Opportunities to Promote Medications for Opioid Use Disorder in Federally Qualified Health Centers

JANUARY 2024

By Meryl Schulman and Ashley Jasko, Center for Health Care Strategies

Acknowledgements

Contents

TAKEAWAYS

- Medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone, are an evidence-based, yet underutilized approach to treating opioid use disorder (OUD).

- Federally qualified health centers (FQHCs) are uniquely positioned to increase access and reduce inequities related to MOUD, given the populations they serve, their reach in communities across the country, and their ability to integrate physical and behavioral health services. Despite this, many health centers do not yet offer MOUD, and among those that do, few offer all three U.S. Food and Drug Administration-approved medications.

- This report outlines findings from an environmental scan to better understand the barriers and facilitators to FQHCs providing MOUD. It details opportunities at the community health center, state, and federal levels to support the provision of these medications for OUD.

Overview

Nationally, approximately three million people have or have had an opioid use disorder (OUD) — including from both prescription opioids and illicit drugs.[1] Opioid-related deaths continue to rise, with highly potent synthetic opioids (e.g., fentanyl) now contributing to nearly 70 percent of overdose deaths.[2] In addition, polysubstance use — the use of more than one drug simultaneously — is a growing issue and contributing to opioid overdose.[3] This includes the use of stimulants, like cocaine and methamphetamine, alongside opioids.[4] Relatedly, xylazine — a non-opioid tranquilizer used in veterinary medicine that is commonly referred to as "tranq" — is a new contributing factor to opioid overdose deaths.[5] The continued rise of fentanyl and the prevalence of polysubstance use add to the complexity of the opioid epidemic and to managing OUD and substance use disorder (SUD) more broadly.

Medications for opioid use disorder (MOUD)[6] offer an evidence-based approach to managing SUD, promoting engagement in treatment, which in turn can reduce the risk of overdose mortality.[7] Medications approved by the U.S. Food and Drug Administration (FDA) — buprenorphine, methadone, and naltrexone, often provided in combination with behavioral therapy — are considered the gold standard for OUD treatment (see MOUD sidebar on page 7). Despite this, MOUD remain under-prescribed by health care providers and many people with OUD do not have access to these medications.

Medicaid covers approximately 40 percent of non-elderly adults with OUD; however, many Medicaid beneficiaries do not receive MOUD.[8] A recent report from the Office of the Inspector General found that one third of Medicaid beneficiaries with OUD did not receive MOUD through Medicaid or Medicare (for those who are dually eligible for Medicaid and Medicare).[9] This same report underscored disparities in access to MOUD for Medicaid

beneficiaries who identify as Black or African American, are under age 19, and for those who have a disability and/or blindness.[10] Racial and ethnic disparities persist related to the types of MOUD people with OUD have access to. One study found that facilities providing methadone were more likely to be in highly segregated African American and Hispanic/Latino counties. Meanwhile, facilities offering buprenorphine were more likely to be in highly segregated white counties.[11] While both medications are highly effective in treating OUD (see MOUD sidebar on page 7), methadone is highly regulated, and can only be provided for the treatment of OUD at Opioid Treatment Programs (OTPs),† whereas buprenorphine can be prescribed in an office-based setting.

Federally qualified health centers (FQHCs) are a key facet of the health care safety net, providing access to primary health care services regardless of an individual's ability to pay. The Health Resources & Services Administration (HRSA) funds almost 1,400 FQHCs and 100 look-alike organizations, and together these programs have more than 15,000 locations across the country.[14] FQHCs provide critical services to communities that are underserved and historically marginalized, including communities of color, individuals who are unhoused, migrant and farmworkers, and veterans, among others. Nationally, 63 percent of health center patients are members of racial and ethnic minority groups compared to 40 percent of the general U.S. population.[15] Furthermore, 80 percent of patients served by FQHCs in 2022 were either uninsured or publicly insured and 90 percent had income at or below 200 percent of the federal poverty line.[16] Given their patient population and reach, health centers are well-positioned to increase access to and reduce inequities in MOUD treatment.

About Funding for Federally Qualified Health Centers

FQHCs have a unique funding model that primarily includes revenue generated through:

- **Prospective Payment System (PPS)**, a specific payment system for Medicare, Medicaid, CHIP, and Qualified Health Plans under the Affordable Care Act, that ties payments to the costs of services.[12]

- **Section 330 Grants**, which support ongoing operations of health centers and are authorized under Section 330 of the Public Health Service Act. Section 330 grants are issued by the Health Resources & Services Administration, through the Community Health Center Fund and annual appropriations. To qualify for a 330 grant, health centers must meet certain requirements, such as using an income-based fee scale.

Additional FQHC funding might include: private insurance reimbursement, state, local, and private grants, Title X, other federal grants, and contracts with the Veterans Administration or state and local corrections authorities.[13]

---

† For more information on Opioid Treatment Programs see: https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program.

FQHCs are making progress in providing MOUD. National surveys taken in 2018 and 2019 of a representative sample of community health centers found that the percentage of health centers offering MOUD increased from 48 to 64 percent.[17] In 2019, of health centers offering MOUD, buprenorphine was most commonly provided in 89 percent, while 69 percent reported offering naltrexone, and seven percent reported offering methadone.[18] Health centers in Medicaid expansion states were more likely to provide MOUD than health centers in Medicaid non-expansion states (70 percent and 50 percent, respectively).[19]

To identify opportunities to increase access to MOUD in FQHCs, the Center for Health Care Strategies (CHCS) and The Pew Charitable Trusts conducted an environmental scan exploring opportunities and challenges to offering MOUD within health centers. The national scan included a literature review and interviews with stakeholders working in state and federal policy, FQHCs, and state primary care associations. In addition, CHCS interviewed staff at four additional health centers located in diverse communities across the country about how they adopted MOUD and in many cases, leveraged partnerships to bolster their programs. Based on these findings, this report summarizes select barriers and facilitators to providing MOUD at FQHCs. It outlines opportunities for health centers and state and federal policymakers to support the clinical, organizational, and financial capacity of health centers to increase access to MOUD in these settings.

