RECOMMENDATIONS

PRIOR AUTHORIZATION POLICIES

Recommendation 3-1: The Centers for Medicaid & Medicare Services (CMS) should withhold approval of a Medicaid state plan amendment from states that require prior authorization for medications to treat opioid use disorder. Independent of CMS action, states should remove prior authorization requirements for all Food and Drug Administration-approved medications to treat opioid use disorder in state Medicaid programs and state-regulated private insurers, allowing providers to prescribe whichever formulation and dose is best for an individual patient and without restrictions such as concurrent psychosocial therapy, step therapy, or lifetime limits.

DATA WAIVER REQUIREMENT

Recommendation 3-2: Congress should amend section 303 of the Controlled Substances Act to allow buprenorphine and other medications for opioid use disorder to be prescribed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, or certified nurse midwives without undergoing the mandatory training currently required by law, requiring a Drug Addiction Treatment Act waiver, or limiting the number of patients that can be treated.

Recommendation 3-3: To improve and expand education and training on medications for opioid use disorder and infectious diseases: The Providers Clinical Support System—as the primary federal grantee for training clinicians on evidence-based training, mentoring, and educational resources on medications for opioid use disorder—should consult further with practicing providers and amend their training programs to ensure they are clinically relevant and commensurate with the practitioner's intended role and needs (including for prescribing of medications for opioid use disorder), and should prioritize growth of its mentorship system. The Substance Abuse and Mental Health Services Administration should provide additional funding in future grant announcements specifically to expand mentorship networks for providers.

LACK OF DATA INTEGRATION AND SHARING

Recommendation 3-4: The Substance Abuse and Mental Health Services Administration (SAMHSA) should either further align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act of 1996, or alter the definition of which specific service delivery programs fall under 42 CFR Part 2. To inform this decision, SAMHSA should formally engage with patients, advocacy groups, the general public, and legal experts to better understand the benefits (e.g., greater data access for providers) and costs (e.g., loss of privacy for patients, danger of uncoordinated care) of changing regulations around sharing of substance use information. This engagement should focus on the effects of allowing disclosures of substance use disorder information for treatment rather than solely for payment, health care operations, audits, and evaluations; on the strengths and weaknesses of informed consent as a method for sharing information; and on clinics' current data-sharing practices.

INADEQUATE WORKFORCE AND TRAINING

Recommendation 3-5: In addition to the Opioid Workface Expansion Program for behavioral health trainees, the Health Resources and Services Administration should fund high-quality, clinically relevant training on the care and management of co-occurring opioid use disorder and infectious disease for clinicians working in a wide variety of settings (e.g., primary care clinics, infectious disease care settings, and other settings that treat people with opioid use disorder and related infectious diseases).

Recommendation 3-6: The Health Resources and Services Administration should devote additional resources toward—and more widely promote—programs that incentivize providers—including psychiatrists, health service psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors—to work in rural areas where opioid and infectious disease outbreaks are most likely to occur (one such program is the National Health Service Corps Rural Community Loan repayment program, in coordination with the Rural Communities Opioid Response Program within the Federal Office of Rural Health Policy).

Recommendation 3-7: The Health Resources and Services Administration should widen the scope of its Substance Abuse Treatment Telehealth Network Grant Program to support telemedicine approaches for integrating both opioid use disorder and infectious disease services, particularly in rural areas.

Recommendation 3-8: The Department of Health and Human Services should explore policy incentives for providers and clinics to provide a wider array of evidence-based medications for opioid use disorder and to institute universal, opt-out testing and connection to treatment for infectious diseases, especially at methadone-based opioid treatment programs.

Recommendation 3-9: Congress should amend section 303 of the Controlled Substances Act to permit providers to deliver methadone treatment for opioid use disorder in primary care settings.

Recommendation 3-10: The Diversion Control Division of the Drug Enforcement Agency should waive the fee associated with gaining a registration number for health professionals (i.e., medical residents, physician assistants, and qualified nurses) in their residencies or soon after their training is finished to incentivize them to gain buprenorphine prescribing authority early in their careers.

Recommendation 3-11: To better integrate training on opioid use disorder and infectious disease in health professions training:

- The Liaison Committee on Medical Education (LCME) should assure that medical students receive practical, clinically relevant, harm-reduction-focused, case-management-based training on opioid use disorder and infectious diseases assessment, management, and treatment in response to LCME's curricular content standard 7.5 (societal problems).
- The Accreditation Council for Graduate Medical Education should, among its common program requirements, require that residents and fellows receive practical, clinically relevant, harm-reduction-focused, case-management-based training on opioid use disorder and infectious diseases.
- The accreditation bodies for nursing education should assure that students receive practical, clinically relevant, harm-reduction-focused, case-management-based training on opioid use disorder and infectious diseases assessment, management, and treatment through their curricular, programmatic, or competency criteria.
- The Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) should assure that students receive practical, clinically relevant, harm-reduction-focused, case-management-based training on opioid use disorder and infectious diseases assessment, management, and treatment in response to ARC-PA's program curriculum standard number B2.08 (social and behavioral sciences).

