Toolkit: State Strategies to Support Substance Use Disorder Treatment in the Primary Care Safety Net

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As states seek new tools to meet the needs of individuals with substance use disorder (SUD) and opioid use disorder, federally qualified health centers (FQHCs) offer unique resources and examples for developing integrated and cost-effective health care services for complex and chronic conditions. The National Academy for State Health Policy (NASHP) developed this toolkit to share innovations, resources, and lessons learned from five state teams (AL, IL, SD, VA, and WI) that are working to strengthen the capacity of their FQHCs to deliver SUD care.

Introduction

Across states, the primary care safety net provides critical medical and preventive care to patients with acute and chronic needs. Federally qualified health centers (FQHCs) and community-based health clinics that provide care to medically underserved populations, are an integral part of this safety net.

FQHCs annually serve more than 30 million patients in over 13,000 delivery sites, and data indicates that FQHC patients cost Medicaid 24 percent less overall than patients receiving care in other settings. As states seek new tools to help them meet the needs of individuals with substance use disorder (SUD), and particularly opioid use disorder (OUD), FQHCs are a unique resource. The patient reach of FQHCs, combined with support from HRSA to develop integrated services, make these sites ideal points of care for complex, chronic conditions such as SUD.

While FQHCs are well-suited to provide a comprehensive set of services and supports to underserved communities, their unique payment requirements pose barriers for states that want to fully leverage these clinics to combat the opioid crisis. The National Academy for State Health Policy developed this resource to highlight and share state policy innovations, resources, and lessons learned from five state teams that are working to strengthen the capacity of their FQHCs to deliver SUD care. Teams were composed of state Medicaid and behavioral health leaders, as well as state primary care associations and/or FQHC leaders from Alabama, Illinois, South Dakota, Virginia, and Wisconsin.

As NASHP was developing this toolkit, the COVID-19 pandemic emerged and states quickly retooled their SUD treatment delivery systems in order to remain accessible to patients despite lockdowns and social distancing requirements. State actions and policies resulting from those changes are explored in the **Impacts of COVID-19 on SUD Treatment** section of this report.

Substance Use Treatment in FQHCs: Key Features and Challenges

As with all significant delivery system transformations, supporting the delivery of SUD and OUD services within FQHCs requires culture change, supports for providers, and key infrastructure. Table 1 provides an overview of features necessary to facilitate delivery of SUD/OUD services within FQHC settings.

Components Needed to Support SUD Services in FQHCs

Component	Description
Robust provider capacity	A geographically dispersed network of trained licensed and non-licensed providers to meet the SUD/OUD needs of the patient population
Integrated care	A comprehensive suite of primary care and behavioral health services, in addition to SUD treatment, that promotes long-term recovery and improved health outcomes
Linkages to community-based services and care coordination	External supports that are able to be coordinated within treatment trajectories to provide services that meet patient needs and support treatment adherence and recovery
Value-based reimbursement	A reimbursement structure that aligns Medicaid and FQHC payment needs to improve outcomes
Data – and the ability to share it	Patient-level treatment data that supports service needs and can be accessed by necessary providers

Leveraging FQHCs to help address the opioid epidemic and other SUDs is not without challenges:

- **FQHC payment:** Federal Medicaid regulation requires that FQHCs be reimbursed through either a prospective payment systems (PPS) or through an alternative payment model (APM) that must be agreed to by the clinic and is no less than what clinics would receive through the PPS. This payment methodology can create barriers for states interested in engaging FQHCs in state health reform efforts and can add cost and complexity when designing payment incentives. In a recent US Government Accountability Office report, 27 states noted this fee structure was a challenge in their states' administration of the Medicaid program.

- **Resources:** Health clinics designated through Section 330 of the Public Health Services Act are by definition located in under-resourced areas and/or engage with vulnerable, underserved populations. They may face challenges related to health care workforce scarcity, a lack of community behavioral health resources, and stigma.

- **Regulatory complexity:** State and federal regulations that govern delivery of SUD treatment in primary care settings can be duplicative and/or conflicting, creating a maze of requirements for providers, facilities, and for prescribing medications to treat opioid use disorder (MOUD).

- **Integrated care:** Integrated care models require a multidisciplinary team to support and extend provider capacity to deliver comprehensive care. Team members and service components that are essential to integrated service delivery are not always reimbursed by state Medicaid programs within a FQHC.

Optimizing the role of FQHCs to identify and treat SUD can help states improve access to quality SUD and OUD treatment, especially in rural and underserved areas. This toolkit highlights examples from leading states on how state Medicaid programs and FQHCs can work together to remove barriers and provide comprehensive care for patients with SUD by addressing key challenges in care delivery across the following areas:

- Supporting provider capacity;
- Supporting clinic capacity;
- Tackling stigma;
- Reducing administrative, regulatory, and technological challenges;
- Using available data; and
- Supporting sustainable reimbursement.

Supporting Prescriber Capacity

Primary care practitioners play an increasingly important role in providing comprehensive SUD treatment, especially managing medications. The Drug Addiction Treatment Act of 2000 (DATA 2000) enabled waivered physicians who received eight hours of training to prescribe buprenorphine to 30 patients, with the option of increasing to 100 patients with authorization from the Center for Substance Abuse Treatment. In 2016, the Secretary of the Department of Health and Human Services approved a final rule resulting from the Comprehensive Addiction and Recovery Act of 2016 (CARA) that further increased the patient limit for waivered physicians from 100 to 275, which was ultimately codified in the SUPPORT for Patients and Communities Act.