The report is organized under three key areas of opportunity:

- **Community Health Center-Level Opportunities**
- **State-Level Opportunities**
- **Federal-Level Opportunities**

See also the companion *Integration of Medications for Opioid Use Disorder at FQHCs* case study series that explores how four FQHCs in various settings across the nation are integrating medications for OUD treatment into clinical practice.

Community Health Center-Level Opportunities

Provider-level and organizational factors, including management practices, climate, and culture are directly linked to successful MOUD implementation.[20] Following are opportunities for FQHCs to prepare their staff to work more effectively with people who use drugs, offer MOUD, and create a culture that both facilitates access and engagement in care and promotes access to MOUD and related services and supports.

- **Provide staff education and training on OUD and other SUDs to reduce stigma and increase knowledge.** Stigma toward OUD is prevalent within the health care system, impacting access to adequate SUD treatment.[23] Stigma decreases as providers' familiarity with MOUD increases, particularly knowledge of the benefits of medications and addressing common misperceptions.[24] To reduce stigma and promote staff understanding of OUD treatment and SUD in general, health centers can support access to adequate training for care team members and seek opportunities within training sessions to center the voices of people with lived experience of substance use. Interviewees also noted the importance of training staff on polysubstance use, given the rise of polysubstance use related overdose deaths.[25] Health center staff can identify educational opportunities through their clinical associations, state primary care associations and other local provider organizations/networks, and through state agencies and the federal government (see Appendix for select trainings and resources). Trainings and educational opportunities should be tailored to the needs of the community served and include guidance on how to provide culturally and linguistically appropriate care and services to patients.

Medications for Opioid Use Disorder: An Overview

There are three FDA-approved medications primarily used for the treatment of OUD:

- **Buprenorphine**, a partial opioid agonist available in multiple forms that can be prescribed in an office-based setting;

- **Methadone**, a full opioid agonist currently available through certified Opioid Treatment Programs for OUD treatment; and

- **Naltrexone**, an opioid antagonist that can be prescribed in an office-based setting for the treatment of OUD.

Interviewees for this report underscored the importance of patients having access to all types of medications to meet their needs and preferences, including buprenorphine and methadone, which are more effective in preventing overdose and improving retention in treatment than naltrexone, but are also more heavily regulated by the federal government.[21] One study found buprenorphine and methadone were associated with a 76 percent decrease in the risk of overdose at three months and a 59 percent decrease in overdose risk at one year.[22]

- **Promote harm reduction.**
  Harm reduction is a public health approach that encompasses practical evidence-based strategies aimed at decreasing negative consequences of substance use, including death and disease[26] while continually offering opportunities to people who use drugs to engage in treatment.[27]

In-the-Field Case Study

Explore how **El Dorado Community Health Centers** established its MOUD program and leveraged its partnership with a local community coalition to support its staff in understanding OUD, SUD, and evidence-based treatment.

A harm reduction philosophy recognizes that for many people who use drugs, stopping drug use can be an incremental, non-linear process. Harm reduction promotes an approach to care that is non-judgmental, low barrier, and encourages people to engage and remain in care if they reuse or are actively using. Interviewees underscored the importance of health centers adopting both harm reduction's *philosophical* approach to meet people where they are and not penalize patients for drug use (e.g., flexible appointments, same-day access, leveraging people with lived experience to engage people in care), as well as offering harm reduction *services,[28]* (e.g., naloxone distribution, fentanyl and xylazine test strips, sterile syringes and other tools for safer use, overdose safety planning). New users of harm reduction services are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who do not use the services.[29] Access to harm reduction services, like naloxone and fentanyl test strips, can help prevent overdose and overdose deaths.[30,31] Sterile syringes and other tools can reduce the likelihood of acute infections and help prevent the spread of chronic diseases like hepatitis C and HIV. Syringe service programs are associated with an approximately 50 percent reduction in HIV and hepatitis C incidence, and when coupled with MOUD, transmission of these viruses is reduced by more than two-thirds.[32]

- **Provide access to methadone.**
  With few exceptions, current federal laws and regulations limit access to methadone for the treatment of OUD almost exclusively through OTPs , also known as methadone clinics, of which there are over 2,000 in the U.S.[33] Patients travel to OTPs, initially daily,

In-the-Field Case Study

Learn about **VIP Community Services**, an FQHC in the Bronx, New York that operates as an OTP and Certified Community Behavioral Health Clinic offering buprenorphine, methadone, naltrexone, and comprehensive behavioral health care to patients.

to receive their dose of methadone.[‡] This can create access barriers for patients who do not live close to an OTP, who receive medical care at multiple locations (as opposed to having care co-located at one facility), or who have limited access to transportation. Some providers are finding methadone to be more effective than other forms of MOUD for managing withdrawal and cravings for those who use fentanyl, an opioid far more potent than heroin that has contributed to recent increases in opioid-related deaths.[34] However, limited access to OTPs in many communities makes it difficult for patients to obtain methadone. Health centers can consider two ways to make methadone available onsite for their patients. One option is to partner with an OTP to establish a medication unit at the FQHC. A medication unit can be a mobile or non-mobile facility where patients can obtain methadone, while continuing to receive other OUD care services at an OTP.[35] While this arrangement is uncommon, federal rules allow it, and benefits can accrue to both entities: individuals can have ready access to methadone through FQHCs at a less stigmatizing and potentially more convenient setting, and individuals served by OTPs receiving methadone at the health center can more easily access other medical care. A second option is for FQHCs to obtain certification as an OTP through the Substance Abuse and Mental Health Services Administration (SAMHSA) and register with the Drug Enforcement Administration (DEA).[36] This strategy can benefit health centers and the populations they serve, in areas where there are no OTPs with which to partner, which is often the case in rural communities. Establishing medication units is generally a quicker and less labor-intensive route to provide methadone onsite than pursuing OTP certification, but a small number of FQHCs are also licensed as OTPs (for an example, see the VIP Community Services case study). Beyond onsite options for accessing methadone, health centers with OTPs in their communities can establish formal relationships to refer patients for methadone maintenance. This option, however, does require the patient to travel for treatment, which can prove difficult and time and resource intensive, particularly if the OTP is not located near the health center or where the patient resides. It also exposes patients to stigma that can accompany OTPs. Interviewees noted that people often line-up outdoors at these facilities to receive their medication, and patients and facilities can be met with resistance from members of the communities that host these programs.

