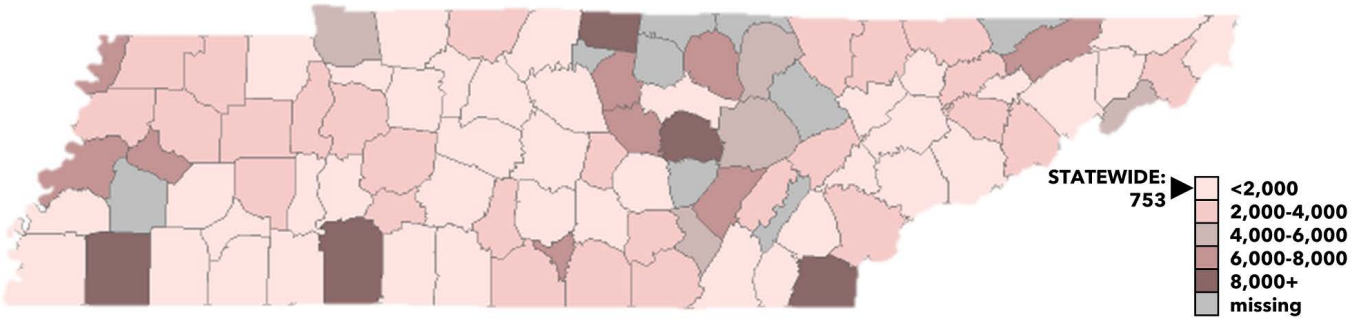
FIGURE 1. NUMBER OF TENNESSEANS FOR EVERY BEHAVIORAL HEALTH PROVIDER



Note: Include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, advanced practice nurses specializing in mental health care and alcohol and drug abuse.
Source: 2016 County Health Rankings, Robert Wood Johnson Foundation

FIGURE 2. SUBSTANCE ABUSE TREATMENT FACILITIES AND BEDS IN TENNESSEE

Note: Represents a point-in-time estimate only based on the facilities that responded to the SAMHSA survey. There is no adjustment for non-response. In 2010, 94.7% of facilities responded. In 2015, 93.2% of facilities responded.
Source: The Substance Abuse and Mental Health Services' National Survey of Substance Abuse Treatment Services (23) (24)

FIGURE 3. OPIOID OVERDOSE DEATHS (2015) AND MEDICATION-ASSISTED TREATMENT LOCATIONS (2017) BY COUNTY

Note: MAT locations includes both opioid treatment programs (OTPs) and providers licensed to prescribe buprenorphine as of May 2017.
Sources: The Sycamore Institute's analysis of data from SAMHSA and CDC (25)

EXAMPLES OF OTHER STRATEGIES

Several targeted strategies being advanced nationally might help to expand MAT capacity in Tennessee:

- To expand access to MAT, the federal government authorized nurse practitioners and physician assistants to prescribe buprenorphine in 2016. Tennessee law explicitly bars all providers except physicians from prescribing buprenorphine. (26) (27) (28)
- NGA suggests one way to increase access to MAT is by requiring buprenorphine waiver training in certain state medical residency programs. (29)
- NGA also recommends that state Medicaid programs cover all approved MAT medications. (6) Some critics of TennCare's decision to stop covering methadone in 2005 (more details below) claim it has limited the number of opioid treatment programs available — particularly in northeast Tennessee. (30)

SUBSTANCE ABUSE TREATMENT SAFETY NET

Federal, state, and local governments fund services for certain low-income adults who are otherwise unable to access or afford needed substance abuse recovery and treatment services. These publicly funded services are often referred to as the safety net.

EXAMPLES OF EXISTING EFFORTS

37%

Safety net-funded treatment admissions for individuals using opioids and/or heroin increased by 37% between 2011 and 2016.

