Bipartisan Policy Center

**VIA ELECTRONIC SUBMISSION**

March 31, 2023

Director Rahul Gupta, MD, MPH, MBA

**RE: Request for Information (RFI) on the 2024 National Drug Control Strategy**

Dear Director Gupta,

The Bipartisan Policy Center (BPC), a nonprofit think tank founded on the principle that government should work for all Americans, is honored to respond to the White House Office of National Drug Control Policy's (ONDCP) 2024 National Drug Control Strategy request for input.

BPC supports bipartisan reforms that will address the opioid crisis, including optimizing federal financing for the continuum of care as well as for detection and surveillance efforts that promote national security. The comments reflect recommendations made in BPC's 2022 report, *Combating the Opioid Crisis: "Smarter Spending" to Enhance the Federal Response*, which focuses on optimizing grant and CMS spending to address the opioid crisis.[1] BPC has also examined how to increase the capacity of primary care providers to deliver behavioral health services, promote new types of behavioral health professionals, build a comprehensive crisis response system, and address border-related issues.[2,3,4,5,6]

BPC commends ONDCP's 2022 National Drug Control Strategy which focused on the supply-side as well as patient care for individuals with opioid use disorder and prevention efforts, particularly for children and youth.[7] BPC is also delighted that ONDCP released a dashboard to track nonfatal overdoses through the Department of Transportation's National Emergency Medical Services Information System (NEMSIS) database, which was similar to prior BPC recommendations to track 911 calls for drug overdoses.[8]

Below you will find BPC's responses organized as follows: Data Collection Plan, Treatment Plan, Counternarcotics Strategy, and Final Thoughts. As BPC's expertise is in data management and treatment, we do not focus as heavily on counternarcotics, but have some recommendations from our immigration and border policy experts on measuring the effectiveness of interdiction efforts and border-focused processes. These BPC staff-developed comments were compiled based on input from advisors, experts, and stakeholders from across every sector of health care. They do not represent official positions of BPC's founders or board of directors.

Bipartisan Policy Center

Sincerely,

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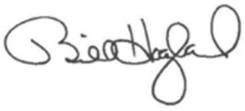

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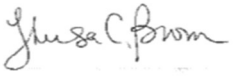

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## DATA COLLECTION PLAN

**Barriers to Data Collection:**

There are structural barriers related to how the federal government makes decisions about mandatory and discretionary spending for patient care, including obtaining appropriate data and defining federal leadership roles. Despite federal data collection processes and systems, they are siloed and do not provide a basis for an informed emergency response.

Barriers to data collection include:

1. **Infrequent and inadequate surveillance metrics.** While tracking mortality is an important and tangible outcome measure, the time lag of 6 to 18 months for data is not conducive to meaningful prevention, treatment, and recovery efforts. Thus, there is a need for additional surveillance and service delivery metrics to better gauge the state of the epidemic in real time.

2. **Government Performance and Results Act (GPRA) measures are burdensome for agencies and grantees.** SAMHSA has been using a set of GPRA measures for decades. These GPRA assessments are collected from agencies combined to evaluate performance and help ensure the continuation of federally funded programs. The measures themselves may be useful, but reports over the years, including a 2010 Senate report, have uncovered that "agencies are collecting a significant amount of information, but are not necessarily using that information to improve their management and results."[9] Programs often treat these measures as a check-the-box exercise that does not lead to meaningful changes, while also imposing a significant administrative burden on grantees.

3. **Federal data systems require updates.** To establish better surveillance and health service delivery metrics, the data collection instruments themselves must be updated. National data sets typically have significant limitations (including higher proportions of missing data, infrequent refreshes, shorter-term outcomes, and lower quality metrics), and for opioid-related health outcomes, there is a pattern of inconsistencies and underreporting that make it difficult to compare outcomes. The data systems for federal grant programs are both outdated and siloed, and agency-specific systems are largely insufficient for capturing the scope of the opioid crisis as the metrics used are too downstream and have significant data lags. As a result, the systems which collect program data are fragmented and contain metrics that are not comparable.