[‡] Current regulatory framework allows for more flexibility regarding take-home doses of methadone. For more information, see: https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance.

- **Consider partnerships between FQHCs and Certified Community Behavioral Health Clinics.** FQHCs are increasingly partnering with Certified Community Behavioral Health Clinics[37] (CCBHCs) to offer enhanced behavioral health services, including for people with OUD. CCBHCs are a relatively new and growing service model, and currently there are more than 500 CCBHCs nationally.[38] As part of their designation from SAMHSA, these clinics must provide a comprehensive range of mental health and SUD services. As of 2022, 82 percent of CCBHCs directly offer at least one type of MOUD, and 16 percent offer all three forms.[39] Currently 32 percent of CCBHCs report partnering with one or more FQHCs.[40] Interviewees noted that CCBHCs and FQHCs report an array of benefits related to partnering to support patients with OUD. Partnerships between FQHCs and CCBHCs can help both entities better provide whole person care — patients at FQHCs can access specialty behavioral health services from the CCBHC, and patients at the CCBHC can access primary care services at the FQHC. Relatedly, CCBHCs commonly bring deep expertise in SUD specifically, and can support FQHCs in the provision of MOUD and in managing more complex cases among people with polysubstance use or co-occurring serious mental illness and SUD if they do not have the expertise in house. CCBHCs are also required to provide peer services, a critical support for engaging and supporting people with SUD in treatment.[41] Patients at an FQHC that partners with a CCBHC can access these peer services to support them in their care. Beyond partnership, health centers can also pursue CCBHC certification directly.

> **In-the-Field Case Study**
>
> Explore how **Access Family Care**, an FQHC, and **Clark Community Mental Health Center**, a CCBHC, partnered to develop an MOUD program in Southwest Missouri for health center patients with OUD.

- **Address housing instability among patients.** In 2021, health centers served nearly 1.3 million patients facing housing instability or homelessness.[42] Interviewees underscored the importance of stable housing when supporting people with OUD in their recovery, and research has shown that homelessness is associated with higher risks for opioid use and overdose.[43] Health centers can consider strengthening partnerships with local housing and homeless services organizations to build connections to housing resources. They can help ensure

> **In-the-Field Case Study**
>
> **Greater Portland Health**, an FQHC and a Health Care for the Homeless Program in Portland, Maine, provides a comprehensive MOUD program and wrap-around supports for people with OUD and who are also experiencing homelessness.

patients remain on MOUD when residing in a shelter or supportive housing facility, and that these facilities help promote access to MOUD.[44] Health centers serving a high percentage of individuals experiencing homelessness could consider applying for a specialty designation from HRSA to become a Health Care for the Homeless (HCH) grantee.[§] While access to these grants are limited, becoming an HCH grantee provides additional funding to help patients connect with more stable housing and also helps health centers develop MOUD programs and connect with a national network of peers through the National Health Care for the Homeless Council. HCH grants also require FQHCs to provide SUD services.[45] As of 2021, around 300 of nearly 1,400 health centers were HCH grantees.[46] National Health Care for the Homeless Council notes that entities that are already designated FQHCs are best positioned to compete for limited HCH grant resources as they are already compliant with HRSA health center requirements.[47]

Learning from Health Care for the Homeless Program on Providing MOUD

Among health centers, HCH programs provide a disproportionately large share of buprenorphine-based treatment. One of the keys to success for HCH programs is the adoption of a more flexible approach to services based on patient needs, rooted in the philosophy of harm reduction. This strategy of low-barrier care can improve access to treatment for all patients and be adopted by other FQHCs. This includes offering walk-in appointments, using nurse-driven models of care, and providing care outside clinic walls through outreach services (e.g., street medicine). For additional information on this topic, see:

- **Addressing the Opioid Crisis: Medication-Assisted Treatment at Health Care for the Homeless Programs**

- **Medication-Assisted Treatment (MAT) for Opioid Use Disorder for People Experiencing Homelessness**

[§] For more information on the Health Care for the Homeless Program, see: https://nhchc.org/wp-content/uploads/2021/04/How-to-become-an-HCH.Final_.pdf.

State-Level Opportunities

States can use a variety of policy and program levers to support FQHCs in providing OUD treatment. Opportunities for states generally fall within three areas, as described below: (1) funding and reimbursement strategies; (2) workforce development and partnership supports; and (3) reviewing and amending regulations and policies that may impede access to MOUD.

Funding and Reimbursement

- **Engage health centers to discuss prospective payment system (PPS) rates and/or alternative payment models.** As required under federal law, Medicaid reimburses FQHCs through an encounter-based PPS that offers a bundled rate for each primary care visit — no matter the service type or intensity.[48] In calculating site-specific PPS rates, states account for all services in an FQHC's scope that are covered by Medicaid. The PPS rate is based on a scope of services that could include medical and behavioral health care, as well as nonbillable services such as transportation, language translation, care management, and connection to other community services. States and FQHCs (or the primary care associations that represent them) can consider meeting to discuss how PPS factors into decisions about adding new services, such as comprehensive MOUD treatment, and whether alternative payment models could provide better incentives for integration.[49]

- **Incorporate OUD-specific performance measures into payment models for FQHCs.** Some states and Medicaid managed care organizations have value-based payment contracts with FQHCs, noting that value-based payments may not be less than the amount the FQHC is entitled to under the PPS methodology. States may consider including value-based performance measures related to prescribing of MOUD in line with clinical guidelines. Such quality measures could increase access to treatment for patients while better aligning payment incentives to FQHCs for providing such care. Quality measures could account for health disparities and outcomes measures can be disaggregated to detect any disparities by outcome.

- **Leverage opioid settlement funds to support MOUD adoption.** States are determining how to distribute an expected $50 billion in settlement funds from opioid-related lawsuits.[50,51] States are taking different approaches to coordinating across state, local, and community entities allocated or awarded settlement funding dollars, 70 percent of which must be spent on "opioid remediation efforts."[52,53] States and counties can leverage this funding to support the adoption of MOUD throughout the health care safety net. For example, states and counties could invest in infrastructure development to support training and capacity building for providers,

including at health centers looking to provide or currently providing MOUD. Examples could include funding learning collaboratives, mentorship programs, scholarships to SUD training conferences, and covering the costs of virtual and on-site consulting to help clinics overcome implementation barriers.