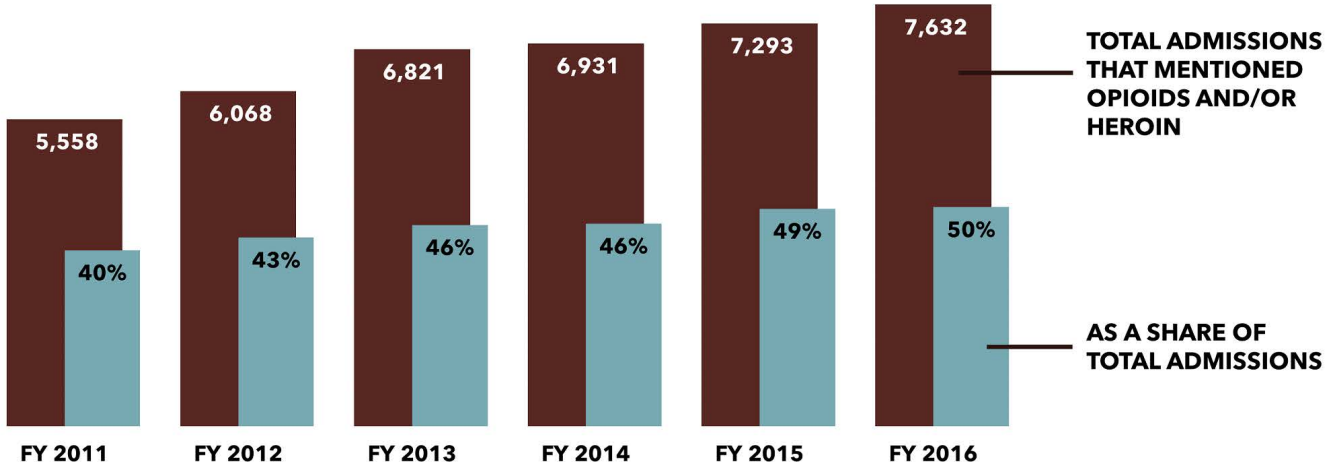
TDMHSAS supports safety net substance abuse recovery and treatment for adults with incomes below 133% of the poverty level and with no access to other sources of coverage (e.g. TennCare, employer-provided health insurance). Between 2011 and 2016, the number of total treatment admissions funded by TDMHSAS increased by 10%, from 14,000 to nearly 15,400. Admissions for opioids and/or heroin abuse increased by 37%, from about 5,500 to 7,600 (**Figure 4**).

These increases, however, do not match increases over the same time period for opioid misuse outcomes (e.g. 60% increase neonatal abstinence syndrome (NAS) cases (31) (32), 70% increase in opioid- and heroin-related hospitalizations (33), 44% increase in overdose deaths associated with all opioids (including heroin)). (34) In 2016, the top treatment services funded by TDMHSAS were residential treatment, halfway houses, and intensive outpatient care. (35)

Figure 5 shows total estimated funding for TDMHSAS' Community Substance Abuse Services since FY 2010-2011. The most recent budget for FY 2017-2018 includes $6 million in recurring funding to provide treatment services for an additional 2,000 individuals. (36) (37)