4. **Difficult to assess the proportion of the illicit drug supply that border seizures represent.** For decades, Customs and Border Protection (CBP) has reported on its drug seizures at ports of entry and by Border Patrol between ports of entry or at checkpoints near the border. However, no known metric for "total supply" exists, forcing "drug seizures" to serve as CBP's primary metric. Without this understanding, it has been difficult to measure whether the level of seizures that CBP records is representative of

better interdiction effectiveness or simply an increase in overall smuggling attempts.[10,11,12]

**Recommendations:**

## 1. Establishing Core Metrics

Given the need for better surveillance metrics and more frequent reporting to inform policymakers and guide funding priorities, BPC recommends that ONDCP support federal departments and key agencies, such as CDC and SAMHSA, to ensure that opioid-related programs are collecting "core surveillance" metrics that pull from existing national data sets.

Currently, the primary outcome metric used to understand the scope of the opioid crisis is the CDC's mortality data, which leaves federal agencies and decision-makers with blind spots around prevalence. In lieu of prevalence measures, policymakers use SAMHSA's National Survey on Drug Use and Health (NSDUH) to estimate the number of heroin users across the population, though it is likely a drastic undercount.[13] Both mortality and information about population-wide utilization are useful, but these alone do not enable timely surveillance; thus, the federal response should rely on other data sets besides the NSDUH for this function.

BPC recommends that agencies use measures that are reliable and accurate and are not dependent on voluntary self-reporting to conduct surveillance and assess prevalence.

Core measures for consideration include:

a) **Emergency department (ED) overdoses** from a combined metric that includes:

- The Drug Overdose Surveillance and Epidemiology (DOSE) system[14], a data set managed by the NCHS at the CDC. DOSE collects data from 42 states on syndromic data (contained within are total ED visits and ED visits for suspected opioid-, heroin-, and stimulant-involved overdoses per 10,000 within 48 hours).

- The Healthcare Cost and Utilization Project (HCUP) at the Agency for Healthcare Research and Quality (AHRQ) collects ED overdose visits (entitled "ED treat-and-release") by payer—Medicare, Medicaid, private insurer, uninsured—and opioid-related inpatient stays by payer.

In December 2022, ONDCP began tracking nonfatal overdoses in a dashboard housed through the NEMSIS, which collects information from incidents resulting from EMS activations for emergency care and transport in response to 911 calls for assistance.[15] This dashboard illustrates the most up-to-date information

about the number opioid overdoses within the past 365 days, the percentage difference as a point of comparison, and the average EMS response time over 365 days. Moreover, users can view rates of nonfatal overdoses by state and by county.

ED overdoses from both the DOSE and the HCUP could be cross-referenced with metrics from ONDCP's Non-Fatal Opioid Overdose Surveillance Dashboard to determine a more accurate number of overdoses—especially nonfatal overdoses—and obtain a more accurate understanding of the scope of opioid-related outcomes for those which end up in the ED.

b) **Positive urine tests after intake** from the Arrested Drug Abuse Monitoring (ADAM) Program[16], a survey discontinued in 2014 due to budget cuts, could be re-introduced to gather and report data—including urine samples—from arrestees, who are approximately 50 times more likely to test positive for opioids than the proportion of NSDUH respondents. The data collected via the ADAM has been used in the past to identify prevalence of drug use through isolating a high-risk sample and without relying on self-report. The ADAM program would first be re-established in the former 10 sites: Atlanta, Charlotte, Chicago, Denver, Indianapolis, Minneapolis, New York, Portland, Sacramento, and Washington, DC. These selected sites would provide "geographic spread," with the ability to track regional trends, and maintain consistent, biannual data collection points to note changes over time. This program would need to be funded at least at the 2012 baseline of $10 million per year, with additional resources needed to expand the program to all 50 states.

c) **Rapid sampling methodology for mortality** from the CDC's National Center for Health Statistics' (NCHS) National Vital Statistics System through their Provisional Drug Overdose Death Counts.[17] While being collected and reported currently, this rapid sampling would identify a representative subset of coroners or medical examiners (C/MEs) across all 50 states and the District of Columbia. Currently, the provisional counts are presented for reporting jurisdictions based on measures of data quality: 1) the percentage of records where the manner of death is listed as "pending investigation," 2) the overall completeness of the data, and 3) the percentage of drug overdose death records with specific drugs or drug classes recorded.[18] The NCHS uses data from the counties[19] with higher levels of completeness (at least 90%), while counties with historically low levels of completeness (<90%) contain a footnote. Nevertheless, these metrics include all overdose deaths and do not report drug specificity at the county level.

