Program Advisory Meeting Summary

DELIVERY SYSTEM AND PAYMENT MODELS

July 10, 2019

Program Advisory Meeting: Delivery System and Payment Models

Note: This summary is not intended to be a consensus document, but instead represents the breadth of discussion and guidance provided to FORE during the meeting. The use of the term "participants" does not imply majority agreement.

Executive Summary

On July 10, 2019, the Foundation for Opioid Response Efforts (FORE) convened an advisory meeting in New York, NY, to identify the challenges that patients with opioid use disorder (OUD) commonly face in accessing appropriate treatment. The group also considered the delivery system and payment model changes that are needed to facilitate access to treatment. The meeting objectives were threefold:

- to enhance FORE's understanding of current practices for delivering and paying for the prevention and treatment of OUD;
- to gather recommendations on how FORE could advance promising practices through grantmaking, convening, and information dissemination; and
- to obtain guidance on areas of work or topics FORE should avoid, including those with the potential for unintended consequences.

This report summarizes the attendees' discussion.

I. GAPS BETWEEN EFFECTIVE TREATMENT AND PEOPLE WHO NEED CARE

The meeting started by highlighting the need to connect people with OUD to effective care. FORE staff presented evidence of the effectiveness of medication-based treatment (MBT),[1] noting that this approach can save lives, reduce the spread of infectious diseases such as Hepatitis C and HIV, and facilitate employment, caregiving, and productivity. Despite these benefits, 2016 data on the availability of MBT in facilities across the country shows very few programs offer all three medications approved by the U.S. Food and Drug Administration to treat OUD. Additionally, many individuals who self-identify as having a substance use disorder (SUD) do not perceive the need for treatment. The reasons given include the reluctance to stop

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[1] *While the term medication-assisted treatment (MAT) is widely used to describe the combination of FDA-approved medication and behavioral health supports, for the purposes of this document and discussion, we will use the term medication-based treatment (MBT) to reflect the significance of medication in a patient's treatment plan.*

using illicit substances; lack of health insurance; stigma surrounding OUD and treatment (e.g., fears of something having a negative impact on an individual's job or reputation); and lack of knowledge about treatment options and facilities.

Advisory meeting participants were asked to consider the impediments to effective treatment and recommend strategies for overcoming them. They were also asked to identify delivery systems and payment models that could facilitate access to treatment.

In preliminary comments, participants noted that the length and amount of funding FORE offers will have a bearing on the types of applicants and projects submitted. As a strategy for encouraging partnerships among applicants and promoting shared learning, they recommended that FORE consider holding annual grantee meetings as other foundations, such as the Robert Wood Johnson Foundation, have done. They also suggested that FORE consider projects that address mental health conditions that often accompany substance use disorders.

Participants said the foundation could play an important role in establishing the evidence base on effective strategies for increasing access to treatment, with the caveat that such efforts must recognize that barriers to care are a function of both treatment demand (patient knowledge) and capacity constraints. Further, the access challenge is not solely about getting into care, but also having the system capacity to keep people in treatment for the long duration required for successful outcomes. The participants also recommended that the foundation be aware of which programs and efforts already receive federal funding and identify unmet needs and underserved populations that do not receive sufficient funding (e.g., women, youth, and the LGBT community). This review should also identify unmet needs for recovery services.

II. CURRENT AND PROMISING DELIVERY MODELS

While participants identified several current and promising models of connecting people to medications for opioid use disorder (MOUD) as described below, they noted that successful outreach and linkage programs are needed because referral to treatment remains a problem. Potential solutions include increasing "low barrier" treatment options (e.g. through programs that do not require abstinence for enrollment, creating multiple entry points for treatment (a "no-wrong-door" approach), and offering comprehensive services that provide a full continuum of care in one location. FORE was also reminded that addiction treatment has always been a cottage industry in the U.S. and that an integrated national system is needed.