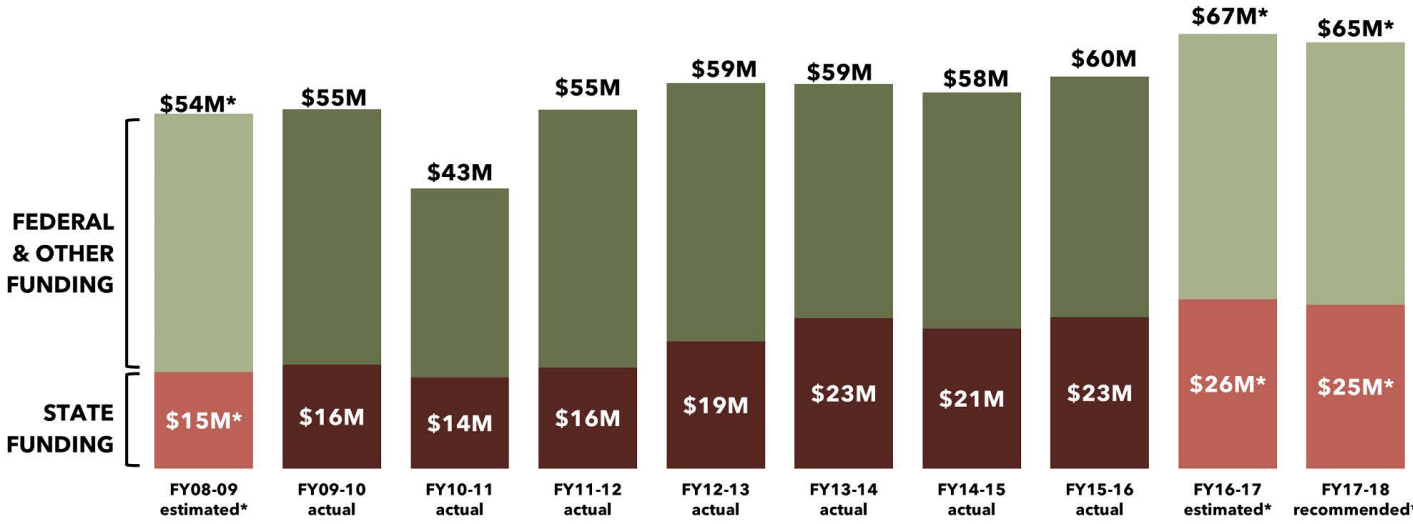
In addition, Tennessee is slated to receive at least $13.8 million in one-time funding over 2 years to expand opioid treatment via the 21st Century Cures Act passed by Congress in 2016. Tennessee was awarded $13.8 million of this funding in April 2017, and additional funding is expected in 2018. TDMHSAS will use these funds to expand MAT, treatment services for pregnant women, treatment in rural areas, and recovery support services. TDMHSAS has not yet released estimates of how many additional individuals they will be able to serve with these dollars. (38)

FIGURE 4.
TDMHSAS-FUNDED ADMISSIONS THAT INCLUDED OPIOIDS AND/OR HEROIN



Note: Includes admissions where either opioids or heroin was indicated as a substance of abuse.
Source: TDMHSAS (11)

FIGURE 5. TOTAL FUNDING FOR TENNESSEE COMMUNITY SUBSTANCE ABUSE SERVICES



* Mid-year estimates and recommended budget numbers are not considered comparable to actual year-end expenditures. During the period shown, actuals have been, on average, 10% lower for this program than mid-year estimates. FY 2016-2017 and FY 2017-2018 do not reflect the $13.8 million recently received from the federal government for opioid treatment.
Sources: The Sycamore Institute's analysis of funding for Community Alcohol and Drug Abuse Services / Community Substance Abuse Services in the TDMHSAS from the FY 2009-2010 through FY 2017-2018 Tennessee State Budgets (36)

EXAMPLES OF OTHER STRATEGIES

Tennessee policymakers should closely track how well investments from state and federal sources meet treatment needs — in terms of both reaching more low-income people and achieving individuals' treatment goals. Despite the recent increases in the number of individuals misusing opioids served by TDMHSAS, unmet need remains. According to a 2014 TDMHSAS estimate, about 10,000 individuals below the poverty level were in need of state-funded treatment for prescription opioid addiction. The unmet funding need to treat all of these individuals totaled about $29 million. (39)

TDMHSAS does not publicize waitlist estimates, but a 2016 audit found that the wait time for a detox bed can be weeks. (40) New funding increases should help meet some of this need, but

it will be important to track this progress and to plan for a transition when one-time federal dollars are no longer available. It will also be important to study the long-term outcomes of individuals who participate in TDMHSAS-funded treatment.