Given these considerations, the NCHS could identify a selective sample of C/MEs nationwide with 75 counties: two total (one from an urban and one from a rural jurisdiction) from the 24 states whereby the population is at least five million people; and one from each of the 26 states whereby the population is fewer than

five million people, and the District of Columbia.[20] The C/MEs in the selected counties would submit deaths along with toxicology reports immediately to the NCHS, and the NCHS would establish a projection model for deaths along with the Provisional Drug Overdose Death Counts that are already being reported.

d) **Health service delivery metrics:** Better health service delivery metrics are needed to assess the effectiveness of OUD treatment systems.[21] Ideally, these metrics would align across the discretionary programs which fund treatment service as well as CMS claims data in order to compare patient outcomes.[22] There should be timely reporting from both mandatory and discretionary programs with metrics that correspond with progressive stages specific to those already identified as having OUD or post-overdose, including, for example, the following in order:[23]

- **Engagement in care**, or the percentage of individuals with OUD receiving specialty services;
- **MOUD initiation**, which examines the percentage of individuals engaged in care (as noted above) who have received MOUD at least once;
- **Retention**, which notes the percentage of individuals who continue to receive MOUD (as noted above) for at least 180 days; and
- **Remission**, which notes the percentage of individuals who have continued MOUD (as noted above) and who no longer meet the criteria for OUD.

These critical numbers are not available through current reporting. Most importantly, it is difficult to compare behavioral health outcomes in CMS data sets with those collected in the SABG program data, making it difficult for states to truly understand the impact of each funding source.[24] ONDCP should work with the HHS secretary to identify core service delivery" metrics via the T-MSIS, HCUP, and the relevant discretionary data sets (e.g., the SABG data set). CMS has recently added its Core Set of Adult Health Care Quality Measures for Medicaid, which provides an alternative set of health service delivery metrics.[25] The Adult Core Set includes 12 behavioral health measures, including three opioid-specific measures: "Use of Opioids at High Dosage in Persons Without Cancer", "Concurrent Use of Opioids and Benzodiazepines", and "Use of Pharmacotherapy for Opioid Use Disorder".

## 2. Work with SAMHSA to Replace GPRA Measures with "Core Metrics" Using an Existing Office of Management and Budget (OMB) Waiver

As noted previously, many recipients of SAMHSA funding have expressed frustration around collecting and reporting GPRA measures. Collecting these measures distracts from grantees' abilities to use their limited resources to collect data that would better

demonstrate patient outcomes.[26] To circumnavigate this requirement, BPC recommended that agencies—particularly SAMHSA—could submit an OMB waiver in accordance with 2 CFR § 200.102(d), which reads:

*"Federal awarding agencies may request exceptions in support of innovative program designs that apply a risk-based, data-driven framework to alleviate select compliance requirements and hold recipients accountable for good performance."*

This waiver would allow SAMHSA and other relevant agencies to replace the GPRA measures with appropriate "core metrics" as an alternative reporting system.[27,28] Principles which could guide replacing GPRA measures include selecting metrics which have valid and reliable data collection tools, a demonstrated ability to evaluate programs, and capture patient outcomes.

### 3. Guide HHS Agencies to Undergo Relevant System Updates

Although BPC recommended that agencies adopt core metrics, relevant data systems will require updates to support such efforts to align program data. ONDCP can guide agencies to update the systems needed to collect the metrics rapid sampling for mortality, ED visits, and health service delivery.

*Rapid Sampling for Mortality*

Currently, federal programs leverage mortality data for disseminating funds and other program activities. However, Coroners and Medical Examiners (C/MEs) should be required to report mortality more frequently. To implement their rapid sampling technique for mortality, the NCHS would require C/MEs from the 75 selected jurisdictions to report their overdose deaths and toxicology in real time to the CDC Provisional Death Data.[29] Rather than wait seven months or more for these provisional data and one year for the final mortality data, the updated reporting could migrate to the CDC WONDER data set where mortality data are compiled and published, which could then be made available to the general public more frequently. This updated reporting structure would enable the federal government to have a more accurate understanding of deaths from opioid overdoses like they do for COVID-19 and enhance their ability for mortality to be used for surveillance purposes and inform policy.

The timeliness of this data would be critical to both the evaluation of federal opioid spending as well as a main component of the formula for the SOR grant. CDC has existing authority through the NCHS to release public-use data files "as soon as they have been prepared and the necessary reviews have been obtained, including review by the NCHS Disclosure Review Board." NCHS also has existing authority to work with other federal agencies, states, and private nonprofit entities to carry out its work, which allows this expedient release of mortality data.

