of opioids prescribed per person was three times higher in 2015 than it was in 1999. [6]

Starting around 2010, a confluence of factors together created an intense acceleration in heroin use. These factors included a law enforcement crack down on so-called "pill mills," a reexamination of prescriber practices amongst the medical community, a reformulation of OxyContin that made it harder to crush (and therefore abuse), and the creation by states of prescription registries so that pharmacists and doctors could detect patients who "doctor shopped" for painkillers and forged prescriptions.

Of course, these efforts to better control prescription opioids were a rational response to their widespread abuse, but they created a vacuum in which cheap heroin and synthetic opioids like fentanyl, entering the United States from Mexico, became a ready and abundant alternative. As prescription painkillers became more expensive and harder to obtain, Mexican drug traffickers were happy to fill the void.

According to the 2015 National Drug Threat Assessment Summary Report, the threat posed by heroin in the United States is "serious and has increased since 2007." That is because "heroin is available in larger quantities, used by a larger number of people, and is causing an increasing number of overdose deaths." [7] Now, "in some regions of the country, roughly two-thirds of deaths from opioids can [] be traced to heroin, including heroin that medical examiners either suspect or are certain was laced with fentanyl." [8]

Though opioids were once marketed as safe and non-addictive, there is now agreement among the scientific, medical, and public health communities that opioids are highly addictive. Even some pharmaceutical companies have acknowledged the addictive nature of the drugs they are selling. [9]

Of the 20.5 million Americans that had a substance abuse disorder in 2015, two million of them had a disorder involving prescription pain relievers and 591,000 had a disorder involving heroin. [10] After six days on a prescription opioid, a person's risk of becoming addicted doubles, and after 12 days the risk quadruples. Yet many doctors continue to prescribe courses of opioids for 60 or even 90 days. Indeed, "opioid prescribing rates have increased nearly three-fold,

from 76 million prescriptions in 1991 to approximately 207 million prescriptions in 2013. This remarkable volume of opioid prescribing is unique to the United States, where prescribing in 2015 was nearly four times what it was in Europe." [11] Statistics show that "drug overdoses, predominately from opioids, now exceed car crashes as the leading cause of unintentional death [in the United States]. More than twice as many Americans have died from this prescription opioid overdose epidemic than during the Vietnam War." [12]

No part of the country is safe. While there is a role for the federal government in combatting the opioid epidemic, it is incumbent upon the leaders and policy makers in every state to take action to protect the health and safety of their citizens. Arizona is no exception.

# II. Arizona's Own Opioid Crisis

Like many other states around the country, Arizona is experiencing its own opioid crisis. On June 5, 2017, Governor Doug Ducey declared a public health state of emergency, calling for a statewide effort to reduce opioid deaths in Arizona.

Following the declaration, the Governor's Office released an Enhanced Surveillance Advisory, which mandated specific reporting requirements in cases of suspected opioid-related deaths and overdoses. Medical professionals are now required to report opioid-related data to state health officials within 24 hours of the opioid overdose-related event. This new reporting requirement has revealed important information and data necessary to understand the current epidemic in Arizona. The numbers are staggering.

## A. Arizona's Opioid Epidemic by the Numbers

According to state data, there were over 205 million opioid pills prescribed in Arizona in 2017. This immense volume of prescription opioids is taking its toll on Arizonans.

Seven hundred and ninety Arizonans died from opioid overdoses in 2016. On average, that is more than two Arizonans per day, a 74% increase since 2012. And the number of opioid deaths in Arizona is still increasing: according to state tracking numbers, 564 people are "suspected of dying from opioid-related overdoses between mid-June and mid-November [2017]." [13]

In the second half of 2017 alone, there were 4,153 possible opioid overdoses reported; 14% of those suspected overdoses ended in death. Of the possible opioid overdose cases, 56% were using at least one prescribed opioid. In that same time period, 380 Arizona babies were born exhibiting possible drug-related withdrawal symptoms. [14] And since 2012, heroin deaths have tripled in Arizona. [15]

In addition to the hard numbers, the state's data reveal a disturbing narrative: A majority of suspected opioid overdose incidents occurred in a personal residence; 55% of those suspected of an opioid overdose had an opioid prescription written for more than six days; and only 47% of them were referred to behavioral health services after the overdose incident. In other words, this epidemic is not characterized by back alley criminals and illegal drugs (though that is a component). Rather, the picture of the opioid crisis is average people, using legal medicines prescribed by their doctors in their own homes, and then not getting the help they need.