- **Consider whether payment parity in reimbursement is warranted for OUD-related telehealth and in-person visits.**[54] Recent studies showed that using telehealth during the pandemic helped more patients to start and stay in buprenorphine treatment, and provided increased access to behavioral health services.[55] State Medicaid programs have the authority to reimburse for OUD-related telehealth services at the same payment rate as in-person visits, and they can do so without having to submit a state plan amendment to the Centers for Medicare & Medicaid Services (CMS).[56] Forty-six state Medicaid programs and the District of Columbia issued guidance that expanded access to or coverage of telehealth during the COVID-19 pandemic.[57] As of May 2020, Medicaid programs in 38 states and D.C. provided payment parity for some telehealth services, although the extent to which states include OUD services is not clear.[58] States can consider whether it is warranted to establish parity among rates for OUD-related telehealth services (including audio-only visits) and in-person visits, including for buprenorphine induction, which was permitted by the federal government under the COVID-19 public health emergency and is permitted under subsequent extensions.[59] Regardless of the approach a state takes, interviewees underscored the importance of monitoring utilization of both telehealth and in-person visits, ideally disaggregated by race and ethnicity, to ensure equitable access and outcomes.

Workforce and Partnerships

- **Integrate training on OUD/SUD into clinical training and licensing.** As previously mentioned, provider stigma and lack of provider training and education related to SUD, harm reduction, and prescribing medications for SUD including MOUD is a contributing factor to health centers not offering MOUD. Interviewees noted that many providers acknowledge that they do not have the skills or confidence in their ability to provide MOUD, even after completing the previously required eight-hour X-waiver training, and among health centers that do not provide MOUD, many cite limited confidence and skill among providers as a barrier to offering the medications.[60] Effective January 2023, Congress eliminated the X-waiver requirement and patient cap for prescribing buprenorphine, but replaced it with an eight hour training requirement in opioid or other SUD for providers obtaining or renewing a DEA number to prescribe controlled substances.[61] Interviewees underscored the importance of integrating training on MOUD and SUD in medical, nursing, physician assistant, and other clinical programs to help build a provider workforce that has sufficient knowledge and

understanding of treating people with SUD and prescribing MOUD. States might consider incentivizing education on SUD and MOUD and supporting the development of trainings and curriculum alongside other partners. For example, Arizona passed a state law that required public and private medical schools to provide at least three hours of education on OUD to providers whose degree may allow them to dispense drugs regulated by the DEA.[62] Interviewees also acknowledged the importance of state licensing boards facilitating ongoing learning by integrating requirements for coursework on SUD prior to a provider seeking licensure.

- **Leverage grants on SUD to support clinician training and capacity building.**
  Interviewees recommended that states leverage federal grants to support clinician training and capacity building related to providing MOUD. Interviewees underscored challenges related to training clinicians due to the lost patient time and revenue experienced when staff are engaged in training. To ensure that these costs are covered, and that SUD treatment is prioritized by health centers, states could use federal opioid funding or SAMHSA funding to offer specific MOUD implementation grants that would encourage FQHCs to build sustainable programs or augment existing programs. Beyond these grants, interviewees noted the importance of ongoing technical assistance and mentorship (as noted above, federal law requires that providers authorized to prescribe controlled substances complete eight hours of SUD-related training), as opposed to one-time webinars and conferences that were considered to be insufficient. Implementing MOUD programs is a complex adaptive process, and FQHCs will often need intensive virtual or on-site support to navigate common implementation challenges. States can use grant opportunities to support more intensive or ongoing training or learning collaboratives and can work with their local primary care association to do so.

- **Leverage grants to facilitate partnerships.** Interviewees underscored the importance of grants to cover the staff time and resources dedicated to building and formalizing working relationships. For example, Missouri has a history of supporting partnerships between FQHCs and mental health organizations through grants provided by the state Department of Mental Health. The grants are designed to promote primary care and behavioral health service integration for people with SUD. In addition to financial support, participating partnerships receive technical support from the state primary care association and behavioral health council.[63,64] States can consider issuing grants to facilitate partnerships between FQHCs and other community entities (e.g., OTPs, CCBHCs, jails) that could augment, serve as a referral source, or support the development of their MOUD programs.

Regulation and Policy

- **Review state policies and regulations that may impede access to OUD treatment.** Interviewees acknowledged that policies and regulations in some states can make it more difficult for patients to receive MOUD in office-based settings, including FQHCs.

  - **Prior Authorization:** Some state Medicaid agencies use utilization management mechanisms to ensure medically necessary use of MOUD outpatient drugs, such as prior authorization.[65] FQHC staff that were interviewed, however, underscored the significant administrative burden of prior authorization and the associated delays in access, potentially leading to reuse. States can consider reducing administrative burdens by removing or reducing prior authorization requirements for the most common and evidence-based forms of MOUD. This follows a trend in recent years among state Medicaid agencies as well as other insurers of reducing or otherwise prohibiting the use of prior authorization for MOUD and can be particularly important given the small window of opportunity providers have to initiate MOUD when a person decides they are ready for treatment.[66]

  - **Counseling Requirements:** While initial best practice suggested that counseling was an important complement to MOUD, current research shows that medication alone lowers OUD overdose deaths and lengthens treatment stays.[67] Some state policies still include counseling requirements as a condition of receiving medication for OUD. While counseling can be a significant help to patients, expert bodies, such as the National Academy of Sciences and the American Society of Addiction Medicine, state that counseling should not be a condition for receiving these medications.[68, 69] States can consider removing counseling requirements as a condition of treatment to remove barriers to accessing MOUD.

  - **Assessments:** Some states require comprehensive medical and behavioral health assessments before prescribing medications for OUD.[70] Requiring a lengthy assessment before prescribing, when not medically necessary, may delay MOUD induction, which could lead to harm or even overdose death, given the limited window of opportunity to engage in treatment once a person decides to pursue it. State policy can be shaped to encourage low-barrier, on-demand treatment. Interviewees noted that assessments are often more accurate after treatment is initiated and withdrawal symptoms have abated.