*ED Visits*

The core surveillance metrics also specify using ED visits through the DOSE and HCUP systems. As it stands, the DOSE system receives data as frequently as every two weeks, but not all states are funded to provide data, and some states have delays in data reporting. For example, the DOSE estimates for nonfatal overdoses during the beginning of the COVID-19 pandemic came from 42 states and did demonstrate a substantial rise in ED visits for suspected overdoses at the same time as a dramatic decline in total ED visits. Ultimately, the function of the NSDUH to gauge population-wide drug use should be replaced by the four core surveillance metrics.

*Health Service Delivery Metrics*

BPC also recommended that HHS agencies collect and align health service delivery metrics, beginning with engagement into care and initiation of MOUD in the short term, followed by retention and remission outcomes. Single State Agencies, the primary recipients of the SOR and SABG programs and health care systems should collect the core health service delivery metrics on a quarterly basis so that they are available in the SABG data set, Transformed Medicaid Statistical Information System (T-MSIS), and HCUP. After integrating these common measures, T-MSIS could then move further to collect the additional five recovery-focused performance measures from SAMHSA's Treatment Episode Data Set (TED): employed/in school full or part-time; in stable housing/living situation; without arrests in prior 30 days; drug use abstinence; and attending social support of recovery programs. This common set of reporting requirements would allow continuous, timely evaluation of the progress of programs and policies addressing the opioid crisis.

4. **Guide CBP and other federal agencies to collect and report better metrics for effectiveness of border interdiction efforts.**

To really assess how effective drug interdiction efforts are at reducing drug availability in the U.S., BPC recommends that CBP report estimates of drug supply alongside the number of drug seizures. At least directionally, the combination of these measurements could give a better understanding of the effectiveness of border interdiction efforts and evaluate expenditures on differing methods. ONDCP could guide CBP and DHS to work with other federal agencies to develop a method for estimating overall drug supply in the U.S. Such a methodology should be based on data collected on interior drug seizures, information gleaned from patients with regard to their usage habit and ability to acquire drugs, intelligence on the street prices of drugs and other data points. While imperfect, without some attempt to understand the total supply in the U.S., policymakers remain unclear about the effectiveness and efficiency of drug interdiction efforts at the border or internationally on specific drugs or overall drug supply and availability in the U.S.

## TREATMENT PLAN

**Barriers to Treatment:**

There are also barriers around access to addiction treatment, both from decisions about funding and regulatory hurdles that limit treatment capacity. Though critical, treatment is just one part of the continuum of care—prevention, treatment, harm reduction, and recovery. Often the resources needed for addiction treatment are spread across the criminal justice system, social welfare agencies, and state and local government.[30] While there are structures in place to administer care, they tend to be siloed, limiting the overall emergency-level response by all levels of government and society.

Barriers to treatment include:

1. **Insufficient and inconsistent SUD coverage, especially for recovery services.** Despite an expansion in insurance coverage for SUD services, there are still coverage gaps for SUD services within Medicaid, Medicare, and Marketplace plans.[31] This can have profound effects on the delivery of treatment and recovery across payers, especially for MOUD. Medicare coverage gaps may have large but predictable nationwide impacts, while Medicaid coverage varies by state. Many state Medicaid programs cover select SUD services, particularly medications.[32,33] However, several of these services often require prior authorization. Recent policy changes to telehealth coverage during and as the result of the COVID-19 pandemic PHE have encouraged CMS to make treatment more accessible via telehealth in their 2023 Physician Fee Schedule. SUD services are included as a Medicaid Essential Health Benefit under the ACA, though the types of SUD services for which this definition extends is not specified.

   Marketplace plans, which are privately operated, are required to cover behavioral health treatment (e.g., psychotherapy and counseling), mental and behavioral health inpatient services, and SUD treatment, including preexisting conditions and at parity with physical health services, under the ACA.[34,35,36] Coverage for these plans may vary by state.[37] With all of the limitations, there is an urgent need to ensure equitable access to care in line with the provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires most health plans to cover treatment for mental health and SUDs no more restrictively than treatment for physical health conditions.[38] Over the years, it has been difficult to enforce compliance with these rules.