## B. The Economic Impact of the Crisis, Arizona and Nationwide

The numbers make it clear that Arizona is in crisis. This crisis could, if left unchecked, have devastating impacts to Arizona's economy. A nationwide economic impact report estimated health care costs in Arizona from opioid abuse at $699 million total, and $341 million in 2015 alone. [16]

Nationwide, the overall economic burden of the prescription opioid epidemic is estimated at $78.5 billion. [17] Prescription opioids "are powerful, highly addictive drugs that have the potential to cause impairment, increase the risk of workplace incidents, errors and injury even when taken as prescribed. Prescription painkillers also profoundly increase workers' compensation costs, increase the length of worker disability and increase work time lost. Opioid prescription abuse also significantly increases the use of emergency room services, hospitalizations and other medical costs." [18] And evidence shows that the largest cost of the opioid epidemic is to the workplace: a recent study put that cost at $25.6 billion in the form of lost earnings and employment. [19]

What's worse, these economic estimates fail to take into account the economic value of the loss of life: "Taking a conservative estimate of twenty to thirty thousand opioid-related deaths a year and multiplying those numbers by five million dollars— a figure commonly used by insurance companies to value a human life . . . that loss of life alone costs the economy an additional sum of between a hundred and a hundred and fifty billion dollars a year." [20]

We know this to be true from the experience of other states facing their own opioid epidemics: their economies are struggling. In states like Ohio and West Virginia, amongst the hardest hit by the crisis, lagging economic growth and low economic mobility have been linked to higher overdose death rates. [21] In addition, the high costs of medical care and treatment, criminal justice, and lost productivity are draining resources that could otherwise be devoted to important state needs like education and economic development initiatives. A recent study by Ohio State University shows "a staggering economic toll of $6.6 billion to $8.8 billion a year—about the same amount [Ohio] spends annually on K-12 education." [22]

It is an unfortunate reality that "the opioid crisis and depressed labor force participation are now intertwined in many parts of the U.S." [23] A recent economic study revealed that nearly half of all prime working-age male labor-force dropouts—roughly seven million men—currently take pain medication on a daily basis. [24]

The opioid crisis has an additional impact on the economy in the form of "organized retail theft," which refers to the act of stealing from a retail establishment with the intent to resell or trade the merchandise for money or something else of value. [25] In the context of the opioid crisis, addicts steal merchandise and then trade it for drugs or, sometimes, money that they can use for drugs. According to the Tucson Metro Chamber of Commerce, organized retail theft has cost citizens and retailers in Pima County alone an estimated $5.8 million. [26]

It is clear that "there are major consequences to the economy, not just to the employer and employee who are losing productivity but also to civil society. If people don't have jobs, they don't have money to spend in the grocery store, on gasoline. It's the old multiplier effect: the socioeconomic burden is much broader than on any individual or any firm." [27]

The question is: how does Arizona save its population and economy from this growing crisis?

# III. SOLUTIONS

Despite the grim statistics, there are solutions that could have enormous impacts. There is an essential role for state government and the private sector to tackle the threat of the opioid crisis head-on. While some solutions are easy, some will be more difficult because they are expensive, unconventional, or still carry a social stigma. What is certain, though, is that all of the solutions on the table are backed by evidence and have real potential to save lives. [28]

## A. State Government Solutions

State government is well positioned to institute important reforms that can have a huge impact. In

Arizona, Governor Ducey has taken a critical first step by declaring a state of emergency and ordering real-time data reporting. By collecting and tracking data on suspected opioid overdoses and deaths, amongst other information, Arizona's Department of Health Services can have a better understanding of the problem and how to target solutions to the populations who most need it.

Using data collected pursuant to the Governor's emergency declaration, Arizona's Department of Health Services issued the Opioid Action Plan Report recommending a variety of regulatory and legislative reforms aimed at increasing patient and public awareness and preventing opioid use disorders; improving prescribing and dispensing practices; reducing illicit acquisition and diversion of opioids; improving access to treatment; and reducing opioid deaths. [29]

The ADHS recommendations span legislation, regulatory changes, and executive order; in addition, ADHS includes recommendations to address federal barriers.

On the legislative front, ADHS has many helpful recommendations, including:

- Imposing a five-day limit on all first fills;
- Requiring different labeling and packaging for opioids by, for example, packaging them with red caps instead of white;
- Requiring a limit and tapering of opioid doses;
- Requiring e-prescribing for Schedule II controlled substances;
- Eliminating the practice of doctors directly dispensing opioids;
- Requiring pharmacists to check the statewide prescription drug database prior to dispensing an opioid or benzodiazepine; and
- Requiring at least three hours of opioid-related continuing medical education for all professions that prescribe/dispense opioids.