Key state actions for success:
Invest in training
Engage key partners
Support mentors and peer-to-peer learning

The CARA-directed regulatory change also temporarily expanded waiver eligibility to nurse practitioners and physician assistants with the completion of 24 hours of training. This policy change allows states to address geographic prescriber shortages, particularly in rural and underserved areas in which nurse practitioners are more likely to practice than physicians. Nurse practitioners and physician assistants are not, however, authorized to prescribe to more than 30 patients, and all of these regulatory provisions are currently set to expire on Oct. 1, 2023. Providers who have received a waiver to prescribe these medications and consented to releasing their practice information may be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) buprenorphine practitioner locator.

While receiving a waiver to prescribe buprenorphine is critical, many practitioners never move beyond this first step. Nationally, approximately 90,000 physicians – less than 10 percent of all

physicians – are waivered to prescribe buprenorphine. Despite the rule change allowing an increase in patient limit, many waivered prescribers do not prescribe to their full capacity. According to SAMHSA's practitioner locator tool, of the 90,000 waivered physicians, approximately 63,000 provide treatment to 30 patients or less. To increase the number of waivered physicians and encourage those already waivered to treat more patients, states may want to consider targeting training and offering other supports to these providers.

Target training: As part of the ITMATTRS 2 program, the state of **Colorado** partnered with the University of Colorado's Department of Family Medicine, the Colorado Health Extension System (CHES), and the Implementing Technology and Medication Assisted Treatment and Team Training in Rural Colorado, to build treatment capacity in counties with few providers by compensating providers to participate in waiver trainings. The program, funded through the state's Office of Behavioral Health, trained 804 practitioners, 110 practices, and increased treatment capacity for 6870 additional patients in underserved areas across the state.
In **Pennsylvania,** the Wright Center for Community Health, an FQHC look-alike and a designated Pennsylvania OUD Center of Excellence, used opioid prescribing data to increase MOUD prescribing capacity: The Center identified prescribers in its community with high opioid prescribing patterns and reached out to those providers with buprenorphine waiver training opportunities. The effort was effective in both curbing excessive opioid prescribing and building MOUD prescribing capacity.

Engage key partners: Kentucky worked to increase access to SUD treatment services as part of the Kentucky Opioid Response Effort (KORE), a partnership among the Kentucky Primary Care Association, the Department for Behavioral Health, Developmental and Intellectual Disabilities, and the Hazelden Betty Ford Foundation (HBFF), The project, supported by federal State Targeted Response (STR) funding, increased access to SUD services by building infrastructure in FQHCs and rural health clinics through trainings for prescribers, support for telehealth services, and integrating peer support specialists. Kentucky also identified building provider capacity to administer MOUD in primary care as a key milestones in its Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan in 2018. The state has been successful in doubling the number of waivered physicians from 500 to 1,000 waivered physicians.

Support mentors and peer-to-peer learning: Providers who would like to begin prescribing buprenorphine, particularly in rural areas, may not have immediate access to colleagues who can answer questions and help address their initial concerns. **Florida** saw an increase in its prescribing capacity after investing STR and State Opioid Response (SOR) resources in peer-to-peer mentoring and training for prescribers. The program assigns seven MOUD-experienced physicians to various areas of the state to provide technical assistance to FQHCs, hospitals, and behavioral health providers by supporting service delivery and developing treatment protocols. Similarly, to support FQHCs interested in implementing a Preferred Office-Based Opioid Treatment (OBOT) model in their centers, the Virginia Department of Medical Assistance Services (DMAS) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) partnered with two FQHCs, New Day Recovery (a rural site) and Daily Planet Health Services (urban site), to provide technical assistance and act as mentors to FQHCs starting the preferred OBOT process.

Building Clinic Capacity

The complex array of biological, psychological, and social factors that contribute to SUD often require both medical and behavioral health interventions that not all FQHCs are equipped to provide. Evidence-based practices feature multidisciplinary teams, care coordination, and integrated behavioral health supports, not all of which may be sustained by a fee for service model or found in primary care safety net settings.

Key state actions for success:
Leverage non-physician providers
Build practice capacity for team-based, multi-disciplinary care
Leverage telehealth

Leverage non-physician providers: Developed at Boston Medical Center, the Massachusetts Nurse Care Manager (NCM) model allows registered nurses to play a critical role in the delivery of outpatient MOUD treatment using buprenorphine and naltrexone. Serving as the primary point of contact for the patient throughout treatment, the NCM performs intake, manages screening, and provides ongoing education and support to the patient. Massachusetts initially supported the expansion of the NCM model into 14 community health centers (CHCs), and the Massachusetts Department of Public Health provided funding for program startup, including covering the initial cost of a full-time NCM. The state also permits NCMs to bill for individual medical visits through the state's Prospective Payment System, ensuring that services remain cost-effective while providing a team-based approach to care. Outcomes from the program include an increase in waivered physicians and increased access to MOUD. Research also indicates a correlation between time in the program and a reduction in utilization of services, such as emergency department and inpatient hospitalization.