   SUD coverage for Medicare and Medicaid also does not extend to include social services critical to prevention and recovery. Evidence suggests that there is a relationship between various social risk factors—namely housing insecurity, low socio-economic status, educational attainment, food insecurity, neighborhood violence (especially during childhood), and poor access to transportation—and increased risk of substance use disorders.[39,40,41,42,43] However, prevention and

recovery services which aim to address these factors are typically not included as a benefit under Medicare and Medicaid.[44,45] The COVID-19 pandemic has certainly exacerbated many risks of OUD/SUD and prompted the need for assistance programs (e.g., rental assistance, stimulus checks) using both discretionary and mandatory dollars.[46,47] As the conclusion of the COVID-19 pandemic PHE nears, experts are grappling with the prospect of confronting future challenges as these assistance programs are phased out, presenting an opportunity to examine the extent to which mandatory programs can support SUD prevention and recovery efforts.

2. **Low reimbursement for SUD services.** While rates vary by state, reimbursement for SUD treatment is lower than for comparable behavioral health services (e.g., mental health treatment, family and marriage therapy). The ability to reimburse at a higher rate is impeded by the historically widespread use of generic or inaccurate coding which do not provide an accurate assessment of SUD service utilization.[48] Billing codes used for services rendered are often inconsistent and sometimes coded as SUD treatment, but more often coded under generic codes.[49] Updates to the Medicare Physician Fee Schedule for SUD services in recent years allow for more precise billing codes that more accurately assess and account for OUD patient risk and are pay-for-performance; this would give CMS the ability to better track utilization and expenditures for SUD by levels of care, identify opportunities for expanding reimbursement rates, and could help assess access disparities. Still, adoption of these codes has been slow.

3. **Limited provider capacity.** SUD treatment services are provided by a broad range of practitioners, including physicians, nurses, social workers, psychologists, and many others. Several groups of practitioners, such as SUD counselors and peer support/recovery specialists, are currently not eligible for reimbursement under Medicare, though they must meet training requirements that vary from state to state.[50,51] With the recent removal of the X waiver and the COVID-19 PHE concluding, policymakers can expand opportunities to train more provider types (e.g., primary care physicians) to prescribe MOUD (in-person and via telehealth), and work toward further closing the treatment gap.

4. **Overlap of and gaps in programs across agencies.** Opioid-related discretionary funding streams across the entire federal government include programs with overlapping target populations and program objectives. These programs often exist independently of one another, leaving grantees to quilt together a patchwork of federal funding.[52,53,54] Neither Congress nor other federal leaders have conducted a meaningful gap analysis to identify government-wide areas of duplication and programmatic gaps. This makes it difficult to compare program effectiveness and the geographic equity of these investments, as resources needed to address substance use issues in different areas may not be equitably dispersed.[55]

5. **Insufficient formal collaboration and information sharing between federal**

**agencies and departments.** Agencies across the federal government administering opioid-related programs could benefit tremendously from sharing responsibilities, knowledge, capabilities, and expertise, therefore maximizing the impact of their funding.[56] ONDCP regularly convenes executive branch departments to share information and develop program and policy priorities and could encourage departments and agencies to closely collaborate. HHS recently reestablished its Behavioral Health Coordinating Committee (BHCC), which provides a venue for HHS agencies to collaborate, but little is known about formal, established interdepartmental efforts. Moreover, experts have indicated that this process does not necessarily include the appropriate staff with decision-making authority, resulting in duplication and inefficiencies.[57]

**Recommendations:**

1. **Guide Relevant Agencies to Expand Coverage and Enforce Parity Rules for SUD Treatment**

   The lack of enforcement of parity rules continues to marginalize mental health and substance use services, burden on providers, and limit patient access.[58,59] Thus, ONDCP should guide relevant agencies to enforce parity rules, which would expand OUD/SUD coverage for beneficiaries covered by Medicaid MCOs—the majority of Medicaid beneficiaries—and the Marketplace, as well as the other payers.