A. Emergency Department as a Point of Access

Participants identified emergency departments (EDs) as promising delivery sites for initiating MBT, as first responders, ED professionals are in a unique position to connect patients to treatment. They identified three types of patients who present in the ED for issues related to OUD: 1) those who have suffered an overdose; 2) those seeking OUD treatment; and 3) those presenting with an ancillary issue who may also have an OUD. One participant noted that Massachusetts General Hospital has created an algorithm to identify patients who may have an OUD. The algorithm, which is embedded in its electronic health record (EHR) system, is based

on patients' answers to screening questions. Additionally, ED staff wear prominent badges with prompts to encourage patients to discuss their substance use problems.

While Massachusetts has passed a law requiring hospitals to offer MBT in the ED to those seeking treatment, using EDs as a starting point for MBT entails challenges. A large majority of EDs offer only detoxification services and have difficulty linking patients to long-term treatment. Another challenge is that while some ED physicians have obtained waivers to provide MBT, many of those practicing in rural hospitals lack the infrastructure to offer MBT in the ED, even if they are waivered to do so. To illustrate a means of overcoming this, one participant gave the example of a smaller hospital partnering with a larger one to establish an MBT program that leverages telehealth and distance training. Even in urban areas, the number of large hospitals that have created successful infrastructures for offering MBT in the ED are limited. One challenge for these programs is having places to refer patients for ongoing treatment. "Bridge clinics" are a promising approach to provide ongoing treatment to patients who have not yet found outpatient OUD care.

One participant also noted that, by nature of their profession, ED physicians do not have the benefit of seeing the results of successful treatment. As a result, many ED practitioners may not believe that what they do matters for this population. One participant suggested providing clinical case studies to ED staff to demonstrate the connection between their work and long-term patient outcomes.

Another impediment is that even if practitioners are interested in offering MBT, they can only provide a three-day supply of buprenorphine, and the patient must return to the hospital each of those days to receive the supply. This requirement creates unnecessary hospital visits and expenses. A participant suggested a regulatory fix so that providers can prescribe a 72-hour supply of buprenorphine to patients without requiring them to return to the hospital multiple times. Another participant advocated for eliminating the waiver requirement to prescribe MBT as a regulatory fix, as it perpetuates the stigma associated with SUD treatment.

B. Hub-and-Spoke Models

Participants highlighted the success of Vermont's hub-and-spoke model, which relies on specialized drug treatment centers (hubs) for the most clinically complex OUD patients and primary care practices (spokes) to treat patients with less complex needs. They noted that this model is particularly effective in a small state but can be challenging to replicate with larger populations and more complex systems.

They also noted that while MBT is an important tool, it should be complemented by a much larger ecosystem of resources, especially for high-risk patients for whom navigating the system is a challenge. These patients need easy connections across the entire system, as well as a strong safety net of comprehensive physical, behavioral health, and wraparound services. Participants suggested that health homes, which offer team-based care with interdisciplinary supports and are described below, could help alleviate this problem.

The discussion also highlighted that there is a shortage of hubs to which prescribers serving as spokes can turn for support in providing MBT.

C. Medicaid Health Homes

Participants identified health homes, which provide coordinated care to individuals with multiple chronic health conditions, including OUD, as a promising model.[2] In addition to managing both physical and behavioral health conditions, some health homes offer a range of social support services (e.g., housing and other recovery services). The health home model allows diverse health and social care professionals to collaborate and offer patient-centered care.

Participants pointed to Virginia's forward-thinking approach to health homes. The state has used a Section 1115 Medicaid demonstration waiver to establish a full continuum of care for SUD treatment, including allowing for flexibility of reimbursement for services. Virginia's clinical practice transformation effort includes setting explicit goals to increase the number of waivered practitioners. The state has also taken steps to address stigma, increased payment rates, and educated and trained practitioners. Participants recommended such comprehensive programs be studied and replicated.