Build practice capacity for team-based, multi-disciplinary care: Integrated care teams may be composed of various types of providers who support prescribers and help transition patients through complex systems. Both licensed and non-licensed staff, such as counselors, nurses, care managers, and peers, can be key members of integrated care teams and may be leveraged to supplement the work of prescribers. State examples to support integrated, team-based models include the following:

- In an effort to better utilize specialty MOUD services and staff in primary health care settings, the Blueprint for Health, the Department of Vermont Health Access, and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, collaborated to design and implement the hub and spoke model. Under this model, hubs serve as enhanced opioid treatment programs (OTPs) that dispense MOUD, including naltrexone, buprenorphine, and methadone, and also supplement health home services and staffing. Spokes are general medical settings, including FQHCs, that offer office-based opioid treatment (OBOT) services. Administrative agencies that oversee regional health initiatives as part of Vermont's Blueprint for Health deploy spoke staff to participating patient-centered medical home clinics according to the number of Medicaid members receiving treatment.

- As part of the Addiction and Recovery Treatment Services (ARTS) benefit, Virginia Medicaid implemented the Office-Based Opioid Treatment (OBOT) model to support an interdisciplinary approach to care. OBOT care teams must include a buprenorphine-

waivered practitioner, licensed credentialed addiction treatment professional, and a nurse. Optional team members include peer recovery specialists, substance use care coordinators, and certified substance abuse counselors.

- In 2018, through a state plan amendment, the Michigan Department of Health & Human Services (MDHHS) implemented an opioid health home (OHH) model to encourage a team-based, cross-disciplinary approach to SUD treatment and recovery while controlling costs. The OHH consists of a partnership between a lead entity (LE) and health home partners (HHPs), such as an OTP or OBOT. FQHCs can provide OBOT services and receive a per member per month (PMPM) payment. OHH must consist of a health home director, NCM, behavioral health specialist, a peer recovery coach/community health worker/medical assistant, a consulting primary care provider, and a consulting psychiatrist/psychologist.

Leverage telehealth: Telehealth offers states the opportunity to increase access to OUD services by supporting services that remotely connect patients with providers. States can encourage the development of telehealth services for OUD treatment by providing clear guidance on how to provide remote services and how to be reimbursed for them. Virginia Medicaid released a provider bulletin in 2019 to clarify requirements for providing MOUD services via telemedicine. Its guidance included waiver and OBOT model background, defined remote and originating site requirements, and outlined billing codes for telehealth MOUD services. The state provided additional clarification for FQHCs, emphasizing their ability to deliver services via telehealth as both an originating and remote site. Read the Opportunities to Enhance and Implement Telehealth for SUD Treatment section of this report for updated telehealth policy measures taken in response to the COVID-19 pandemic.

Additional Resources:

- The Provider Clinical Support System (PCSS) is a national organization funded through SAMHSA that offers trainings and mentoring to improve treatment of SUD at no cost to health professionals. Providers may join a moderated online discussion forum, ask direct clinical questions via email, or partake in one-on-one mentoring with a regional mentor.
- NASHP's 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce summarizes how states certify, pay for, and supervise their non-licensed workforce through Medicaid agencies. The brief also provides resources to help states develop new approaches to increase their SUD treatment capacity. The report was funded through a cooperative agreement with HRSA.
- This interactive map, created by the University of Michigan's Behavioral Health Workforce Research Center, in partnership with HRSA and the National Conference of State Legislatures, highlights different behavioral health licensure and certification requirements and scopes of practice across states. States can use this resource to compare their professional requirements with those of states across the country and learn how other states are tackling this issue by engaging and training providers at various competency levels.
- HRSA has developed an addiction medicine fellowship program designed to increase addiction medicine specialists practicing in underserved communities.

- The Center of Excellence for Protected Health Information (CoE-PHI), tasked with developing accessible resources and tools for consumers and providers, presented this overview of health privacy and how federal law protects patient records at NASHP's recent convening of its State SUD Policy Institute. CoE-PHI also maintains a resource center on its website that includes guidance on maintaining patient privacy when providing services via telehealth.

Tackling Stigma

As states dedicate resources to build provider capacity for SUD treatment, stigma in communities and among providers can be a significant obstacle to those efforts. The perspective that SUD is a result of personal weakness or choice conflicts with established clinical understanding of SUD as a chronic condition, and can contribute to apprehension among providers about working with this population, and impede state efforts to increase treatment capacity. To increase treatment access, states may need to consider strategies to directly address community and provider stigma by challenging assumptions about the nature of SUD, the language used to describe it, and responsiveness to treatment.

Key state actions for success:
Engage clinicians
Update state language
Promote public education and awareness

Engage clinicians: Several states have developed resource guides for providers that address stigma in clinical practice. In developing its statewide pain management and SUD curriculum for clinical providers in 2018, **Arizona** emphasized the need for destigmatizing language and approaches that highlight the negative impact of stigma on both patients and systems. The **Ohio** Department of Mental Health and Addiction Services included a resource page for health professionals that provides language and stigma reduction materials.
Michigan's Department of Community Health developed a provider toolkit in 2011 designed to fill a gap in resources for provider organizations to develop internal campaigns among staff, recognize and combat stigma at an individual level, and to facilitate necessary conversations to remove stigma as a barrier to mental health treatment.
The **North Carolina** Department of Health and Human Services released a one-page resource guide for organizations and providers working with people with SUD that outlines language choices and how they may affect people seeking services.
The West Virginia Substance Use Response Plan, released in January 2020, includes stigma reduction as a theme throughout, and explicitly addresses the reduction of provider stigma in a stated goal to increase MOUD prescriber capacity.