TENNCARE

Certain low-income individuals rely on Medicaid (known as TennCare in Tennessee) for insurance coverage of needed treatment services. Even before the ACA's Medicaid expansion, Medicaid was the 2nd largest payer nationally for SUD treatment behind publicly-funded safety net and criminal justice-related programs. (41)

EXAMPLES OF EXISTING EFFORTS

TennCare covers behavioral health crisis services and medically necessary inpatient and outpatient SUD treatment services. (42) TennCare also covers naltrexone and buprenorphine with prior authorization. It covers methadone only for those under age 21. TennCare does not currently cover methadone for other enrollees. (43) (44)

TennCare plays a role in providing access to health care — including addiction services — for young pregnant women with opioid addiction in particular. TennCare is the primary payer for NAS cases in Tennessee, and in 92% of those cases, the mothers were covered by TennCare during their pregnancies. (45)

In 2017, the General Assembly passed legislation that requires TennCare managed care organization (MCOs) to begin reporting on their coverage practices for mental health and SUD services. Reports will include whether and how often MCOs use prior authorization for these services and medications compared to other services and medications. (46)

EXAMPLES OF OTHER STRATEGIES

The federal Centers for Medicare and Medicaid Services (CMS) have encouraged states to use Medicaid as a tool to address the opioid epidemic. According to CMS, coverage restrictions and requirements like prior authorization may reduce access to MAT. (47) NGA recommends that state Medicaid programs cover all approved MAT medications and remove barriers like prior authorization. (6)

Additionally, TennCare does not cover inpatient addiction treatment in certain facilities, which may limit access to treatment and residential treatment capacity in the state. Medicaid prohibits addiction treatment for non-elderly adults in facilities with more than 16 beds. Intended to limit the use of mental health institutions, the rule has also impacted the number of inpatient beds available for low-income individuals who need drug treatment. In 2015, CMS encouraged states to apply for waivers from the rule to expand Medicaid-funded treatment options for opioid abuse. (48) A number of states have applied for the waiver. To date, TennCare has not. (49)

In 2016, the state's 3-Star Healthy Task Force proposed to cover low-income adults with behavioral health needs via TennCare as a way to address the opioid epidemic and reduce criminal justice costs. An estimated 64,000 low-income, uninsured Tennesseans had SUDs in 2013. (50) TennCare eligibility expansion could increase access to addiction treatment services for many of these individuals. States that have expanded Medicaid have seen an 18% reduction in unmet need for addiction treatment services among low-income adults. (51) The task force's proposal is on hold while Congress considers legislation to roll back or repeal the ACA's Medicaid eligibility expansion.

PRIVATE HEALTH INSURANCE

What and how private insurers cover addiction services can influence enrollees' access to treatment and the larger health care system's capacity to provide treatment. The majority (58%) of non-elderly Tennesseans get health insurance from a private insurer. (52)

EXAMPLES OF EXISTING EFFORTS

Some evidence suggests **MAT usage may be lower among privately insured Tennesseans who abuse opioids than those in other states**. According to the Blue Cross Blue Shield (BCBS) Association of America, Tennesseans covered by BCBS in 2016 had higher rates of diagnosed opioid use disorder than did BCBS enrollees in any other state. Of these, only 32% received MAT – compared to a national average of 37%. (53) BCBS of Tennessee is the state's largest health insurer in all markets — covering 77% of Tennesseans in the large group market (which includes most employer-provided health plans). (54) (55) (56)

Federal law requires equal coverage for addiction treatment, but public awareness is low and compliance rules may be unclear. The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires most private health insurance plans that cover mental health and/or substance use disorder (MH/SUD) to make those benefits at least as generous as their medical and surgical benefits.

The Tennessee Department of Commerce & Insurance is responsible for enforcing MHPAEA requirements for Tennessee's individual market and many employer-provided plans. (57) Enforcement generally stems from complaints filed by individual consumers. The number of complaints filed and actions taken by the TDCI, if any, are not publicly available. Some surveys and reports indicate Americans are largely unaware of MHPAEA requirements, have filed relatively few complaints nationally, and may continue to face barriers to accessing covered MH/SUD services. (58) (59)

EXAMPLES OF OTHER STRATEGIES

Assessing coverage practices, restrictions, and payments for addiction treatment may address some of the underlying drivers of the state's provider and MAT capacity issues and comparatively low MAT utilization rates by Tennesseans covered by private insurance (discussed more above).