Participants also highlighted Maryland's health home pilot program, which has been successful in improving behavioral health outcomes and creating cost savings. The program included "reverse integration," or the integration of primary care into behavioral health settings.

D. Peer Recovery Support

The discussion on access to treatment highlighted the need to better understand barriers to care and why the billions of dollars now spent on treatment have not increased access. Participants noted better outreach is needed to reach patients where they are; such outreach could help reduce stigma and improve compliance with treatment referrals. Participants noted peer support–based services may be effective in addressing both and are especially effective in the ED. For example, in Rhode Island, persons in recovery are trained as peer recovery coaches and placed in the ED to conduct outreach and connect patients who have experienced an overdose with treatment. Several other states are also funding peer development programs for this type of role. Additionally, participants pointed to the need to collect data demonstrating the impact of such programs on patient outcomes. Having such evidence may encourage wider adoption of these models.

E. Telehealth and Other Technology

Participants advocated for using technology to expand access to treatment and patient engagement, especially in areas with a scarcity of physicians, and described technology as an important complement to the delivery system, rather than a substitution. Existing, successful MOUD programs can leverage technology, including telehealth, to reach isolated areas as well as underserved inner-city neighborhoods. However, some participants cautioned that more research

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[2] https://www.integration.samhsa.gov/integrated-care-models/health-homes

is needed to know which technology will work best for different populations, and how it can be adapted for specific settings and/or populations. Lack of information on both impedes implementation. They also cautioned that federal regulations are a barrier to the spread of telehealth services; as an example, the Ryan Haight Act requires an initial face-to-face meeting before offering telehealth services.

Other digital health technologies were considered as a means of strengthening the delivery system. Participants suggested exploring whether network management tools such as Cloud 9 (an app that connects first responders and mental health providers) and OpenBeds (software that enables hospital clinicians to find the nearest and most appropriate SUD treatment programs), could benefit vulnerable populations. They also suggested that data gathered from various technologies could be mined to better understand OUD mortality trends and elucidate the barriers to appropriate treatment. Some participants, however, expressed concern that technology can be an impediment to clinical practice; they pointed to the challenges and administrative burdens that practices faced when adopting EHR systems. They also cautioned that the workforce may not be ready to adopt some of these new technologies.

F. Primary Care

Participants called for a shift in the locus of OUD treatment from the range of inpatient and specialty services to primary care providers (PCPs). PCPs should be encouraged to offer OUD treatment; if they are unable to do so, they should be able to assess their patients and refer to appropriate treatment providers.

More focus is therefore needed on the supports PCPs require in order to provide high-quality OUD care. In particular, understanding is needed of what has been effective in different types of primary care settings, and support is needed to spread and sustain these practices. However, participants again identified stigma as a major barrier to encouraging more PCPs to offer OUD services. Some PCPs who practice office-based opioid treatment may even have separate waiting rooms or separate hours for their patients with OUD. It was suggested that these physicians may be more open to using telehealth to provide MBT services. They noted that stigma is particularly significant in rural areas where there are provider shortages. Funding to expand treatment in these areas is especially needed.

III. CHALLENGES WITH SPREAD AND SUSTAINABILITY

Participants were asked to identify the primary challenges to spreading and sustaining successful OUD-focused delivery models. The challenges they identified — workforce capacity, regulatory barriers, inadequate reimbursement, risk management concerns, and lack of performance measurement — are addressed in the each of the subsequent sections.

A. Workforce Capacity

The lack of physicians, nurse practitioners (NPs), physician assistants (PAs), behavioral health counselors, and psychiatrists practicing addiction medicine remains a major barrier to the

adoption of successful delivery models across the U.S., participants said. Some suggested that the eight-hour U.S. Drug Enforcement Administration (DEA) waiver training to prescribe MBT was too long and discourages physicians from getting their waiver, thus limiting provider capacity, a topic addressed in more detail below. The training seeks to educate physicians about addiction, helps to reduce stigma, and teaches physicians how to comply with DEA regulations so they can avoid liability. Some states have begun to mandate certain related trainings, as in California, where physicians have an option to take an eight-hour training in pain management or the DEA waiver training. Furthermore, training for NPs and PAs is highly variable across states.