Update state language: By addressing potentially stigmatizing language in codes and regulations, states can lead the way in the formal recognition of recovery-friendly language across government systems. These changes in practitioner titles, office and agency names, and regulatory language shift the vernacular – shifts in the language used to talk about SUD can have significant impact on both clinical and systemic interactions. Based on recommendations from the state's opioid task force, **Maine** passed legislation in 2018 to minimize stigma in official regulations, statutes, and guidance by removing the phrase "alcohol and drug" throughout its code sections in favor of "substance use disorder," recognizing the clinical issue at the core of

this epidemic. The bill also removes the phrases "drug addict" and "drug abuser," replacing those terms with "person with substance use disorder." These changes are reflected in state office names as well, the law further directs the Maine Department of Health and Human Services to rename the Office of Substance Abuse and Mental Health Services to the Office of Behavioral Health. A 2019 **North Carolina** bill similarly removed substance "abuse" from its regulatory code language, replacing it with substance "use disorder." The bill addresses these shifts in professional titles as well by changing "certified substance abuse counselor," to "certified alcohol and drug counselor" and "certified substance abuse prevention consultant" to "certified prevention specialist." The same bill restructured licensing for SUD professionals by creating an authority dedicated to the oversight of their credentialing processes.

Promote public education and awareness: States can use education and formal media campaigns to address community-driven stigma. Stigma among community members can pose challenges to building provider capacity when communities express discomfort about SUD treatment being provided in their communities. The *State Without Stigma* media campaign by Massachusetts features stories of people in recovery discussing how stigma affected their engagement with health care providers and often prevented them from seeking treatment. Maryland created two public education campaigns:

> The Alabama departments of Public Health and Mental Health's Stop Judging, Start Healing campaign features a short video vignette about the impact of words like "addict" and "user" and underscores the importance of changing the cultural assumptions around getting help for SUD. This was part of an anti-stigma campaign in the state that won a Silver Addy and the Public Service Award from the American Advertising Awards.

- *Less Judgment, More Compassion* focuses on reframing SUD as a medical condition as opposed to a moral failing, and
- *Talk to Your Doctor* encourages individuals to discuss opioid prescriptions and their accompanying risks candidly with providers.

For New Hampshire's *Anyone, Anytime* campaign, the state created a series of downloadable materials and resources on treatment access, recovery, and naloxone that can be used by health care providers, schools, and members of the public. The *Stop Judging, Start Healing* campaign from Alabama is a series that addresses multiple conditions and the stigmatizing language that perpetuates judgment, including SUD.

Additional Resources:

- The Addiction Technology Transfer Center (ATTC) Network's Anti-stigma Toolkit provides comprehensive guidance for SUD treatment professionals to help understand the origins of stigma and how to combat it in clinical practice and the greater community.
- The Provider Clinical Support System (PCSS) offers online trainings for providers, language resources, and research on stigma's negative impacts on treatment engagement.
- SAMHSA produced a guidance document outlining supports for providers working with pregnant women with SUD, who often face significant stigma, and sometimes legal consequences, when seeking care.

Reducing Administrative and Regulatory Challenges

Key state actions for success:
Review and remove administrative hurdles
Align state and federal requirements
Streamline processes for managed care billing
Eliminate state-level hurdles to integrated care settings

States have traditionally licensed specialty providers to allow them to deliver a menu of SUD services. With the growing acceptance of MOUD, recognition of the benefits of integrated care, and the need to maximize FQHCs to provide care in rural and underserved areas, the locus of care is increasingly moving from these specialty behavioral health settings into primary care. For state policymakers and providers, this shift can present challenges:

- State regulations intended for specialty behavioral health may not serve the needs of patients and providers in primary care, and
- Paying primary care providers to deliver more integrated, team-based care can be difficult, particularly within the constraints of the federal FQHC PPS methodology.
- For providers, reimbursement for these services through both Medicaid and commercial managed care plans can also present administrative challenges.

The table below identifies areas of common concern across regulatory areas that states can review in their efforts to support more seamless delivery of SUD services within FQHCs.

Common Regulatory and Licensing Barriers

Regulatory and Licensing Area	Potential Barriers
Facility licensing	● Conflicting or duplicative requirements across primary care and behavioral health clinics, multiple layers of licensing to add or deliver behavioral or physical health care in varied settings/facilities
Same-day billing	● Prohibitions on billing for two codes or encounters (e.g., one for physical health code, one behavioral health code) on the same day ● Incorrect/outdated assumptions, practices, or misconceptions among providers
Place of service	● Medicaid and/or licensing language that limits behavioral health services or the use of certain behavioral health codes to specific facilities, such as specialty SUD providers or community mental health centers
Clinical, staffing requirements	● Staffing configurations or requirements (e.g., for team-based care or specific behavioral health services) that are challenging to implement across diverse settings ● Clinical requirements, such as the need to be engaged in counseling when receiving MOUD, use of specific assessments or detailed care plans that are burdensome in diverse settings ● Medicaid and/or licensing language that limits the types of staff who can deliver (and be paid for) certain functions

Facility/physical plant standards	● Physical plant requirements for primary care and behavioral health settings that are duplicative, conflicting, or unnecessarily burdensome.
State privacy laws	● State laws, regulations, or licensing standards regarding privacy and information sharing that conflict, duplicate, or create burdens ● State interpretation of federal law that is overly restrictive
Available billing codes	● Ability for diverse providers to use: ○ Health and Behavioral Assessment Codes; ○ Screening, Brief Intervention, and Referral to Treatment codes; ○ Chronic Care Management codes; ○ Distinct codes for depression and other mental health/substance use screening; ○ Codes for group therapy; or ○ MOUD induction and maintenance codes
FQHCs	● Behavioral health and integrated care services included as part of scope of services/additional services menu ● Policies regarding payment for behavioral health, either as part of the prospective payment system (PPS), or outside the PPS ● Complexity in payment for same-day services, group therapy in conjunction with encounter-based billing

Adapted from: Medicaid Innovation Accelerator Program – Aligning State Policies to Support Physical and Mental Health Innovation, 2018.