NGA recommends that states work to enforce MHPAEA, and SAMHSA has shared best practices for state implementation and enforcement. These include to:

- Ensure open communication with insurers on MHPAEA standards and requirements.
- Standardize materials so insurers know how the state will assess compliance.
- Create templates, workbooks, and other toolkits for the annual insurer filing process so that data are consistent and compliance is clear.
- Assess insurer practices and network adequacy to ensure MHPAEA compliance in fact as well as on paper.
- Collaborate across state agencies (e.g. health and behavioral health departments) and with consumer groups. (60)

Several pieces of legislation introduced in the Tennessee General Assembly in 2017 aim to raise awareness of MHPAEA requirements and ensure Tennessee's enforcement of MHPAEA (see text box).

TENNESSEE PRIVATE HEALTH INSURANCE: PENDING LEGISLATION

SB 839 / HB 1244 would make state insurance law consistent with the requirements in MHPAEA and require the Tennessee Department of Commerce and Insurance to enforce MHPAEA. *Senate status: Assigned to the Senate Commerce and Labor Subcommittee / House status: Expected to be considered on the first 2018 calendar of the House Insurance and Banking Subcommittee.*

SB 835 / HB 871 would require a consumer and provider education campaign on MHPAEA. *Senate status: Referred to the Senate Commerce and Labor Committee / House status: Assigned to the House Insurance and Banking Subcommittee.*

SB 836 / HB 479 would require the Tennessee Department of Commerce and Insurance to put in place MHPAEA enforcement mechanisms. *Senate status: Referred to the Senate Commerce and Labor Committee / House status: Assigned to the House Insurance and Banking Subcommittee.*

TREATMENT FOR NON-VIOLENT OFFENDERS

TDMHSAS works with the state's judicial system to coordinate behavioral health care for individuals in the criminal justice system. In recent years, state policymakers have made efforts to expand access to treatment for these individuals primarily through recovery courts.

EXAMPLES OF EXISTING EFFORTS

Recovery courts offer treatment services and alternative sentences for non-violent offenders who are veterans or have substance abuse and/or co-occurring mental illness. Recovery courts have been around since 1997, but TDMHSAS began oversight in 2012. The structure and specific available services vary by court. Participants receive various services such as residential or outpatient treatment, safe and sober housing, employment, child support and custody issues, and family counseling. (61) TDMHSAS has increased the number of offenders served by recovery courts from about 1,400 in 2013 to over 4,800 in 2016. (11) Of Tennessee recovery court participants, 81% became employed or saw improvement in their job status and 63% maintained an independent living situation after completing the program. (62)

EXAMPLES OF OTHER STRATEGIES

Education about evidence-based opioid addiction treatment such as MAT, behavioral interventions, and other support services could help recovery court judges shape their programs. National best practices recommend that recovery courts provide access to MAT. (6) In some areas of Tennessee, pregnant women have reportedly been sent to a county jail to detox, which puts both the mother and fetus at risk. (63) MAT with methadone (and increasingly buprenorphine) is the standard of care for pregnant women with opioid dependence. If MAT is not available or not wanted by the woman, detox should be medically supervised by an experienced physician. Some studies have found that sudden withdrawal is associated with high relapse rates, preterm labor, fetal distress, or fetal death. (64) Pregnant women, including those in recovery courts, should have access to evidence-based treatment managed by an obstetrician-gynecologist and an addiction medicine specialist.

PARTING WORDS

Tennessee has implemented nearly all best practices for reducing the supply of prescription opioids and made some targeted investments in expanding treatment and recovery. Progress has been made, but the negative outcomes of the epidemic continue to mount. As state policymakers mull next steps, they may consider the current prevention and treatment environment in Tennessee and additional national best and emerging practices in these areas.

**This brief was updated on Dec. 12, 2017 to correct information on page 6 about the ability of non-physicians to prescribe buprenorphine in Tennessee.*

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