One participant noted that New York has a certification program for counselors who provide addiction treatment services, though in order to increase system capacity, they need an ongoing supply of personnel to enroll in the program. There is now increasing competition among treatment facilities to hire these staff members. Another participant stated that practitioners are drawn to large cities and prestigious universities, resulting in provider shortages in other parts of the country, especially rural areas. Incentives are needed to persuade providers to offer care in underserved communities. Participants noted that many practitioners have abandoned addiction treatment altogether because reimbursement rates are too low. Payment for these services must increase to attract the workforce. It was also suggested that addressing administration barriers in practice may incent providers to see patients with OUD.

B. X Waiver

Some participants identified the requirements under the Drug Addiction Treatment Act of 2000 (DATA 2000) to obtain a waiver (X waiver) to prescribe buprenorphine for OUD treatment as a barrier to capacity building. Participants raised the "X the X waiver" initiative for discussion. Some felt that eight hours of training was an impediment for busy physicians, especially those looking for an excuse not to obtain a waiver. Others argued that eight hours of training was a worthwhile and not a significant time burden given the value of the training. amount of time because the substance of the training is valuable. Continuing medical education (CME) requirements could be leveraged to encourage physicians to pursue the X waiver training, but one participant cautioned that not all states have CME requirements. Separately, participants suggested the need for methods to identify practitioners who have X waivers, but who have not reached their patient limit, and creating effective referral mechanisms.

C. Medicaid Health Homes

While Medicaid programs have expanded use of the health home model, some participants said that existing health homes are not living up to their potential. In particular, they noted that health homes have focused too much on patients who are already seeking services, rather than reaching out to engage patients who may need help. Health homes also need to focus more on addressing the social determinants of poor health, such as unstable housing and food insecurity. Participants recommended increased outreach and care coordination to overcome both issues. They also recommended co-locating medical and social services to promote coordination, with the caution that this could also limit consumer choice.

D. 42 C.F.R. Part 2

Federal regulation 42 C.F.R. Part 2 (Part 2) protects the privacy of individuals with SUD by prohibiting unauthorized disclosures of patient records, even across a hospital's EHR system. Some participants argued that the privacy protections under Part 2 restrict coordination of care among physical and behavioral health providers. As a result, some providers may be unaware of their patient's OUD diagnosis and treatment. Other participants cautioned against loosening privacy restrictions, pointing to the need to balance patient autonomy and dignity with the ability to have comprehensive information when treating the patient. They noted that circumnavigating Part 2 simply requires patient consent, and that many of the perceived barriers reflect a misunderstanding of the actual law. Without Part 2, patients may worry that their confidentiality may be compromised and not seek treatment. Others countered that physicians use Part 2 as an excuse for not collecting data and that it perpetuates stigma by segregating mental health from physical health, which prevents appropriate holistic care. Reflecting the complexity and contentiousness around this topic, participants disagreed as to whether FORE should take up this issue.

E. Quality Measures: Defining and Rewarding Success

Participants noted the importance of redefining "success" in addiction treatment. Historically, success has been defined by negative urine drug screens and no relapse events, an approach that further stigmatizes people in recovery. Participants recommended that FORE support development of outcome measures and/or metrics for assessing MBT services and incorporate them into payment models to incent their use and improve outcomes.

One participant commented that we need reimbursement models that do not incentivize inpatient care. Current reimbursement models incentivize detoxification, traditional 28-day inpatient stays, and 30-day supplies of medication, even though patients often need long-term maintenance and management of their OUD. This approach incents patients to churn in and out of treatment and to relapse. Participants agreed that patients should not lose coverage due to relapse or noncompliance, and that plans should cover support services that have traditionally been excluded.