Review and remove administrative hurdles: Several states have undertaken extensive review of their behavioral health regulation to better support integrated care, including SUD. **New York** developed integration protocols as part of its Delivery System Reform Incentive Payment (DSRIP) waiver initiative: licensed clinics could deliver some behavioral health services if the percentage of these services provided by the clinic does not exceed 49 percent of their total claims. The state also developed guidance for clinics that co-locate and/or share space with behavioral health providers. **South Dakota** created a streamlined process for FQHC accreditation that retains the standards and expectations for SUD agencies while increasing the ability of FQHCs to deliver SUD treatment services. That state also clarified that MOUD is considered a medical encounter when delivered in FQHCs and can therefore be billed separately on the same day as behavioral health services.

Align state and federal requirements: Both FQHCs and MOUD are highly regulated at the state and federal levels. As health clinics, FQHCs are governed by Section 330 of the Public Health Service Act as well as Medicaid and Medicare regulations. MOUD are regulated under the Controlled Substances Act and by SAMHSA and the Drug Enforcement Agency (DEA). Navigating compliance and aligning separate regulatory structures while ensuring appropriate licensure and system integration presents a significant challenge to states. As part of NASHP's State SUD Policy Institute, teams from **Alabama**, **South Dakota**, and **Wisconsin** each worked closely with FQHCs and/or the PCA in their state to review how HRSA health clinic certification requirements intersect with, and sometimes duplicate, state regulations for delivering SUD services.

Streamline processes for managed care billing: Pennsylvania entered into an agreement with the state's seven largest commercial insurers to remove the prior authorization requirement for MOUD. Pursuant to the agreement, these insurers now provide coverage without requiring pre-approval of:

- A minimum of one buprenorphine-naloxone combination product;
- Methadone for purposes of MOUD;
- Naltrexone, in both injectable and oral forms; and
- A minimum of one form of nasal naloxone, not subject to quantity limits.

In removing this requirement, Pennsylvania has ensured consistent MOUD coverage across the state's commercial insurance, Medicaid fee-for-service, and Medicaid managed care plans. For more information about Pennsylvania's process, contact Megan Barbour, Pennsylvania Insurance Department Policy Director.

In **Kentucky**, the state's Medicaid managed care contract requires managed care organizations to expedite credentialing. The typical 90-day credentialing window is shortened to 45 days for SUD providers. **New Hampshire**, through its SUD Community of Learning initiative, convened leading managed care company representatives and SUD providers to discuss common MCO billing challenges and provided guidance to providers on how to avoid common impediments to billing SUD services.

Effective Use of Data

States can assist FQHCs in providing better care to individuals with SUD by supporting the use and appropriate exchange of data at the provider level.

Key state actions for success
Maximize prescription drug monitoring programs
Provide guidance on sharing behavioral health data

Maximize prescription drug monitoring programs (PDMPs): Forty-nine states across the country have instituted PDMPs, electronic databases that collect and maintain an inventory of prescriptions for controlled substances, which make PDMPs valuable tools for both practice and policymaking. Patient-level PDMP data assists prescribers and dispensers in understanding the scope of a patient's prescription history and can alert providers to dangerous co-prescriptions or high levels of opioid exposure. PDMPs also provide distinct provider information that can be used by licensing boards to review prescribing practices, and the aggregate, de-identified data from PDMPs can help states target policy interventions.

Illinois' system, PMPnow, is able to integrate prescriber data into electronic health records (EHR) and other medication management platforms, allowing easier prescriber access to a patient's controlled substance prescription history. This integration of data systems has facilitated significantly faster search results and easier access (prescribers no longer have to enter their user name and password for each new search), provided 24/7 access, and streamlined clinical workflow. Requests through the PMPnow to view PMP data are automatically prompted upon patient presentation in the emergency department.

Provide guidance on sharing behavioral health data: To address the lack of capacity to treat OUD, the **New Hampshire** Bureau of Drug and Alcohol Services convened a panel of practitioners from health care, behavioral health, and specialty SUD treatment services, and the New Hampshire Medical Society to develop a compendium of recommendations and resources for implementing and delivering MOUD in a range of settings.
The compendium includes a model patient consent form, guidance for patient, intra-office, and external communications about patient behavioral health information, and a sample treatment agreement. Unified consent forms can also streamline the consent processes.

Maryland developed a behavioral health data sharing system that prompts SUD providers to complete a release of information (ROI) form before providing SUD services to patients. The release permits the state's Administrative Services Organization to share patient data with providers indicated by the patient, including the patient's MCO, which facilitates care coordination.

Additional Resources:

The Center of Excellence for Protected Health Information (CoE-PHI), funded by SAMHSA, provides resources, training, and technical assistance to providers and other stakeholders. Resources include a decision tree, which providers can use to determine whether the Part 2 rules applies to them or not, FAQs that explore sharing patient SUD records in hospitals and large health care networks, and a sample consent form authorizing disclosure of confidential SUD patient records.