  - **Licensing:** States vary in their requirements for when a provider organization needs to apply for a specialty SUD license. Interviewees recommended that states review these regulations and, as needed, adjust or clarify them for providers, so it is clear to FQHCs when an SUD license is necessary. States could also consider allowing FQHCs to be deemed as a licensed SUD provider.

- **Scope of Practice Rules:** Each state has a set of scope of practice rules that details the roles and services a credentialed health care provider can legally perform.[71] This leads to variation across states regarding which providers can offer what services. As such, interviewees noted that state licensing boards can seek to clarify to providers, including FQHCs, the scope of practice rules concerning the type of behavioral health counselor allowed to be reimbursed for SUD counseling.

- **Restrictions on Same-Day Billing for Physical and Behavioral Health:** Interviewees also noted that restrictions on same-day billing in FQHCs for medical and behavioral health visits can make it difficult to provide MOUD and related behavioral health supports. Some states still restrict same-day billing for physical and behavioral health services in FQHCs, which was historically implemented to limit fraud, waste, and abuse in the Medicaid program.[72,73] States can take steps to assess these regulations and consider making changes accordingly.

- **Behavioral Health Carve Outs:** Lastly, states that have a behavioral health carve-out can consider encouraging the inclusion of FQHCs in behavioral health organization networks to ensure that FQHCs can seek reimbursement for related services. For example, Colorado's Department of Health Care Policy and Financing has a contract with a behavioral health organization that must offer contracts to FQHCs in their service area.[74] States can also meet with FQHCs to understand if there are administrative barriers that limit them from receiving payments for SUD treatment, and what could be done to make it easier for health centers to participate in SUD treatment networks and seek reimbursement for services.

Federal-Level Opportunities

The federal government plays an important role in increasing access to MOUD through FQHCs, given its role in regulating medications and providing funding support for FQHCs. Interview and research findings underscored the importance of the federal government: (1) creating supplemental funding opportunities for health centers to increase access to MOUD; (2) supporting the use of OUD-specific quality measures; and (3) maintaining flexibility on relevant telehealth policies and clarifying guidance on SUD data sharing.

Funding

- **Consider FQHC-specific grants to build or strengthen MOUD and SUD programs.** HRSA has supported health centers with grants, technical assistance, and training to integrate behavioral health prevention and treatment services into primary care, which includes the provision of MOUD and related counseling services.[75] Interviewees noted that beyond its existing grants, HRSA could consider issuing

grants for health centers to establish new MOUD programs or to augment existing programs. Interviewees suggested that grants could specify required services (e.g., care management) or providers (e.g., peer recovery specialists), and that the federal agency could use grant reporting to better understand the costs associated with OUD and SUD treatment and how it impacts patient outcomes. Information gleaned through these initial grants could inform future investments in this space.

- **Offer supplemental grants to encourage FQHCs to partner with OTPs to launch medication units**. The federal government currently allows FQHCs to qualify as OTP satellite medication units to dispense methadone.[76] HRSA, perhaps in collaboration with SAMHSA, which oversees certification for OTPs, could offer grants to cover staff time involved in FQHCs creating formal partnerships with OTPs that outline a division of responsibility and funding for space, methadone storage requirements, staffing, and coordination of services. These grants could be accompanied by technical assistance to support formation of these relationships, since the arrangements can be complex.

Quality Measurement

- **Include a quality-of-care measure focused on OUD treatment in HRSA's Uniform Data System for FQHCs.** Each year, FQHCs are required to report into the Uniform Data System (UDS), a core data set that includes patient characteristics, services provided, clinical process and health outcomes, number of patients receiving MOUD, and number of providers authorized to prescribe buprenorphine, among other metrics. The UDS also includes quality of care measures related to provision of evidence-based treatment. To encourage FQHCs to provide higher quality care for the treatment of OUD, HRSA could incorporate a quality-of-care measure for OUD treatment (e.g., prescription or administration of pharmacotherapy to treat OUD).[77] It could also stratify and analyze the data by demographic to help ensure more equitable access and outcomes.

Regulations

- **Consider maintaining telehealth flexibilities for buprenorphine induction.** Research conducted during the COVID-19 pandemic found that allowing providers to prescribe buprenorphine via telehealth helped more patients start and stay in treatment and provided increased access to behavioral health services.[78] As of this report being published, the DEA and SAMHSA have issued a Second Temporary Rule Extension that waives the in-person visit requirement for buprenorphine initiation through November 11, 2024 for all patients.[79,80] Interviewees noted that it would benefit patients served by FQHCs to continue to have the option of starting buprenorphine through a telehealth consultation rather solely through an in-person visit.[81,82]

- **Clarify guidance on data sharing for SUD.** Interviewees noted that compliance with 42 CFR Part 2 continues to be a source of confusion for health centers. Many providers report they do not know the circumstances under which the rule — designed to protect the confidentiality of SUD patient records — applies to information-sharing between health care providers. This confusion, according to FQHC interviewees, creates care coordination barriers between medical and behavioral health providers treating SUD, and can dissuade some health centers from treating SUD. In December 2022, SAMHSA released a proposed rule intended to simplify consent form requirements for information-sharing that are part of 42 CFR Part 2.[83] To further ensure understanding, interviewees suggested that a "one-pager" simplifying the language on how patient data can and cannot be shared would ensure more confidence and consistency in interpretation across provider organizations. It would also clarify what can be included on patient problem lists, which provide a summary of patient's current medical issues and history.

Conclusion

FQHCs are uniquely positioned to expand access to MOUD, particularly for individuals most impacted by the opioid epidemic, such as people with low incomes and those who face the greatest disparities in readily accessing MOUD, such as people who identify as Black or African American. While there is widespread consensus that MOUD should be included as part of standard health care services, there are many challenges to making this a reality, such as limited provider training, stigma, financial barriers, and regulations and policies that impede access to MOUD. There are opportunities to overcome these barriers through thoughtful investment in capacity building, education, technical support, and modernizing policies and regulations to support integration. Beyond these opportunities, it is important to underscore the role that Medicaid plays in providing access to SUD treatment for people with OUD who have low incomes, particularly in states that have expanded Medicaid.