F. Patient Protection and Affordable Care Act

Participants noted that delivery models for OUD treatment will be significantly affected if the Patient Protection and Affordable Care Act (ACA) is struck down, as the law significantly expanded Medicaid and made SUD treatment an essential health benefit, enabling many individuals with OUD to gain coverage. The constitutionality of the ACA is currently being challenged in the U.S. Court of Appeals for the Fifth Circuit. If the ACA is struck down, participants fear that many people will lose coverage, and very few models would be sustainable over time.

G. Low-Dose Prescribing

Participants identified prescribing improper doses of buprenorphine as a challenge. While physicians fear liability with the DEA if they prescribe too high a dose, too low a dose may

ineffectively treat their patients. The risk of overdose is greater if patients are undertreated with buprenorphine. Patients also may be more prone to relapse, including by self-medicating their withdrawal symptoms with opioids or other substances. A clinician who identifies continued substance use by a patient may assume the patient is simply noncompliant without realizing that the dose is inappropriate. Additionally, inappropriate low-dose prescribing may result in patients dropping out of treatment prematurely because they perceive it to be ineffective.

H. Recovery Assistance

Participants stressed the need for a delivery system with the capacity to provide comprehensive care including treatment and recovery supports over a long duration. They noted patients not only need assistance with the transition into recovery, including ongoing therapeutic relationships, but also often need help with housing, education, and employment services. Without such assistance, patients are at high risk of relapse. The health home model may be one way of providing these care coordination services.

IV. PAYMENT AND FINANCING MODELS

Participants were asked to consider financial barriers to access and identify payment models that might better expand and sustain access to treatment. General comments included the observation that current funding is not being deployed in a manner that is resulting in an adequate supply of providers. Mechanisms are also needed to pay for wraparound services. There is not one version of the "right care model"; instead, there are many nuances, and clinical teams and delivery models need to be adapted to most effectively meet patients' needs.

Across all forms of health insurance, potential barriers to access include: prior authorization requirements; artificial caps or limits on length of treatment, which are not consistent with addiction treatment guidelines; high-deductible plans; and churning on and off of Medicaid or other health insurance coverage.

A. State Policy and Funding

1. Medicaid

State Medicaid programs are continually looking for innovative ways to create a continuum of care for vulnerable populations. For example, 24 states, including Virginia, Maryland, and Rhode Island, have used Section 1115 Medicaid demonstration waiver authority to develop health home models and enroll high-risk patients. States are also supporting peer recovery coaches, but evidence is needed to help guide states on what to fund. Furthermore, a better understanding of how to translate the evidence base into effective policy is needed.

Participants noted that Medicaid programs have their own barriers to care. One barrier includes churning: Medicaid beneficiaries may gain and lose coverage because eligibility requirements are variable and timeframes for reapplying and showing continued eligibility can be challenging to meet. Vulnerable patients may therefore lose coverage for their medications

and critical treatment services. While the ACA included requirements to simplify the renewal process, Medicaid enrollment and renewals are now declining. Work requirements, a major contributing factor, result in barriers to coverage and perpetuate stigma. Even the rate of Medicaid enrollment for children is declining. These trends have significant potential to keep patients from receiving the care they need.

Another barrier includes registering with the Medicaid program as an MBT provider. In addition to obtaining an X waiver, some Medicaid programs require providers to register with them before covering prescriptions for buprenorphine. This additional administrative requirement can serve as a barrier because many practitioners are unaware of it. Participants suggested developing an easier way for the DEA to communicate with Medicaid programs to report that a practitioner received an X waiver. Participants also noted that MBT providers often lack basic infrastructure to bill Medicaid, which is one of the reasons that they often do not accept it.