Supporting Sustainable Reimbursement

Medicaid programs must reimburse FQHCs either through the PPS, which requires states to set cost-based, per-visit payment rates for individual clinics, or through a qualifying APM. APMs must reimburse FQHCs at least as much as they would receive under PPS and be agreed to by each clinic.

To support access to care, state Medicaid agencies are employing a range of care delivery models that integrate both the physical and behavioral health needs of patients with SUD. All of these models focus on integrated care delivery and care coordination but approach reimbursement differently, some directly through rates and others through enhancements on top of base payments.

Description	State example
Section 1115 Medicaid Waiver	
In a July 2015 state Medicaid director letter, the Centers for Medicare & Medicaid Services (CMS) announced an opportunity for states to submit 1115 demonstration waivers to transform SUD service delivery. Five states received waivers under this guidance. Additional guidance to states in 2017 led to 22 more states gaining approved waivers for a total of 27 states that now have waivers in place.	Approved in December 2016, **Virginia's** waiver created the Addiction and Recovery Treatment Services (ARTS) benefit in Medicaid, which aligned services and therefore, payment, to the American Society of Addiction Medicine's levels of care. With this waiver, Virginia developed an office-based outpatient treatment (OBOT) model that is easily integrated into primary care settings, and several of the state's FQHCs participate as OBOTs. Costs are incorporated into an existing PMPM payment and are based on increased reimbursement rates for OBOT services to incentivize provider engagement.
Section 2703 Opioid Health Homes	
Health homes provide a mechanism to focus and coordinate care for individuals who have multiple complex chronic conditions that create both high needs and high costs. Services offered as part of a health home are eligible for a 90 percent enhanced Federal Medical Assistance Percentage over 10 quarters, and states are given flexibility in designing their payment methodologies to meet the needs of both patients and providers. Four states currently administer heath home models for individuals with SUD, and CMS has provided a state resource center with technical assistance materials for interested states.	**Michigan** developed an opioid health home (OHH) model that is currently being implemented in the region of the state with the highest number of Medicaid members with OUD, with plans for expansion. Structurally, Prepaid Inpatient Health Plans (PIHP) serve as the lead entity for a health home and partner with MOUD treatment providers, including FQHCs, to ensure intensive integration of care services. PIHPs receive a monthly per member base rate that is higher the first month to reflect a more significant level of care, and providers submit Z-codes; these are all submitted as encounters and reconciled as providers meet defined quality metrics, resulting in a "per member per month plus" payment.
Section 1905(t) Primary Care Case Management	
The Primary Care Case Management model offers an approach in which providers receive monthly capitation payments for care coordination/care management in addition to service reimbursement. It	Idaho's Healthy Connections program is a blend of existing PCCM and a Patient Centered Medical Home (PCMH) model. In 2017,

shares some features of a health home and can support care coordination in areas that do not have managed care. Federal guidance supports the use of this authority to support integrated care models.	Idaho Medicaid began to incorporate value-based payments into Health Connections, and in 2019, Idaho's Medicaid agency submitted a state plan amendment for this new payment model, which awards payments to FQHCs based on how much they improve costs and quality of care provided to Medicaid enrollees. Primary care providers are paid on an FFS basis, plus a PMPM case management fee, qualifying for one of four reimbursement tiers based on their capabilities. While not specific to SUD, the model offers states another potential avenue for engaging FQHCs in integrated, team-based care.
Managed care/coordinated care authority 42 CFR 438.208	
Carving behavioral health services into Medicaid under managed care can reduce duplication and ensure care management and coordination. By providing all of these services under an umbrella of managed care, services are aligned with needs across providers and are measured against uniform quality metrics across Medicaid. If FQHCs are not paid the full PPS or APS, the state is required to pay a wraparound payment to ensure compliance with (CFR).	Washington does this via contractual language with Medicaid MCOs that strengthens and further defines expectations for SUD services – especially coordination, which requires compliance monitoring and quality assurance. This Integrated Apple Health program was developed regionally and brought together the previously siloed physical health, mental health, and SUD services provided through Medicaid. Payment remains under a capitated PMPM that includes the costs for all three types of services.

Impacts of COVID-19 on SUD Treatment

With the emergence of COVID-19 in early 2020, states have been compelled to very quickly revise and restructure health care service delivery. This is especially challenging for SUD treatment, which requires significant care coordination, specific payment models, and often, a team of providers. Continuing access to SUD treatment remains a critical issue for states, as the social and economic impacts of the pandemic threaten to exacerbate already-increasing overdose rates.

In order to ensure that treatment remains available, state Medicaid programs have adapted policies, particularly those around telehealth for SUD, following federal changes and guidelines that were established under the President's emergency order. While the shift to telehealth is

central to the ability to provide treatment, policymakers are also focusing on components that foster access to treatment, including the adaptation of privacy rules when sharing patient data as well as how to support both patients and behavioral health workforce in a drastically altered pandemic environment.

This addendum provides COVID-specific information and resources on telehealth options, service provision and data sharing during the pandemic, and budget implications to states and health centers as they continue to ensure that access to evidence based treatment remains available.