   There are several mechanisms ONDCP could support, including:

   - CMS and the Department of Labor (DOL) increase funding for parity enforcement of Employee Retirement Income Security Act (ERISA) plans by the DOL.
   - CMS and the DOL ensure state and federal regulators strengthen enforcement and compliance activities by empowering regulatory agencies to enforce parity laws and require monitoring agencies to regularly report on steps taken to enforce compliance.[60]
   - CMS and the DOL monitor and enforce standards to phase out nonquantitative treatment limitations (NQTLs), processes, or criteria which limit the scope of benefits provided under an insurance plan.[61,62] NQTLs include strategies like formulary design for prescription drugs, prior authorization requirements, and concurrent review of in- and out-of-network services; and they may reveal plans that fail to meet network adequacy, reimbursement, and utilization management of benefits.[63] However, though NQTLs include prior authorizations, rate setting methodologies, and other aspects of managing benefits, they do not have the direct authority over plans that are sold to multiple employers, and the NQTLs lack authority to assess civil monetary penalties.[64,65] Thus, there is an

opportunity to re-examine how enforcement of these rules is authorized and implemented.
- Congress granting the DOL the power to issue civil monetary penalties, which is a key recommendation of former President Obama's Parity Task Force.[66]

ONDCP can also direct CMS to promote the use of Section 1115 waivers for nonmedical services which align with social risk factors and contribute to SUD and addiction to state Medicaid agencies.[67,68,69,70,71] Further, CMS could use various means, including audits and improved reporting, to ensure that with states and waiver recipients are using these funds for interventions most likely to be effective, and that those terms are reviewed and enforced.

Relevant nonmedical services include:

- Housing security
- Transportation
- Employability
- Food security
- Education and school-based health
- Anti-violence[72]

Some states have already begun to use their Section 1115 waivers in this way. One state, California, uses its Section 1115 waivers to coordinate care for high-risk and high-utilizing Medicaid ("MediCal") enrollees, and notes that SUD patients are one of the target populations, though it does not explicitly target non-medical services.[73] North Carolina uses a Section 1115 waivers to pay for nonmedical services, creating an array of available wraparound services for Medicaid beneficiaries in general.[74]

ONDCP could also guide states to use their Section 1115 waivers to relax Medicaid coverage restrictions for incarcerated individuals.[75] The SUPPORT Act of 2018 required the HHS secretary to issue a letter to state Medicaid directors within a year of enactment, but to date, HHS has not released this letter. Congress has appropriately introduced bipartisan legislation to do this (e.g., Medicaid Reentry Act, which enables Medicaid-eligible incarcerated individuals to restart benefits 30 days pre-release)[76] and most recently this has been proposed as part of a larger social spending package. In the absence of these, a handful of states have used their Section 1115 waivers to fund reentry strategies that help individuals before and after incarceration.[77]

### 2. Guide CMS to Increase Medicaid and Medicare Reimbursements for OUD/SUD Treatment

In response to recent billing code changes, ONDCP could guide CMS to provide communications and instructions (e.g., a toolkit[78]) to educate health care providers and administrators of Medicare Advantage and Medicaid MCO plans about the use of SUD-related service billing codes.[79,80,81] This will ensure that there is a shared understanding of which codes are available and incentivized based on higher payments.[82] Currently, with the ways in which generic billing codes are used, it's difficult to determine the expenditures associated with various clinical practices. Moreover, there are minimal efforts to develop pay-for-performance billing codes for SUD services, limiting the ability to link payment with clinical quality.[83]

With rising drug overdose mortality rates, it is important for CMS to leverage the information gleaned from the new billing codes to ensure that the payment reflects the cost of providing SUD services and accurately assess levels of risk. Widespread adoption of these billing codes would also be a critical element in understanding SUD service costs and utilization.[84] CMS could use the codes to assess service delivery patterns, track utilization and expenditures, and increase incentives. OUD/SUD services are not reimbursed as highly as they are for other services under the current Physician Fee Schedule.[85] CMS should review and make adjustments to newer billing codes to ensure that risk adjustments are capturing costs.

3. **Guide HHS to reinstate the time and distance-to-provider standards for Medicaid network adequacy and require additional quantitative measures.**

To ensure that enough behavioral health providers are available to provide services and support primary care providers needing interprofessional consultation, ONDCP could work with the secretary of HHS to make updates to network performance standards across payers and health plans.