The health centers and opportunities highlighted in this report represent an array of approaches to provide MOUD and a range of related services that strengthen treatment outcomes. Opportunities addressed include providing methadone, partnering with CCBHCs and other community providers to jointly serve patients with OUD, and addressing the social needs of patients, particularly housing. This report can inform the activities of FQHCs, states, and the federal government to better position health centers in offering MOUD as a routine part of delivering care and participating in coordinated community efforts to help improve the lives of people with OUD.

• • • • • • •

Appendix: Select Trainings and Resources to Support Clinicians in Providing MOUD

- **Anti-Stigma Toolkit** (Addiction Technology Transfer Center Network) offers guidance for health care professionals on how to understand and combat stigma related to SUD.

- **Buprenorphine Mini-Course: Building on Federal Prescribing Guidance** (American Medical Association, American Society of Addiction Medicine (ASAM), and Shatterproof) is a free, one-hour course to support clinicians on prescribing buprenorphine to people with OUD.

- **Grayken Center for Addiction Training & Technical Assistance at Boston Medical Center** offers education, technical assistance, and capacity building for health care providers and their staff to care for people with SUD, including free pre-recorded and live trainings and a mobile application with interactive clinical algorithms to support providers in offering MOUD.

- **Learning Hub** (National Health Care for the Homeless Council) offers an array of free trainings, webinars, as well as information on regional trainings, conferences, symposiums, and other learning opportunities on harm reduction, effective communication and building trust, neurobiology of addiction, and trauma-informed care, among others.

- **Online training course on OUD treatment** (ASAM) provides clinicians with eight hours of training on offering buprenorphine in an office-based setting at a low cost.

- **Opioid Response Network** provides technical assistance on the opioid and stimulant crisis to states, territories, and other stakeholders.

- **Provider Clinical Support System** (SAMHSA) offers training opportunities and mentoring programs to support clinicians in providing evidence-based prevention and treatment of OUD and chronic pain.

- **Select OUD trainings** (Centers for Disease Control and Prevention) support clinicians in prescribing buprenorphine, assessing and addressing OUD, and using motivational interviewing in patient care, among other topic areas.

- **Zero Overdose** offers trainings on overdose safety planning, particularly for CCBHCs.

ENDNOTES

[1] M. Azadfard, M.R. Huecker, J.M. Leaming. *Opioid Addiction*. Treasure Island, FL: StatPearls Publishing, 2023. Available at: https://www.ncbi.nlm.nih.gov/books/NBK448203/.

[2] J. Baumgartner and D. Radley. The Commonwealth Fund. "Overdose Deaths Declined but Remained Near Record Levels During the First Nine Months of 2022 as States Cope with Synthetic Opioids." March 2023. Available at: https://www.commonwealthfund.org/blog/2023/overdose-deaths-declined-remained-near-record-levels-during-first-nine-months-2022-states.

[3] Centers for Disease Control and Prevention. "Other Drugs." Available at: https://www.cdc.gov/drugoverdose/deaths/other-drugs.html.

[4] Ibid.

[5] National Institute on Drug Abuse. "Xylazine." Available at: https://nida.nih.gov/research-topics/xylazine.

[6] For more information on medication-assisted treatment (MAT), see Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/medications-substance-use-disorders.

[7] National Institute on Drug Abuse. "Medications to Treat Opioid Use Disorder Research Report: How Effective Are Medications to Treat Opioid Use Disorder?" Available at: https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder.

[8] K. Orgera and J. Tolbert. Kaiser Family Foundation. "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment." May 2019. Available at: https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/.

[9] A. Maxwell. U.S. Department of Health and Human Services, Office of Inspector General. "Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns". September 2023. Available at: https://oig.hhs.gov/oei/reports/OEI-BL-22-00260.pdf.

[10] Ibid.

[11] W.C. Goedel, A. Shapiro, M. Cerdá, J.W. Tsai, S.E. Hadland, and B.D.L. Marshall. "Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States." *JAMA Network Open*, 3, no.4 (2020). Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663.

[12] S. Rosenbaum, J. Sharac, P. Shin, and J. Tolbert. Kaiser Family Foundation. "Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained". March 2019. Available at: https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief/.

[13] Ibid.

[14] Bureau of Primary Health Care, HRSA (Heath Resources and Services Administration). "Health Center Program: Impact and Growth." Available at: https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth.

[15] National Association of Community Health Centers. "Community Health Center Chartbook 2020." Available at: https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf.

[16] National Association of Community Health Centers. "Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis." January 2023. Available at: https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf.

[17] B. Corallo, J. Tolbert, J. Sharac, A. Markus, and S. Rosenbaum. Kaiser Family Foundation. "Community Health Centers and Medication-Assisted Treatment for Opioid Use Disorder." August 2020. Available at: https://www.kff.org/report-section/community-health-centers-and-medication-assisted-treatment-for-opioid-use-disorder-issue-brief/.

[18] Ibid.

[19] Ibid.

[20] N. Jacobson, J. Horst, L. Wilcox-Warren, A. Toy, H. Knudsen, R. Brown, et al. "Organizational Facilitators and Barriers to Medication for Opioid Use Disorder Capacity Expansion and Use." *Journal of Behavioral Health Services and Research*, 47, no.4 (2021): 439-448. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7578054/.

[21] Harvard Health Publishing, Harvard Medical School. "Comparing medications to treat opioid use disorder." January 2018. Available at: https://www.health.harvard.edu/blog/comparing-treat-opioid-use-disorder-2018010313021.

[22] S. E. Wakeman, M. R. Larochelle, O. Ameli, C. E. Chaisson, J. T. McPheeters, W. H. Crown, et al. "Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder." *JAMA Network Open,* vol. 3 (2020)*.* Available at: https://pubmed.ncbi.nlm.nih.gov/32022884/.

[23] B. K. Madras, N. J. Ahmad, J. Wen, and J. Sharfstein. "Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers within the Treatment System." *National Academy of Medicine Perspectives 2020*, (2020). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8916813/.

[24] J. Dickson-Gomez, A. Spector, M. Weeks, C. Galletly, M. McDonald, and H. D. G. Montaque. "You're Not Supposed to be on it Forever": Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids." *Substance Abuse: Research and Treatment,* vol. 16 (2022). Available at: https://journals.sagepub.com/doi/full/10.1177/11782218221103859.