2. Block Grants

Participants stated that historically, block grants have been used to pay for the majority of addiction treatment services in the U.S. These noncompetitive, formula grants are mandated by the U.S. Congress. SAMHSA administers the Substance Abuse Prevention and Treatment Block Grant (SABG), which provides funds and technical assistance to each state to plan, implement, and evaluate activities that prevent and treat substance use disorder and promote public health.[3] Participants expressed concern that a majority of block grants were provided under fee-for-service arrangements. Yet, such arrangements often categorically exclude certain important services needed to treat OUD. For example, participants noted that while patients may require buprenorphine-assisted treatment, most of the funding from block grants is allocated for methadone-assisted treatment.

B. Private insurance

1. Cost-Sharing Responsibilities

High-deductible health plans have become more commonplace over the past 10 years. Participants noted that high deductibles and out-of-pocket costs are major barriers to care. Even a $10 copayment can prevent low-income patients from seeking treatment. Plan participants who haven't met their deductible may behave like individuals who lack health insurance and forgo care.

2. Pharmacy Benefit Managers

Participants expressed concern about the frequent lack of coordination between the medical and pharmacy operations of health plans. They noted that a patient may receive inpatient addiction treatment, but upon discharge, the pharmacy benefit manager (PBM) administrating the pharmacy benefits may not cover the patient's medications, with the health plan blaming the

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[3] https://www.samhsa.gov/grants/block-grants

lack of access on the PBM. Participants expressed concern that states do not have adequate oversight over private health plans and PBMs.

3. Benefit Utilization Management

Participants discussed the use of benefit utilization management policies. They noted that the use of prior authorization for addiction treatment has decreased significantly across private and public plans, although many Medicaid plans still require it. While most agree that it is a barrier, some insurers use prior authorization to ensure that patients are not just receiving a medication but are receiving support services as well. In general, participants recommended that plans abandon the use of prior authorization in addiction medicine.

Participants also noted that some plans still set artificial duration caps on the number of sessions of office-based opioid treatment their members can receive. Coverage may be terminated after six or 12 months, for example. They argued that this type of limitation should be eliminated.

C. Alternative Payment Models

1. Bundled Payments

Participants stated that under the current fee-for-service model, some OUD services have been categorically excluded, including non-medical services that provide value, such as connections to peer supports and education or job training opportunities. Participants also noted that many payers – public and private – are interested in bundled payment models. These models are an opportunity to expand the types of services provided to meet the needs of a person in treatment and recovery. Participants also noted that evidence has shown that the longer a patient is engaged with therapy, the better the outcomes are – so payment models need to allow for long term, or chronic care.

Participants discussed a payment model that was developed by a working group of insurers and managed care organizations. The workgroup developed a five-year declining bundled payment model, which would occur in three phases. The first phase would include coverage for pre-recovery and stabilization services for fewer than 30 days, including emergency care and detoxification.[4] Coverage during this phase would consist of fee-for-service payments because such patients are difficult to risk stratify. The second phase would include coverage for recovery initiation and active treatment for up to 12 months. The third phase would include coverage for community-based recovery management for up to five years. The second and third phases would be remunerated through risk-based payments to a risk-bearing provider entity.[5] Case rates for episode-of-care payments would be derived through risk stratification, using retrospective patient claims and adjusted in later months on the basis of decreased clinical acuity and reduced risk factors.[6] The payment would be comprised of three mechanisms:

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[4] https://www.healthaffairs.org/do/10.1377/hblog20181211.111071/full/
[5] https://www.healthaffairs.org/do/10.1377/hblog20181211.111071/full/
[6] https://www.healthaffairs.org/do/10.1377/hblog20181211.111071/full/

capitated/bundled payments, quality achievement payment, and performance bonuses.[7] Participants noted that the working group is looking for opportunities to deploy this model with payers. They also noted difficulty in recruiting providers to participate in this model.