The Arizona Legislature should be prepared to closely consider these recommendations in the coming session.

In addition to legislation, ADHS also recommends:

- Regulating pain management clinics to prohibit "pill mill" activities;
- Reducing obstacles to treatment including, for example, expanding Arizona's "Angel Initiative," which enables citizens to walk into a police precinct, turn in their drugs and request treatment without fear of prosecution, and also to get help securing safe placement for their child(ren) while in treatment in lieu of placing them in the foster care system; the program is currently only operational in Maryvale;
- Requiring all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curricula; and
- Expanding evidence-based primary prevention programming to reach more children and youth in a coordinated manner.

The ADHS Opioid Action Plan recommendations also address the serious issue in Arizona with so-called "continuity of care." According to ADHS, "Individuals face a range of obstacles preventing them from entering or gaining access to substance abuse treatment, including lack of knowledge regarding access to services; shame and stigma; denial of substance use disorder or substance misuse; costs and lack of insurance/Medicaid; transportation; treatment waiting lists; and prior negative treatment experiences." [30]

The numbers bear this out. Fourteen percent of individuals with a possible opioid overdose in 2017 were previously hospitalized in 2016 for an opioid-related cause. Of those, 9% resulted in a fatal overdose. From 2005-2015, 33% of suspected opioid-related deaths had a prior hospitalization, with an average of nearly three visits prior to death.

That means hospital admissions and emergency room visits provide an opportunity to introduce peer support and provide a referral to behavioral health services, yet Arizona currently lacks the infrastructure to do so. Specifically, Arizona does not have a program that connects people to trained peer recovery coaches,

nor does it have a first responder model for offering opioid-related support, both of which would greatly impact the continuity of care.

Finally, ADHS recommends developing and maintaining a 24/7 call service to provide consultation to prescribers seeking clinical guidance and referral services to patients seeking treatment for opioid use disorder. This type of service could include a central repository of available network capacity and a website of opioid use disorder treatment providers, provide real time consultation and guidance, emergency resources and referrals.

The ADHS recommendations are the culmination of multiple meetings with partner agencies, stakeholders and policymakers, and include recommendations that target everyone from patients to prescribers to pharmacies to law enforcement and beyond. Many of them are straightforward and non-controversial, including limitations on first fills, red cap requirements, and regulating pill mill activities. Even the recommendations that may be more difficult or expensive, however, can have a major impact and save lives. The State Legislature, Department of Health Services, and Governor's Office should move forward with the recommendations, as they present an excellent opportunity to begin to tackle this crisis.

In addition, there are discreet pressing problems that Arizona's state government is best-positioned to address. Those include: changing the framework for behavioral health, addressing addiction in Arizona's prison population, addressing addiction in Arizona's Medicaid population, and maintaining a functional and effective centralized database of prescription information.

## 1. Changing the Framework for Behavioral Health

Arizona must change the framework for behavioral health by ensuring access to medical professionals for the diagnosis and treatment of the underlying conditions that often lead to addiction, and once addiction is a factor ensuring access to medication-assisted treatment options. [31]

Effective treatment programs are not an optional part of the solution; they are essential. Yet there are not currently enough treatment providers or sufficient counseling options for individuals who need them. "In the absence of treatment programs, addicts will eventually lose their jobs, homes, families and support systems. They turn to crime—often prostitution or organized retail theft—in exchange for money or drugs."[32] And, in our current prison system, which lacks sufficient treatment opportunities, those individuals will likely not get the treatment they need.

Ensuring access to medication assisted treatment ("MAT") options once addiction is a factor is also essential. MAT is a general term that refers to one of three therapies: methadone and buprenorphine (often referred to as Suboxone) are opioids that help stave off withdrawal symptoms and reduce cravings, and Vivitrol blocks the brain's opioid receptors and is designed to keep people from getting high if they use drugs. [33] MAT is widely seen as the most effective treatment for opioid addiction.