In behavioral health integration with primary care, one of the most common reasons primary care physicians express concerns about identifying behavioral health conditions—and therefore providing some level of integrated care—is the lack of available behavioral health providers for both of these purposes. In fact, health plan networks often include participating behavioral health providers who are not taking new patients or have long wait times for appointments. Furthermore, methods for ensuring network adequacy are not standardized and vary significantly. Qualified Health Plans participating in the ACA Marketplaces, for example, are required to identify whether providers are accepting new patients, but Medicaid and Medicare Advantage do not include such requirements. It is therefore no surprise that most behavioral health and primary care providers continue to operate in silos. However, evidence demonstrates that integration is most likely to succeed when financial flexibilities and incentives are present to support services, such as interprofessional consultations, and address patients' holistic needs, such as through the availability of behavioral health providers for referral.[86]

ONDCP could also work with the secretary of HHS to hold health plans accountable for time and distance standards and develop core network performance metrics for application across HHS regulated plans. These metrics should include a defined set of quantifiable measures, such as wait times, providers who are taking on new patients, and those who have not submitted a behavioral health claim during the past six months. Having a core set of network adequacy standards across programs would facilitate compliance for plans subject to parity laws and also align and simplify requirements for insurers that participate in multiple federal programs. SAMHSA and CMS could also fund the development of cultural competency network adequacy and performance measures for behavioral health, as the demographics for addiction patients have begun to shift in recent years as fentanyl has become more pervasive.

4. **Guide the federal government to establish a minimum federal exemption for those convicted of nonviolent crimes to become peer support/recovery specialists, community health workers, or paraprofessionals.**

To allow individuals to become behavioral health support specialists—peer support/recovery specialists, community health workers, and paraprofessionals—ONDCP could outline a minimum federal exemption for those convicted of nonviolent crimes. People in the criminal justice system remain among the most vulnerable because of unmet behavioral health needs.[87] Globally, approximately 30% of males and 51% of females in the criminal justice system suffer from a SUD.[88] Individuals involved in the criminal justice system who are experiencing a substance use disorder, a mental illness, or both have an elevated risk for a myriad of poor health and social outcomes, infectious diseases, hospitalizations, unstable housing, and reimprisonment.[89,90,91]

The relationship between behavioral health conditions and involvement in the criminal justice system is complicated by upstream factors, such as trauma, exposure to violence, and stigma. These factors are further obfuscated by barriers associated with reentering the community (e.g., securing housing, finding employment, reconnecting with family members, avoiding reincarceration), intensifying mistrust toward the numerous institutions involved in people's daily lives.[92] Involving behavioral health support specialists because of their relevant lived experience can be an effective engagement tool.[93,94]

One such program already using this approach is a California-based model called the Transitions Clinic Network (TCN), which integrates formerly incarcerated CHWs into primary care teams.[95] Including the CHWs both builds awareness of the criminal legal system and bridges knowledge gaps in health care among both care teams and patients. This reduces mistrust in the medical system and facilitates patient-provider communication. A study on TCN noted that formerly incarcerated

patients receiving primary care were highly engaged in their care, including chronic disease treatment plans and nonmedical services such as housing.[96]

Some states have already begun allowing behavioral health support specialists with histories of incarceration in certain instances. For example, Texas requires that peer certification entities investigate select disqualifying offenses over specific time intervals. These include capital offenses over one's lifetime, and other offenses such as kidnapping within 15 years preceding the date of application.[97] A report focused on Texas's peer specialist program found improvements across various social indicators (e.g., employment) and criminal behavior.[98] With clear parameters, federal and state entities can control prospective behavioral health support specialists' entry into their fields while benefitting patients.

The federal exemption must balance the desire to protect and assist underserved patients with the benefits of maximizing inclusion. Thus, with states assuming the certification responsibilities, the federal government can craft the exemption to establish a minimum requirement, and states can allow for a wider exemption when appropriate.

- **Prospective behavioral health support specialists with criminal histories can qualify for the federal exemption only if convicted of a nonviolent offense.** To be eligible for the federal exemption, convictions must also be federal; state-level convictions would be automatically disqualified. According to 18 U.S.C. § 16, a "crime of violence" is defined as either an offense whereby an individual uses, attempts to use, or threatens to use physical force, or involves another felony offense that involves substantial risk of physical force against a person or property.[99,100] Examples of nonviolent crimes include property crimes (e.g., burglary and theft), white-collar crimes (e.g., fraud, tax-related crimes), prostitution, gambling and racketeering crimes, bribery, and certain drug and alcohol-related crimes. As many prospective behavioral health support specialists might have SUD and/or drug and alcohol-related offenses, the federal exemption would apply only to relevant federal offenses unless states elect to allow additional exemptions for state-level drug and alcohol offenses.[101]
- **Prospective behavioral health support specialists with criminal histories must reflect patient populations' lived experiences.** Often, similar backgrounds help support specialists serve as real-life role models for formerly incarcerated patients with behavioral health issues, and they aid in fostering connections. However, to be eligible for the federal exemption, the behavioral health support specialist must have a criminal history that aligns with patients' experiences. To ensure this, employers should submit documentation of these similarities to the DOJ. The department, in turn, would approve the employers' documentation of the following: demographics and experiences across patient populations; organizational guidelines about federal hiring legislation; recruitment and onboarding processes; and a hiring justification for the

prospective behavioral health support specialists.