Opportunities to Enhance and Implement Telehealth for SUD Treatment

Prior to COVID-19, telehealth offered states the opportunity to increase access to OUD services by connecting individuals seeking treatment with providers remotely, though initiating treatment with buprenorphine or methadone required an in-person examination per the Ryan Haight Online Pharmacy Consumer Protection Act. In response to the COVID-19 pandemic and the declared public health emergency, the Drug Enforcement Administration (DEA) and SAMHSA now permit providers to begin buprenorphine treatment (known as induction) using telehealth without an in-person evaluation. Although the DEA and SAMHSA initially diverged on the issue of telephonically prescribing buprenorphine, the DEA later clarified that authorized providers may prescribe buprenorphine over the telephone to new and existing patients with OUD without examining the patient, either in person or using telemedicine.

States help to ensure continued access to treatment by supporting providers with necessary resources and guidance to deliver services via telehealth. **Virginia** is supporting telehealth (including telephonic) delivery of all SUD services in part by offering telehealth payment parity, but also by implementing clinical flexibilities, such as waiving requirements for urine drug screens and counseling referrals for patients receiving MOUD. **South Dakota** was well-positioned to provide SUD treatment via telehealth, and its accredited agencies were able to quickly pivot at the beginning of the pandemic to shift delivery of services to telehealth. South Dakota Medicaid had reimbursed telehealth SUD services prior to the pandemic and will continue to do so after the public health emergency ends. As a result of COVID-19, South Dakota Medicaid has allowed the provision of select SUD services via audio only in limited circumstances and will evaluate continued coverage of audio only services at the conclusion of the public health emergency. Policymakers anticipate that the state will continue to see an increase in utilization of telehealth beyond the pandemic.

States will also find resources through HRSA's Office for the Advancement of Telehealth (OAT), which supports the uptake of telehealth technologies by funding a series of programs. States can refer to the following HRSA resources, among others:

- The Substance Abuse Treatment Telehealth Network Grant Program, which is intended to improve and expand access to health care services, training for providers, and available health information.

- The Evidence-Based Tele-Behavioral Health Network Program, which is designed to increase access to behavioral health care services in rural communities and create an evidence-base for determining the effectiveness of tele-behavioral health care.
- The Licensure Portability Grant Program, which assists state professional licensing boards in reducing statutory and regulatory barriers to the provision of telemedicine.

Telehealth supports for patients and providers. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided over $2 trillion in economic relief, of that $291 billion has gone to state, local, and tribal governments, and $1.32 billion has been dedicated to health centers for the prevention, diagnosis, and treatment of COVID-19. Although CARES Act dollars may not make up for lost revenue, health centers may lean more heavily on grant funds to offset fixed operational costs. HRSA's guidance to health centers indicates that funds should be used to improve and maintain safety, provide testing and treatment for COVID-19, and improve telehealth capacity while supporting staff salary and benefits.

While health centers have been central to providing COVID-19 testing and treatment in their communities, they also continue to provide treatment for SUD. In addition to implementing telehealth flexibilities, states can consider opportunities to use funding to support them. South Dakota used CARES funding to support the ongoing needs of providers and has also used SAMHSA's Emergency Grants to Address Mental and Substance Use Disorders during COVID-19 to purchase telehealth equipment for state agencies. Mississippi used emergency grant funds to create and sustain tele-MAT in rural areas, while Rhode Island established a Buprenorphine Tele-Induction hotline to assess patients and prescribe medication. Georgia used this funding to upgrade technology and video-conferencing capability to support deaf individuals with SUD as well as to obtain housing resources to quarantine/isolate individuals with SUD experiencing homelessness.

Virginia used CARES funding to purchase Zoom accounts for providers, as well as to provide Chromebooks for group therapy sessions in clinics. Patients can visit clinics to have their vitals taken and a drug screen completed, use Chromebooks in separate rooms for a Zoom counseling appointment, and then see their prescriber in-person to receive MOUD. These and other state strategies are outlined in NASHP's April 2020 blog, States Rapidly Develop their Telehealth Capacity to Deliver Opioid Use Disorder Treatment.

How States Can Support Uptake of Telehealth During and Beyond COVID-19

Adopt Medicaid payment parity policies to encourage uptake of telehealth services;
Reimburse a broad range of telehealth services;
Subsidize provider cost of starting and maintaining telehealth technology and infrastructure;
Mitigate workforce challenges by certifying multiple provider types;
Provide technology and infrastructure to ensure supply meets demand;
Ensure consistent access to internet connectivity for both patients and providers;
Appoint telehealth champions in both health care and policy settings; and
Offer providers telehealth training opportunities and technical assistance resources.

Licensure Supports for Existing and Emerging Behavioral Health Providers

The pandemic has also led states to waive certain licensure requirements for behavioral health providers in order prevent issues that may hinder or delay the provision of new licenses and license renewals, which could exacerbate existing workforce shortages. Several states and Washington, DC have waived licensure requirements for health care providers to practice across state lines as long as the provider maintains good standing with an issuing state board. Emerging providers are given special consideration as well. New Jersey is granting emergency graduate licenses to recent graduates of accredited social work and counseling master's and doctoral programs who have not yet passed a licensure exam but are working toward licensure requirements, and Virginia waived internship hours required for new Substance Abuse Treatment Practitioner licenses.

States are also waiving telehealth training requirements for licensees in order to bolster accessibility for telehealth services. Georgia reduced the telehealth training hours required for behavioral health providers at the outset of the pandemic, requiring one hour to begin telehealth services and allowing providers to get the remaining hours within the following six weeks. Alabama suspended requirements for specialized telehealth training, provided that a licensee engages in continuing education to complete the required 15 hours of training. The Federation of State Medical Boards has published a state-by-state listing of telehealth waivers and rule changes that provides individual state details and links.