Despite evidence that MAT programs are effective, [34] they can carry some level of social stigma: some see them as a continuation of drug dependence, while others see them as a panacea. [35] The truth is that different forms of MAT work differently for different people, and some individuals don't respond to MAT at all. Still, there is plenty of evidence to show that, generally, MAT programs are the most effective treatment for opioid addiction.[36] Major public health organizations, including the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the World Health Organization, "all acknowledge medication-assisted treatment's medical value," and many are calling MAT the new gold standard for opioid addiction treatment. [37]

Vermont—one of the few states that has seen an overall decline in opioid addiction rates—has implemented a novel approach to ensure access to behavioral health services and MAT. Vermont has implemented a "hub and spoke" model that weaves together existing

infrastructure already dispensing substance use disorder medication. [38] The hub-and-spoke model organizes the state into seven "hubs" that administer MAT, counseling and other health services, and "spokes," which are three-person primary care teams comprised of a care coordinator/clinician, nurse and physician for every 100 patients. The program and its success are a testament to the cooperative efforts of state government and local partners, including the "state legislature, the governor's office, and six different [Vermont] State departments such as the Departments of Mental Health, Corrections, and Health. At a more micro level, there are local partners that play a role; from federally qualified health centers to housing authorities, hospitals, police agencies and methadone clinics." [39] This level of dedication and coordination on the part of the state and private sector could be a helpful model for other states, including Arizona.

Finally, it is essential that we destigmatize behavioral and mental health disorders, including underlying behavioral health problems as well as opioid and heroin addiction themselves. While declining a drink as a "recovering alcoholic" is accepted and commonplace, recovering heroin and prescription opioid addicts face a different kind of social stigma that can make it more difficult to seek help. There is also a strong correlation between opioid addiction and underlying mental health disorders (from anxiety and depression to other more serious conditions), and simply treating the addiction—through medication or otherwise—is not enough. Indeed, as one prominent psychiatrist has pointed out, "[m]edication can do only so much when patients' lives need fixing." [40]

## 2. Addressing Addiction in Arizona's Prison Population

Arizona's problem with opioid use disorder is compounded in the prison setting. According to an ADHS survey, 77% of inmates assessed at intake have "significant substance abuse histories," yet only 2% are enrolled in addiction treatment. [41] Because drugs are readily available in prison, the majority of individuals leave incarceration still addicted. This leads to higher recidivism rates and an ever-increasing burden on the criminal justice system.

For those already incarcerated, medication assisted treatment" could be the key. Arizona's Department of Corrections (ADC) recently launched a pilot program that would administer an injection of Vivitrol to eligible inmates prior to release. [42] The program, which Governor Ducey called for in his January 2017 State of the State Address, is a "huge deal," for ADC, as it is the first time it has implemented a MAT program for Arizona inmates. [43]

ADHS supports increasing access to Vivitrol and naloxone for individuals exiting state and county correctional institutions and increasing access to MAT therapy for individuals with opioid use disorder while incarcerated.

While a good start, Arizona's pilot program is relatively small and it only reaches inmates exiting prison. ADC hopes to reach 100 inmates in the first two years of the pilot, yet a full 81% of inmates will leave prison addicted to drugs or alcohol. Only 3% of individuals in jail will get substance abuse treatment through the Department of Corrections prior to entering prison. Once in prison, most incarcerated individuals will only receive substance abuse treatment 90-180 days prior to release; even in the case of the Vivitrol pilot, a participating inmate will only receive an injection prior to release, rather than upon entering prison. While in community supervision (Arizona's version of a parole program), individuals may have support to continue treatment. Once community supervision ends, however, it is unclear to what extent support and wraparound services for treatment are available.

A better solution would be to enroll incoming inmates in a MAT program upon entering the prison system. Opioid addicted individuals can be easily identified in jail, so that MAT can be started from day one. Upon release, individuals will have had the benefit of a significantly longer runway in a MAT program; ensuring these individuals have wraparound services to continue treatment outside prison will make success even more likely.

Rhode Island has already done this. In Rhode Island, inmates are screened when they arrive at the state's

single prison campus, and those with opioid use disorders are given the option of treatment. Inmates can take methadone or buprenorphine for up to a year, and restart treatment before they are released; Vivitrol is given a month or two before release. The program also includes counseling. The treatment is provided by a behavioral healthcare nonprofit with clinics around the state; inmates can transition to one of those clinics when they are released to continue their care. [44]

Readily accessible behavioral health and drug treatment programs must be available to individuals who need them, including Arizona's prison population.

## 3. Addressing Addiction in Arizona's Medicaid Population

The Arizona Healthcare Cost Containment System (AHCCCS), Arizona's Medicaid program, is a $12 billion program that operates under an integrated managed care model. Health plans contracted with AHCCCS coordinate and pay for medical services delivered by more than 70,000 health care providers for 1.9 million individuals and families in Arizona. [45]

Given its broad reach and coverage base, AHCCCS has an essential role to play in combatting Arizona's opioid crisis. In response to the Governor's opioid Executive Order, AHCCCS has already put in place new policies and documents that operationalize requirements for prior authorization for short-acting opioids, as well as the seven-day opioid limitation for short-acting opioids called for in Governor Ducey's Executive Order, amongst other things. [46]