Recommendation 3-12: State Medical Boards (and equivalent licensing bodies for other health professionals) should encourage providers to take continuing education focused on harm reduction in fulfilling their continuing education requirements.

STIGMA

Recommendation 3-13: The Substance Abuse and Mental Health Services Administration should support implementation of multi-level, sustainable, evidence-based, and measurable intervention strategies aimed at reducing stigma in clinical settings against people who use drugs, people who inject drugs, and people undergoing treatment with medications for opioid use disorder or who have infectious diseases. Such efforts should be targeted toward a range of health professionals (e.g., counselors, prescribing health professionals, front-desk staff, and others) across geographic regions of the United States, and the evaluations and results from these interventions should be made publicly available.

PAYMENT AND FINANCING LIMITATIONS

Recommendation 3-14: Congress should ensure that federal funds can be used to purchase injection equipment at syringe service programs.

Recommendation 3-15: The Substance Abuse and Mental Health Services Administration should support programs attempting to implement quality care through integrated services (e.g., from colocated services to fully integrated) through grants that provide technical assistance on implementation of integration strategies, while also collecting data to form an evidence base about the best strategies for future integration.

Recommendation 3-16: The Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration and other government funders should require that organizations receiving funding for opioid use disorder and infectious disease services submit information on a regular basis with data related to the opioid care cascade model and their plans for using the care cascade model to prevent, identify, treat, and promote recovery for patients with opioid use disorder.

Recommendation 3-17: Congress should authorize and appropriate funding for the Health Resources and Services Administration to comprehensively address the needs of low-income uninsured or under-insured individuals with co-occurring opioid use disorder and infectious diseases. Such an effort should encompass a full range of services—including integration of prevention and treatment services—as well as services that address the social determinants of health (e.g., housing and transportation). Furthermore, the effort should develop clear metrics of success and require participating organizations to report these metrics as a condition for participation. The committee recognizes that policy makers will need to wrestle with program specifics such as the specific services to be covered, coordination with other federal programs, program standards, and eligibility levels.

SAME-DAY BILLING RESTRICTIONS

Recommendation 3-18: State Medicaid administrators should revise their billing policies to allow for more than one visit in a given day (e.g., allow for one physical and one behavioral visit per day; allow multiple providers to bill on the same day for the same patient; or allow the same provider to bill on the same day for different diagnoses, such as opioid use disorder and infectious disease).

Recommendation 3-19: The Centers for Medicare & Medicaid Services should issue an Information Bulletin to state Medicaid programs, sharing information about how states have removed same-day billing restrictions and highlighting the importance of removing these restrictions for providing integrated care.

LIMITS ON HARM-REDUCTION SERVICES

Recommendation 3-20: Individual clinics, health care programs, and providers should incorporate harm-reduction strategies into both infectious disease and opioid use disorder care, such as by linking patients to syringe service programs, distributing naloxone, adopting a harm-reduction philosophy focused on patient-centered care, prescribing pre-exposure prophylaxis (PrEP), and providing safe drug use and safe sex education.

Recommendation 3-21: States should lift the remaining bans on evidence-based syringe services, offering syringe services at publicly funded health departments and allowing for independently operated syringe service programs.

Recommendation 3-22: The Substance Abuse and Mental Health Services Administration should make available grants for researchers from a broad set of disciplines (medicine, nursing, epidemiology, behavioral science, health policy, and implementation science) to conduct research on the integration of opioid use disorder and infectious disease care under a harm-reduction lens.

DISCONNECT BETWEEN THE HEALTH AND CRIMINAL JUSTICE SYSTEMS

Recommendation 3-23: Through federal grant funding, state block grants or direct appropriations, states should fund—and correctional facilities should offer—evidence-based screening and treatments for opioid use disorder and co-occurring infectious disease.

Recommendation 3-24: Clinics and organizations that treat opioid use disorder and infectious diseases should coordinate with law enforcement and correctional facilities to better track and maintain records of patients entering and exiting the criminal justice system.

Recommendation 3-25: Through federal grant funding, state block grants or direct appropriations, states should fund high-quality, evidence-based reentry services for prisons and jails, including medications for opioid use disorder and infectious disease, as well as linkage to care in the community and harm-reduction services following release (e.g., naloxone to reduce the risk of fatal overdose).

Recommendation 3-26: State Medicaid administrators should adjust policies to ensure that individuals previously enrolled in Medicaid before entering the criminal justice system are automatically reenrolled at the time they are released.

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