Navigating Data-Sharing and Privacy Laws

Two federal laws come into play when sharing patient information: the Health Insurance Portability and Accountability Act (HIPAA), and 42 Code of Federal Regulations Part 2 (Part 2). Providers will need to be familiar with both in order to ensure that patient privacy is maintained while coordinating care, and both laws have been subject to recent changes as a result of federal COVID-19 response efforts.

HIPAA	**42 CFR Part 2**
Applies to covered entities (most health care providers, health plans, health care clearinghouses) and **business associates.**	**Applies to Part 2 Programs** (federally assisted SUD programs) and most recipients of Part 2 records.
Protects privacy and security of general health information and gives patients certain rights.	Protects privacy and security of records identifying individuals as seeking/receiving SUD treatment.
Purpose: Protects health data integrity, confidentiality, and accessibility	**Purpose**: Encourages people to enter and remain in SUD treatment by guaranteeing confidentiality.
Permits disclosures without patient consent for treatment, payment, and health care operations.	**Requires** patient consent for treatment, payment, and health care operations, with limited exceptions.

Source: The Center of Excellence for Protected Health Information

HIPAA rules: The Office of Civil Rights (OCR) within the federal Health and Human Services (HHS) department has recognized that, in light of COVID-19, states will need to maximize the reach of their health care providers and in so doing, providers may need to utilize technologies that are not fully compliant with HIPAA. OCR has indicated that it will not penalize providers for failing to fully comply with certain aspects of HIPAA in so far that they are providing compliant telehealth services to the best of their abilities during the national emergency. Providers may use non-HIPAA compliant video chat platforms like Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype to provide services. Telephonic-only services are also being allowed; SAMHSA has issued guidance strongly encouraging providers to evaluate and treat their patients with SUD using telehealth and/or telephonic technologies, particularly when conducting evaluations and implementing individual or group therapies.

42 CFR Part 2: The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law March 27, 2020 in response to the pandemic, directed significant changes to Part 2 regulations that will bring them into alignment with HIPAA.

- *Eases Part 2 data sharing:* As of March 2021, a patient's SUD treatment record may be used or disclosed by a HIPAA-covered entity, business associate, or program for the purpose of treatment, payment, and health care operations, subject to patient consent. A patient's SUD record may then be redisclosed in accordance with HIPAA regulations. Similarly, de-identified SUD information will be shareable with a public health authority.
- *Permits OTPs to share Part 2 data:* Subsequent to the passage of the CARES Act, SAMHSA published revisions to the Part 2 regulations that increase provider reporting to state prescription drug monitoring programs (PDMPs), which went into effect in August 2020. Previously, the Part 2 regulations prevented states from including prescribing data from Part 2 providers, such as OTPs, in PDMP patient information – OTPs were permitted to access PDMPs, but not disclose to patient identifying information to them. Under the revised regulations, OTPs are now permitted to enroll in state PDMPs and report data when prescribing or dispensing Schedule II through V controlled substances, so long as they have patient consent.

For additional information about SAMHSA's revised Part 2 Rules, read NASHP's blog, Federal Rule Change Allows Providers to Share Data Poised to Improve Substance Use Disorder Treatment. Importantly, the CARES Act provisions that amend the Part 2 Rules require SAMHSA to make additional changes before March of 2021. Providers should therefore consider SAMHSA's recent changes to the Part 2 Rules as interim.

SAMHSA also maintains a COVID-19 Resources and Information website, which offers guidance specific to telehealth.

Addressing Pandemic-Driven Stressors for Patients and the Workforce

The effects of the COVID-19 pandemic have been far-reaching, and NASHP has explored some of the impacts on social determinant needs of individuals with SUD as well as the needs of the workforce that provides treatment.

- **Explore and support housing connections for people with SUD**. In response to COVID-19, many states have made efforts to temporarily house individuals experiencing or at risk of homelessness. People with SUD who are experiencing housing instability or homelessness are particularly at risk during this time, and states have taken innovative approaches to strategically house and provide treatment to people with SUD while simultaneously containing the spread of COVID-19. Learn more about these state approaches by reading NASHP's July 2020 blog, States Craft Collaborative Approaches to House the Homeless and Curb COVID-19, and about overall state efforts to offer housing support in NASHP's May 2020 blog, States Weigh the Future of Housing Aid in a Post-COVID-19 World.

- **Support behavioral health workforce.** Workforce shortages and inconsistent treatment infrastructure continue to challenge states' provision of SUD treatment services, but federal flexibilities resulting from the pandemic have empowered states to better support their behavioral health workforces. In a May 2020 blog, Strengthening Workforce Capacity: State Actions to Address Opioid Use Disorder During COVID-19, NASHP covers the tools that states are using to address workforce needs, including modifying licensure requirements, innovative leveraging of licensed providers, and providing buprenorphine waiver trainings. As peers providing services have unique needs as the result of the pandemic, states and providers may also refer to the manual, Supporting Our Greatest Resource: Addressing Substance Use, Misuse and Relapse in the Addiction Treatment Workforce, published by the National Association for Addiction Professionals.

As the pandemic continues, the policy shifts made by both federal and state agencies to maintain SUD treatment access may continue to change or become permanent. State policymakers may experience budget impacts that shape treatment policy and affect reimbursement over time. NASHP will continue to monitor state action on support of treatment in health centers as the COVID-19 and treatment landscapes evolve.

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