In addition, Arizona—via AHCCCS—was the recipient of a two-year, $24 million federal grant to address the opioid crisis. Arizona is using grant funds to expand access to opioid treatment programs throughout the state by opening five 24-hour centers for opioid treatment, including two MAT centers and three crisis centers. The first MAT center opened in October 2017, and a second is planned for 2018. These MAT centers can provide "medication-assisted treatment using methadone, Suboxone, and Vivitrol, in conjunction with psycho-social counseling and medical support. The Community Medical Services clinic provides all three FDA-approved medications, administered by a full-time staff of physicians, counselors, and peer support specialists. Since adding expanded hours [at existing treatment centers], [they have] served more than 200 patients with opioid use disorder, enrolling them in treatment." [47]

As the biggest single payer for healthcare services in the state, AHCCCS can be a driver for transformational change and policy innovation. Roughly 80% of AHCCCS providers see at least two Medicaid plans. That provides a great opportunity for change; if one plan imposes new or different requirements, such as metrics for e-prescribing, other plans will follow.

## 4. Maintaining a Functional and Effective Statewide Database

The Controlled Substances Prescription Monitoring Program (CSPMP) database, run by Arizona's Board of Pharmacy, is a centralized database that grants access to registered practitioners so that they may view substance dispensing information about their patients. Importantly, access is only granted to individuals—not to clinics, hospitals, pharmacies, law enforcement, insurance companies, or otherwise. [48]

The Arizona CSPMP is currently undergoing a system-wide integration with the state's electronic medical records program to make it easier to use and more comprehensive in terms of the information it includes. This integration also better streamlines the availability of data to prescribers. There are still a few ways, though, that Arizona's CSPMP infrastructure could be improved. First, the CSPMP will not necessarily include all prescription information; because of federal Substance Abuse and Mental Health Services Administration rules, information related to methadone treatment programs, including office-based programs, are exempt from reporting methadone to Arizona's CSPMP. As a result, prescribers who do not know that a patient is taking methadone may inadvertently prescribe medications that place the patient at serious risk, even if they check the CSPMP the way the law requires. [49]

Second, the CSPMP system infrastructure could be improved. Currently, the CSPMP only provides a list of prescription information—a menu of drugs a patient has been prescribed. System upgrades could enable the CSPMP to provide a wealth of additional information that would be helpful to doctors and pharmacists, including patient risk assessment educational materials.

Until Arizona has a fully functional, integrated CSPMP system that doctors and pharmacists actually use, the state will not be able to make progress in combatting the opioid epidemic.

## B. Private Sector Solutions

Addiction of all kinds, but especially opioid addiction, has a direct impact on the workplace in the form of lost productivity; an increase in workplace accidents and injuries; an increase in tardiness or absenteeism; theft; high turnover; low morale; and even premature death.

While government efforts to tackle Arizona's problem with opioid addiction are important, Arizona's private sector has an essential role to play. By instituting best practices for mitigating opioid use and addiction, Arizona's business community can save the lives of their employees and their families.

### 1. Business Best Practices for Mitigating Opioid Use and Addiction

There is evidence to suggest that "employers who have strong workplace policies, education, health benefit programs and well-trained managers create safe and healthy environments in which both employees and business thrive." [50] That includes adopting strong and clear drug-free workplace policies and drug testing that focus on prescription drugs as well as other types of drugs, as well as putting in place the right kind of employee assistance program (EAP).

"Employers committed to safe and healthy workplaces have a responsibility to address the opioid epidemic. These employers can do so with strong employee policies, alliances with health benefits and workers' compensation plan providers, education, expanded drug-free workplace testing and access to treatment programs." [51]

Businesses can partner with their health plans and their workers' compensation carrier to ensure that they have appropriate coverage for opioids that follows updated guidelines, and also that the coverage is properly managed. This could involve the use of "prescription benefit managers" (PBMs), who have the ability to run reports and deploy a variety of "flags" when prescription medicine abuse or misuse is occurring. Employers can also ensure that they offer sufficient coverage for alternative treatments, including physical therapy, acupuncture, and new non-opioid medications.

Employers should also institute good employee assistance programs. Just like retirement plans and health insurance, employee assistance programs are considered employee benefits. EAPs are intervention programs that are designed to offer employees assistance in resolving personal problems, whether they be related to alcohol, drugs, or other behavioral or emotional issues. EAPs involve more than simply counseling services; they can include everything from counseling for depression, stress anxiety, grief or alcohol and drug abuse to assistance with issues in the work-place, aid in time of financial difficulties, help with family and marital issues, legal assistance, and other types of educational seminars.