2. Value-Based Health Care

A participant expressed concern about the application of pay-for-performance in addiction medicine, raising concern about risk of the dollars saved being directed to services other than addiction treatment and behavioral care services. Participants also cautioned that pay-for-performance models have been tested for over a decade, and for the most part, they have not been strongly correlated with cost savings or increases in quality of care. They noted that the model can work for providers who are motivated to improve value and quality because it is the right thing to do, but the payment models have been limited by how few quality measures are currently available.

3. Metrics

Participants noted that core quality metrics for OUD treatment do not exist. As noted above, they need to be developed and then tied to payment. They should also be broad enough to measure the use and effectiveness of providing wraparound services, such as psychosocial services, child-care, transportation, and employment services, which can increase treatment retention and improve outcomes. According to the National Drug Abuse Treatment Outcome Studies, patients need to stay in treatment for at least 18 months for it to be effective.[8] Quality metrics should also capture the extent to which patients are receiving services and the right dose of medications on a timely basis. The more all the patients' needs are addressed, the more effective the treatment and the better the outcomes will be.

V. SPECIFIC SUGGESTIONS

At the end of the meeting, FORE asked participants to identify one or two projects that FORE could support or undertake to address the issues discussed during this meeting. Participants identified the following:

A. White Papers and Other Educational Materials

Participants suggested FORE support the development of white papers and other educational materials on:

- Key policy issues, such as benefit design and the need for holistic care, not just medications;
- Current coverage policies of private and public health insurers;
- The hub-and-spoke model;
- The use of NPs and PAs to enhance treatment capacity;

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[7] https://www.healthaffairs.org/do/10.1377/hblog20181211.111071/full/
[8] http://www.datos.org/

- The differences between office-based opioid treatment, opioid treatment programs, and other delivery models including what is successful and not, and why, along with profiles of the most promising models and the challenges to implementation;
- A "policy crosswalk" between promising delivery models and policies that can support or hinder implementation;
- Assessment of office-based opioid treatment and primary care-based MBT, with recommendations on how to make both more effective based on a literature review;
- How to achieve "low barriers to access," how to retain patients in treatment, and how to create the right doors to access treatment, with examples of all;
- Data collection and a white paper analyzing treatment interventions, exploring factors that improve and impede individuals from entering treatment, addressing differences between rural and urban areas, and providing recommendations on successful interventions;
- How digital technologies can be used to augment workforce capacity, noting readiness for adoption, adoption rates, and impediments to spread. This paper should include data collection;
- How social services, including transportation, food, and child care, can successfully be implemented into an OUD continuum of care;
- Sustainable recovery services that can be linked to existing delivery systems — highlighting the importance of support services and the need for Medicaid coverage of such services;
- A compendium to the American Society for Addiction Medicine criteria delineating the types of recovery supports that would be appropriate at each level of care, addressing coverage for each method and helping payers understand the return on investment that treatment provides;
- An inventory of federal and state funding provided for OUD treatment (including Specializing in Opioid Addiction Recovery, or SOAR) that assesses the impact of programs and activities receiving such funding, and could be used to avoid duplicating efforts.

B. Research

Participants suggested FORE fund research assessing:

- The impact of government-sponsored loan forgiveness programs on the availability of workforce and access to care;
- Organizational strategies and success factors for collaborative, community-based initiatives;
- The cost and value of treatment in comparison to not receiving a diagnosis or treatment, along with research on the number of people who have signs of OUD but are not diagnosed; and
- The number of providers who have waivers, their patient panel sizes, and excess capacity for treatment in order to determine whether increasing the DATA 200 patient cap made a difference in terms of access.

C. Meetings or Conferences

The participants recommended FORE:

- Bring a multidisciplinary group together across states and universities to explore "no wrong door" programs and make recommendations for their spread; and
- Convene community-based organizations, law enforcement, and first responders to develop prevention strategies, including harm reduction, and foster linkages to treatment.