[25] Centers for Disease Control and Prevention. "Other Drugs." Available at: https://www.cdc.gov/drugoverdose/deaths/other-drugs.html.

[26] For more information on harm reduction, see: Substance Abuse and Mental Health Services Administration, and National Harm Reduction Coalition. Available at: https://www.samhsa.gov/find-help/harm-reduction; For more information on the principles of harm reduction, see: National Harm Reduction Coalition. Available at: https://harmreduction.org/about-us/principles-of-harm-reduction/.

[27] R. Post, R. Boss, and L. Green. Technical Assistance Collaborative. "Boosting the Power of Harm Reduction: Creating a Comprehensive and Culturally Responsive System of Care Serving People Experiencing Homelessness with Substance Use Disorders." November 2022. Available at: https://www.tacinc.org/wp-content/uploads/2022/11/Boosting_the_Power_of_Harm_Reduction_2022-11-10_FINAL.pdf.

[28] For more information on harm reduction services like syringe services programs, see: National Health Care for the Homeless Council. Available at: https://nhchc.org/wp-content/uploads/2023/06/Health-Centers-SSPs-Final.pdf.

[29] H. Hagan, J.P. McGough, H. Thiede, S. Hopkins, J. Duchin, E.R. Alexander. "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors." *Journal of Substance Abuse Treatment*, 19, no. 3 (2000): 247–252. Available at: https://pubmed.ncbi.nlm.nih.gov/11027894/.

[30] Centers for Disease Control and Prevention. "Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips." Available at: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html.

[31] National Institute on Drug Abuse. "Naloxone for Opioid Overdose: Live-Saving Science." Available at: https://archives.nida.nih.gov/publications/naloxone-opioid-overdose-life-saving-science.

[32] Center for Disease Control and Prevention. "Syringe Services Programs (SSPs) Safety & Effectiveness Summary." Available at: https://www.cdc.gov/ssp/syringe-services-programs-summary.html.

[33] Substance Abuse and Mental Health Services Administration, "Opioid Treatment Program Directory." Available at: https://dpt2.samhsa.gov/treatment/directory.aspx.

[34] Substance Abuse and Mental Health Services Administration. "Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings." June 2021. Available at: https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf; L. Facher. Stat News. "Fentanyl Isn't Just Causing Overdoses. It's Making it Harder to Start Addiction Treatment." November 2022. Available at: https://www.statnews.com/2022/11/16/fentanyl-isnt-just-causing-overdoses-its-making-it-harder-to-start-addiction-treatment/.

[35] Substance Abuse and Mental Health Services Administration. "Certification of Opioid Treatment Programs (OTPs)." Available at: https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program.

[36] Ibid.

[37] For more information on Certified Community Behavioral Health Clinics, see: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/certified-community-behavioral-health-clinics.

[38] National Council for Mental Wellbeing. "What Is a CCBHC?" Available at: https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/.

[39] National Council for Mental Wellbeing. "2022 CCBHC Impact Report." October 2022. Available at: https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/.

[40] Ibid.

[41] For more information on Certified Community Behavioral Health Clinics, see: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/certified-community-behavioral-health-clinics.

[42] Health Care for the Homeless." July 2023. Available at: https://www.nachc.org/resource/health-care-for-the-homeless/.

[43] K. M. Doran, N. Rahai, R. P. McCormack, J. Milian, D. Shelley, J. Rotrosen, et al. "Substance Use and Homelessness Among Emergency Department Patients." *Drug Alcohol Depend*, vol. 188 (2018): 328-333. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6478031/.

[44] Corporation for Supportive Housing. "Supportive Housing and the Opioid Crisis." January 2021. Available at: https://www.csh.org/wp-content/uploads/2021/01/SUPPORTIVE-HOUSING-AND-THE-OPIOID-CRISIS-update.pdf.

[45] National Health Care for the Homeless Council. "So You Want to Start a Health Care for the Homeless Program." April 2021. Available at: https://nhchc.org/wp-content/uploads/2021/04/How-to-become-an-HCH.Final_.pdf.

[46] Ibid.

[47] National Health Care for the Homeless Council. "So You Want to Start a Health Care for the Homeless Program." April 2021. Available at: https://nhchc.org/wp-content/uploads/2021/04/How-to-become-an-HCH.Final_.pdf.

[48] National Association of Chronic Disease Directors. "Federally Qualified Health Centers: Medicaid and Medicare Reimbursement for the National DPP Lifestyle Change Program." March 2022. Available at: https://coveragetoolkit.org/wp-content/uploads/2022/03/FQHCs-Medicaid-and-Medicare-Reimbursement-for-the-National-DPP-Lifestyle-Change-Program.pdf.

[49] California Department of Health Care Services. "Federally Qualified Health Centers Alternative Payment Methodology." Available at: https://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx.

[50] National Academy for State Health Policy. "State Approaches for Distribution of National Opioid Settlement Funding." Available at: https://nashp.org/state-approaches-for-distribution-of-national-opioid-settlement-funding/.

[51] For more information on opioid settlement funds, see: Opioid Settlement Tracker. Available at: https://www.opioidsettlementtracker.com/globalsettlementtracker.

[52] S. Mermin, R. Falkner, and K. Greene. National Academy for State Health Policy. "Understanding Opioid Settlement Spending Plans Across States: Key Components and Approaches." December 2022. Available at: https://nashp.org/understanding-opioid-settlement-spending-plans-across-states-key-components-and-approaches/.

[53] For more information on how states are approaching distribution for national opioid settlement funding, see: National Academy for State Health Policy. Available at: https://nashp.org/state-approaches-for-distribution-of-national-opioid-settlement-funding/.

[54] To support states in implementing telehealth reimbursement policies, the Centers for Medicare & Medicaid Services developed the following toolkit and supplemental resource: (1) State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth – COVID-19 Version; and (2) State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth – COVID-19 Version: Supplement #1.

[55] N. Krawczyk, B.D. Rivera, C. King, and B.C.E. Dooling. "Pandemic Telehealth Flexibilities for Buprenorphine Treatment: A Synthesis of Evidence and Policy Implications for Expanding Opioid Use Disorder Care in the United States." *Health Affairs Scholar*, 1, no. 1 (2023). Available at: https://academic.oup.com/healthaffairsscholar/article/1/1/qxad013/7203714?login=false.