In the opioid context, the educational/awareness components are particularly important because addressing drug addiction in the workplace can help to reduce the social stigma associated with it, and make it easier for those who need help to seek out the appropriate assistance they need.

While instituting a good EAP has costs associated with it, studies have found that businesses with EAPs in place see a return on their investment in the form of significant decreases in lost time, sickness and accident benefits, field grievances, and time and money associated with retraining due to employee turnover.

Nevertheless, there are hard costs associated with running an EAP. Smaller companies can ensure their employees have access to a quality EAP through professional human resource companies that may already be handling HR responsibilities like payroll and benefits plans. Local chambers of commerce and foundations also offer EAPs; in Arizona, for example, the City of Surprise offers access to an EAP through KEPRO, a professional EAP provider. [52]

By being proactive and ensuring appropriate opioid coverage and access to education and treatment, employers can have a huge impact on the health and safety of their own employees and economic outlook of their businesses, as well as the health and safety of Arizonans and the economic outlook of the entire state.

## 2. The Role for Workers' Compensation

The use of opioids to manage pain pervades the workers' compensation system. In 2015 alone, Arizona spent approximately $15 million on opioids for workers' compensation claims; OxyContin is the top workers' compensation drug by amount paid for Arizona injured workers, while generic Hydrocodone-Acetaminophen is the top drug by prescription count. Up to 85% of injured workers with more than seven days of lost time received opioids for pain relief in 2015, and one in four workers that receive opioids will become addicted.

The Industrial Commission of Arizona (ICA) is the agency in Arizona that regulates workers' compensation. Its mission is to protect the life, health, safety and welfare of Arizona workers. It has a strong incentive, therefore, to reduce the incidence of workplace injuries and, when injuries do occur, ensure that workers get appropriate treatment that aids recovery and enables them to return to the workplace.

Fortunately, in Arizona workplace injury rates have gone down significantly over the last two years, which in itself reduces the incidence of opioid prescriptions. Arizona's Industrial Commission is proud of the work it has done with business to make workplaces safer and to prevent injuries before they occur.

When injuries do occur, though, it is essential to ensure that workers get appropriate treatment and are able to return to the workforce. According to ICA data, roughly 92,000 new injured workers a year are reported to the Commission; at any given time, roughly 100,000 injured workers are being treated for chronic pain. Based on data showing the rates of use and addiction, especially in the workers' compensation context, the ICA recognized the need to update its prescribing guidelines.

In October 2016, the ICA adopted new treatment guidelines for the use of opioids in managing chronic pain; those guidelines are now published as rules in Title 20, Chapter 5 of Arizona's Administrative Code. [53] The guidelines apply to the management of chronic pain and the use of opioids for all stages of pain management for injured workers, and inform doctors and other prescribers as to the appropriate first line of treatment based on the type of injury presented.

The new guidelines are informed by evidence that shows opioids are not the most effective treatment for the majority of workplace injuries, and that the long-term use of opioids actually slows recovery. Rather, physical therapy, ibuprofen, rest/ice/compression, and even acupuncture are now considered "first-line treatment" options under the new guidelines. The guidelines are very comprehensive, and for each individual condition there is a list of treatments that are indicated. These treatments include many non-opioid treatments for pain. The ICA hopes that these new guidelines ensure that injured workers receive good quality medical care that results in less addiction and gets them back to work faster.

Workers' compensation carriers can also take important internal proactive steps. The claims representative can serve as an important first line of defense to determine the nature of an injury, whether a person is still able to work, and other relevant medical needs and issues. A good claims representative is in a position to monitor narcotic usage and side effects.

Prescription benefits managers who contract with the

major payers, including workers' compensation carriers, are also in a position to monitor and track prescription usage. Their main job is to manage prescription billings and negotiate medication prices. But PBMs also play an important role in evaluating claims data—they have access to information about how many prescription claims are filled and by whom. Some will help put in place internal formularies to guide whether medications are indicated—or not—for certain injuries. In the workers' compensation context, many PBMs are becoming more proactive in putting in place new formularies that would block a range of medications not typically associated with an industrial injury.

## 3. The Role for Private Insurance Carriers

Private insurance carriers have a strong interest in combatting the opioid epidemic: the cost to public and private insurance companies for opioid-related abuse, addiction, diversion and treatment has been estimated in the billions of dollars. A recent study by Blue Cross found that more than 20% of its insureds were prescribed an opioid painkiller at least once in 2015. [54]

Faced with these kinds of statistics, private carriers like United and Blue Cross Blue Shield are now taking steps to prevent opioid abuse and deaths by, for example, more closely monitoring claims. [55] Insurance companies have access to significant amounts of prescription-related data—they have the ability to know who is prescribing what and whether prescribing activity is out of the ordinary for a particular specialty—and are using that data to flag potentially problematic prescribers as well as high-risk patients. [56]

Making sure that alternative treatments are both covered and appropriately recommended is also important. That could include physical therapy, acupuncture, chiropractic care, NSAIDs (both prescription and over-the-counter), and new or existing non-opioid medications as appropriate.