D. Funding Opportunities

The participants suggested that FORE consider funding the following programs and services:

- "No wrong door" programs that expand points of entry for patients seeking effective treatment;
- Strengthening hubs and increasing capacity of spokes in hub -and-spoke models;
- Ongoing MBT training for ED providers, both before and after they receive X waivers;
- MBT training and educational materials for NPs and PAs who obtain X waivers;
- Models for promoting retention in treatment, including those that include wraparound services;
- Programs that leverage telemedicine to increase access to treatment in rural areas;
- A study of effective methods of improving the quality of OUD providers, differentiating between office-based and other treatment programs;
- The development of quality metrics for OUD treatment, which could be incorporated into payment models;
- Research into payment and delivery reforms to validate their efficacy and distribute learnings to the market;
- Comprehensive evidence-based treatment that includes MBT for certain population segments, which could include per capita payments for low income-patients, in-home or telehealth treatment for rural and/or transportation-limited patients, and start-up costs for treatment providers in areas with limited access;
- Initiatives that reduce financial barriers to treatment, such as copayments and coinsurance;
- Initiatives that support retention in treatment such as peer networks, convenient care options, and supporting the families of patients as they engage in treatment; and
- Organize community collaboratives to provide comprehensive services, leveraging technology as needed.

E. Educational Efforts

The participants recommended that FORE:

- Fund a public awareness campaign on the stigma surrounding OUD with the end goal of encouraging individuals with OUD to enter treatment; and
- Partner with a group, such as the American Medical Association or others driving reforms to graduate medical education, to create addiction medicine curricula that can be delivered virtually.

VI. ATTENDEES

The following individuals attended the program advisory meeting. FORE is grateful for their time and contributions. Their participation in the meeting does not constitute their endorsement of this document.

Attendees:

- Peter S. Hussey, Ph.D., Vice President and Director of RAND Health Care; Senior Policy Researcher, RAND Corporation; Professor, Pardee RAND Graduate School (Meeting Chair)
- Kate Berry, Senior Vice President of Clinical Affairs and Strategic Partnerships, America's Health Insurance Plans
- Lawrence S. Brown, M.D., M.P.H., F.A.C.P., D.F.A.S.A.M., CEO, START Treatment & Recovery Centers
- H. Westley Clark, M.D., J.D., M.P.H., Former Director, Center for Substance Abuse Treatment SAMHSA (retired)
- Thomas D'Aunno, Ph.D., Professor of Management and Director of Health Policy and Management, NYU Wagner Graduate School of Public Service
- Rick Harwood, Former Deputy Executive Director of the National Association of State Alcohol and Drug Abuse Directors, Inc. (retired)
- Alister Francois Martin, M.D., M.P.P., Chief Resident, Massachusetts General Hospital; Emergency Medicine Resident, Brigham and Women's Hospital
- Corbin Petro, Co-Founder & CEO, Eleanor Health
- Kitty Purington, J.D., Senior Program Director, Chronic and Vulnerable Populations, National Academy for State Health Policy
- David E. Smith, Founder, Third Horizon Strategies
- J. Alice Thompson, Social Science Research Analyst, Prevention and Population Health Group, Division of Health Integration and Innovation, Centers for Medicare & Medicaid Services
- Harsh K. Trivedi, M.D., M.B.A., President and CEO of Sheppard Pratt Health Systems

FORE Board Members:

- Adrienne Brown, M.S.W., L.M.S.W., Former Senior Administrator, Alcoholics Anonymous World Services and Administration for Children Services

FORE Staff and Consultant:

- Karen Scott, M.D., M.P.H., President of FORE
- Shibani Gambhir, M.P.A., Chief Operating Officer at FORE
- Ken Shatzkes, Ph.D., Senior Program Officer at FORE
- Lydia Tschoe, M.H.A., Program Assistant at FORE
- Stacey L. Worthy, Esq., Partner with DCBA Law & Policy