[56] Medicaid. "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies." January 2021. Available at: https://www.medicaid.gov/sites/default/files/2021-01/covid-19-faqs.pdf.

[57] G. Weigel, A. Ramaswamy, L. Sobel, A. Salganicoff, J. Cubanski, and M. Freed. Kaiser Family Foundation. "Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond." May 2020. Available at: https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.

[58] Ibid.

[59] Federal Register, National Archives. "Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications." October 2023. Available at: https://www.federalregister.gov/documents/2023/10/10/2023-22406/second-temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled.

[60] B. Corallo, J. Tolbert, J. Sharac, A. Markus, and S. Rosenbaum. Kaiser Family Foundation. "Community Health Centers and Medication-Assisted Treatment for Opioid Use Disorder." August 2020. Available at: https://www.kff.org/report-section/community-health-centers-and-medication-assisted-treatment-for-opioid-use-disorder-issue-brief/.

[61] For more information on Congress' elimination of the X-waiver requirement, see: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act.

[62] For more information about the Arizona state law on OUD education requirements, see: Arizona Legislature. Available at: https://www.azleg.gov/legtext/53leg/1S/laws/0001.htm.

[63] Missouri Primary Care Association and the Missouri Behavioral Health Council. "Statewide Behavioral Health and Primary Care Integration: The Missouri Experience." June 2021. Available at: https://www.chcs.org/media/Statewide-Behavioral-Health-and-Primary-Care-Integration-The-Missouri-Experience-Updated-1.24.pdf.

[64] Email from Cindy McDannold, Behavioral Health and SUD Program Manager, Missouri Primary Care Association to Jane Koppelman, Senior Officer, The Pew Charitable Trusts on September 20, 2023.

[65] Centers for Medicare and Medicaid Services. "State Health Official Letter – Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment." December 2020. Available at: https://www.medicaid.gov/sites/default/files/2020-12/sho20005_0.pdf.

[66] B. Andraka-Christou, O. Golan, R. Totaram, M. Ohama, B. Saloner, A.J. Gordon, et al. "Prior Authorization Restrictions on Medications for Opioid Use Disorder: Trends in State Laws from 2005 to 2019." *Annals of Medicine*, 55, no.1 (2023): 514-520. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9897778/.

[67] M. Mancher and A. Lesner (Eds.). *Medications for Opioid Use Disorder Save Lives*. Washington DC: National Academies Press, 2019. Available at: https://www.ncbi.nlm.nih.gov/books/NBK541390/#sec_004.

[68] Ibid.

[69] American Society of Addiction Medicine. "The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder—2020 Focused Update." March 2020. Available at: https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline.

[70] B. Connolly and J. Bluestein. The Pew Charitable Trusts. "States Can Reduce Barriers to Prescribing Buprenorphine for Opioid Use Disorder." May 2021. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2021/05/24/states-can-reduce-barriers-to-prescribing-buprenorphine-for-opioid-use-disorder.

[71] Bureau of Health Workforce, HRSA (Heath Resources and Services Administration). "Behavioral Health Workforce, 2023." December 2023. Available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf.

[72] For more information on same day billing restrictions for physical and behavioral health services, see: CCHP (Center for Connected Health Policy). Available at: https://www.cchpca.org/topic/same-day-encounters/.

[73] Truven Health Analytics. "Financing of Behavioral Health Services within Federally Qualified Health Centers." July 2012. Available at: https://www.thenationalcouncil.org/wp-content/uploads/2021/04/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf.

[74] Colorado Department of Health Care Policy and Financing. "State of Colorado Department of Health Care Policy and Financing Contract with Behavioral Healthcare, Inc. for Behavioral Health Services Program." Available at: https://hcpf.colorado.gov/sites/hcpf/files/Behavioral%20Healthcare%20Base%20Contract.pdf.

[75] Bureau of Primary Health Care, HRSA (Heath Resources and Services Administration). "Behavioral Health and Primary Care Integration." Available at: https://bphc.hrsa.gov/technical-assistance/clinical-quality-improvement/behavioral-health-primary-care-integration.

[76] Substance Abuse and Mental Health Services Administration. "Certification of Opioid Treatment Programs (OTPs)." Available at: https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program.

[77] Partnership for Quality Measurement. "Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)." July 2021. Available at: https://p4qm.org/measures/3589.

[78] N. Krawczyk, B.D. Rivera, C. King, and B.C.E. Dooling. "Pandemic Telehealth Flexibilities for Buprenorphine Treatment: A Synthesis of Evidence and Policy Implications for Expanding Opioid Use Disorder Care in the United States." *Health Affairs Scholar*, 1, no. 1 (2023). Available at: https://academic.oup.com/healthaffairsscholar/article/1/1/qxad013/7203714?login=false.

[79] Substance Abuse and Mental Health Services Administration. "DEA, SAMHSA Extend COVID-19 Telemedicine Flexibilities for Prescribing Controlled Medications for Six Months While Considering Comments from the Public." May 2023. Available at: https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications.

[80] M.H. Fernandez-Vina and S. Doyle. "The Temporary Federal Rule on Telehealth Treatment, Explained." The Pew Charitable Trusts. September 2023. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2023/09/14/the-temporary-federal-rule-on-telehealth-treatment-explained.

[81] Substance Abuse and Mental Health Services Administration. "DEA, SAMHSA Extend COVID-19 Telemedicine Flexibilities for Prescribing Controlled Medications for Six Months While Considering Comments from the Public." May 2023. Available at: https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications.

[82] M.H. Fernandez-Vina and S. Doyle. "The Temporary Federal Rule on Telehealth Treatment, Explained." The Pew Charitable Trusts. September 2023. Available at: https://www.pewtrusts.org/en/research-and-analysis/articles/2023/09/14/the-temporary-federal-rule-on-telehealth-treatment-explained.

[83] Federal Register, National Archives. "Confidentiality of Substance Use Disorder (SUD) Patient Records." December 2022. Available at: https://www.federalregister.gov/documents/2022/12/02/2022-25784/confidentiality-of-substance-use-disorder-sud-patient-records.