## 4. Changing Prescriber Behavior

Changing prescriber behaviors is also essential. Private insurance carriers can help with this through internal quality improvement programs for their contracted physicians. Doctor education and outreach can be particularly effective at, for example, reducing the number of patients being prescribed a dangerous combination of drugs that includes an opioid, a benzodiazepine (e.g. Valium or Xanax), and a muscle relaxer.

Doctor outreach and education can also be an effective method to increase the rate of e-prescriptions, reduce or eliminate doctor dispensing, and change the overall mindset when it comes to prescribing opioids, especially for conditions that may not require them. "In fact, several studies have showed that use of opioids for chronic pain may actually worsen pain and functioning, possibly by potentiating pain perception." [57] Ensuring that doctors have that information, and that prescribing behaviors are consistent across doctors, can have a major impact on the number of patients being prescribed opioids.

Finally, there must be an emphasis on making sure doctors check the CSPMP as legally required. By statute, medical practitioners who possesses a Drug Enforcement Agency license to prescribe controlled substances must register with the CSPMP and are required to check it prior to writing prescriptions for opioids. [58]

Unfortunately, doctors do not always check the CSPMP. There are a variety of reasons for this, including technological and infrastructure limitations. In other cases, though, doctors may not check the CSPMP because they simply don't have the time or because the database is cumbersome and difficult to use. According to the State Board of Pharmacy, as of October 2017, fewer than half the doctors in the state were registered with the system, and only 33% check it as required.

Even with a fully functional and easy to use CSPMP, however, challenges will remain. So-called "mom and pop" practices and rural providers may not have the technology necessary to implement electronic medical records that tie into the CSPMP. Even those with access may not check it.

### 5. The Role for Pharmacies

Pharmacies are the last line of defense between opioids and consumers, yet there is currently no legal requirement that pharmacists check the CSPMP prior to dispensing opioids (though pharmacists are already allowed to register with the database and access the information). The ADHS Opioid Action Plan includes a recommendation that pharmacists be required to check the CSPMP prior to filling an opioid prescription.

Pharmacies can also make a difference in drug disposal and treatment. CVS Caremark recently announced plans to enhance its enterprise-wide initiatives supporting safe drug disposal, utilization management of pain medications, and plans to fund treatment and recovery programs. [59]

Specifically, CVS has said that it will enhance its opioid utilization management approach for all commercial, health plan, employer and Medicaid clients as of February 1, 2018 unless the client chooses to opt out. This includes limiting opioids to seven days for a first fill; limiting the daily dosage of opioids dispensed; and requiring the use of immediate-release formulations. CVS also plans to strengthen counseling services provided to patients filling an opioid prescription, and expand its medication disposal program to better enable people to dispose of unwanted/unneeded medications.

## C. Federal Government Solutions

The federal government also has a role to play. The ADHS Opioid Action Plan highlights some of the most important steps the federal government can take to combat the national opioid epidemic, including:

- Removing the Medicaid Institutes for Mental Disease (IMD) exclusion to allow facilities to receive reimbursement for inpatient substance abuse treatment;
- Removing the pain satisfaction score from the Centers for Medicare and Medicaid Services HCAHPS score;
- Allowing Medicaid to pay for substance abuse treatment in correctional facilities; and
- Providing increased funding to border states to assist in preventing illegal supply and distribution of opioids.

### 1. Eliminating the IMD Exclusion

The federal IMD exclusion significantly impacts access to care for Arizonans seeking mental health or substance abuse treatment. [60] The exclusion is found in Section 1905(a)(B) of the Social Security Act, and has been a part of the Medicaid program since it was enacted in 1965. The IMD exclusion prohibits the use of federal Medicaid funds to pay for care provided to certain patients in mental health and substance abuse disorder residential treatment facilities with more than 16 beds.

In light of the explosion in need for treatment related to opioid addiction and opioid use disorders, there is more need than ever for inpatient treatment facilities. But the IMD exclusion is preventing Arizonans from getting the care they need. According to a capacity survey by ADHS, over 1,200 individuals who presented for treatment within a three-month timeframe in 2017 were unable to receive services due to lack of capacity. Of the 12% of facilities with a waitlist, at least 500 individuals were on those waitlists with the majority waiting for inpatient beds. Due to the IMD exclusion, roughly 24 Arizona facilities have been excluded from Medicaid reimbursement for patients requiring inpatient stays longer than 15 days.

In April 2017, AHCCCS submitted to the Center for Medicare and Medicaid Services (CMS) a request for a waiver from these restrictions. In June 2017, CMS indicated that it would only consider an IMD waiver for individuals with substance use disorder needs as part of a comprehensive state substance use disorder strategy. As such, AHCCCS is moving forward with submitting a comprehensive strategy. In the meantime, though, the IMD exclusion remains in place. [61]

At a minimum, CMS should grant the request for a waiver by AHCCCS; even better, the IMD exclusion should be amended or lifted entirely so that more people can access the care they need.

## 2. Removing the Pain Satisfaction Score from the CMS HCAHPS Survey

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a national, standardized, publicly reported survey of patients' perspectives of the care they receive in the hospital. The survey score is based on 32 different measurements, including patients' perceptions about their communication with doctors and nurses, responsiveness of hospital staff, communication about medicines, cleanliness and quietness of the hospital, discharge information, and transition to post-hospital care. Importantly, in 2012, pain management was added as an element of this score.

In November 2016, CMS reported that it was working to implement a rule change that would remove patient satisfaction related to pain management from the HCAHPS hospital payment scoring calculation, but would retain those questions on the survey itself.

While excluding answers to questions related to pain from the scoring formula is a good first step, it does not go far enough. CMS should remove questions related to pain satisfaction from the survey entirely, as studies have shown that the existence of those questions causes hospital prescribers to feel undue pressure to eradicate pain that results in the overprescribing of opioids.

## 3. Allowing Medicaid to Pay for Substance Abuse Treatment in Correctional Facilities

While a state may enroll incarcerated individuals in Medicaid, states may not provide Medicaid coverage for healthcare services delivered to inmates. [62] Rather, states may enroll individuals but must temporarily suspend coverage during the period of incarceration. The state is responsible, primarily via the General Fund, for costs associated with providing healthcare to incarcerated individuals. The ADC baseline budget for fiscal year 2017 included a line item of $147,137,100 for inmate healthcare contracted services. [63]

Medication assisted treatment is considered a "health-care service" and as such is not reimbursable by Medicaid. Making MAT available to all inmates would add significant additional cost that, without Medicaid reimbursement, makes it unlikely that universal MAT access for inmates would come to fruition in Arizona in the near future.

## 4. Stopping the Influx of Drugs from Mexico

The federal government is responsible for securing the border. Yet, every day, countless illicit drugs cross the border from Mexico into Arizona, including heroin and synthetic fentanyl. The drug smuggling operations are highly sophisticated and systematic. The 2015 National Drug Threat Assessment Summary identified Phoenix, Arizona as an important point of entry because of its proximity to the "West Desert corridor," which it describes as "ideal for smuggling." [64] While some drugs make their way into Arizona through the desert, many drug traffickers "transport the bulk of their goods over the Southwest Border through ports of entry (POEs) using passenger vehicles or tractor trailers." [65] For this reason, "border security" as it is traditionally envisioned—border walls and fences and increasing patrol along the international border—is not necessarily the answer. Stopping drugs from entering through legal ports of entry is critical.

# IV. Conclusion

Arizona is amongst the hardest hit in the nation's opioid epidemic. Yet Arizona has an opportunity to change course. By putting in place sound policies, our state's Executive and Legislature can ensure that there is sufficient access to treatment. That includes solving capacity problems so there are enough options for outpatient and inpatient treatment, MAT and behavioral health programs, educational outreach and awareness, and resources for employers seeking to implement employee assistance programs.

As a society, we must also reexamine our view of acceptable pain. Humans cannot exist without pain; pain cannot be eliminated, it can only be managed. The American Medical Association agrees; last year, it recommended that pain be removed as the "fifth vital sign" in professional medical standards. [66]

Until that happens, Arizona lawmakers, business leaders, and citizens themselves are responsible for protecting the state's future health and welfare. Governor Ducey and other officials in Arizona have already made clear that combatting the opioid epidemic is a priority for the state. Governor Ducey's 2018 State of the State speech called for a special session, in partnership with Legislative leadership, to focus on Arizona's opioid crisis to give it the attention it requires.

Success will require long-term dedication, difficult choices and conversations at all levels, and it will most certainly require more dollars to be spent. Fortunately, Arizona's policymakers and business leaders appear to be up to the task.

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