- **Behavioral health support specialists with criminal histories must administer care only in select instances.** The federal exemption for behavioral health support specialists with criminal histories would apply only in instances when both patients and potential staff have a history of incarceration. As an individual's adherence to treatment can vary, so should support specialists' involvement; behavioral health support specialists should accompany providers in an initial intake visit, and continue with follow-up care when an individual is not engaged sufficiently in behavioral health treatment. In follow-up care, behavioral health support specialists would require additional layers of supervision, and work in designated sites to ensure patient safety.

New federal policies regarding criminal history reporting could include an appeal process. This would give behavioral health support specialist applicants the opportunity to advocate for themselves. The prospective support specialists could include efforts they have made, such as recovery leadership, educational or vocational accomplishments, and employment achievements in their appeals processes. If any new evidence surfaces indicating behavioral health support specialists have violated the federal exemption, the state can revoke their certifications.

5. **Guide CMS to clarify that behavioral health support specialists—peer support/recovery specialists, community health workers, and paraprofessionals—can be considered "auxiliary personnel" as noted within the Medicare Physician Fee Schedule.**

Auxiliary personnel, although not neatly defined, must still meet all state-level licensing requirements. As such, ONDCP can guide CMS to consider—either via agency guidance or the next iteration of the Physician Fee Schedule—further clarifying or providing examples of auxiliary behavioral health services that other providers can furnish alongside marriage and family therapists and licensed professional counselors. More specifically, CMS should name peer support/recovery specialists and community health workers as allowable auxiliary personnel, which would be consistent with their actions toward boosting the roles of peer specialists and community health workers. Furthermore, CMS's updated regulations will likely allow for a better, broader understanding of the role that behavioral health support specialists play in improving behavioral health needs in the short and long term. Congress should consider ways to study related outcome data to better understand behavioral health support specialists' impacts, perhaps to expand behavioral health support specialist reimbursement

CMS's Calendar Year 2022 Physician Fee Schedule (PFS) allowed certain practitioners—marriage and family therapists and licensed professional counselors, specifically—to be paid indirectly when they provide services as auxiliary personnel "incident to" and under the direct supervision of the billing physician. CMS permitted these indirect payments and limited their scopes, considering the increased demand for behavioral health services as a result of the COVID-19 pandemic. CMS's Calendar Year 2023 PFS amended this to allow services to be furnished by marriage and family therapists and licensed professional counselors, as auxiliary personnel, under general supervision (as opposed to direct supervision). Operationally, this means that Medicare can cover services provided by marriage and family therapists and licensed professional counselors under the direction and control of a physician; the billing physician does not have to be physically present at the time of service.

### 6. Guide Departments to "Braid" Discretionary Funding Streams by Directing Similar Opioid-related Programs to Collaborate

ONDCP and the OMB, working with executive branch departments, should work to identify opioid-related programs with similar objectives. Congress, through appropriations report language, would coordinate by requiring federal agencies to collaborate around those specific programs.[102]

Once specified in the Appropriations bill, these programs would formally work together. The programs would synchronize the timing of their funding opportunity announcements (FOA) and their grant period of performance, and share expertise, personnel, resources, and data throughout to maximize impact at the grantee level. Executive branch departments which administer similar programs would submit an annual joint memo to the White House so that coordination efforts can be tracked and lessons learned can inform policy guidance (e.g., in the National Drug Control Strategy)[103] and budget priorities (e.g., in the president's budget).

### 7. Improve Interdepartmental and Intradepartmental Collaboration

In their effort to reduce government-wide fragmentation, the HHS secretary and ONDCP Director should foster greater intradepartmental and interdepartmental collaboration, respectively, on opioid prevention, harm reduction, treatment, and recovery activities. This collaboration should go beyond simply partnering to "braid" similar funding streams to also coordinating opioid-related activities (see Appendix A: Potential Federal Partnerships to Enhance Treatment Capacity). The extent to which this is presently occurring is unclear.[104] HHS's Strategy for Overdose Prevention notes a lack of coordination within HHS.[105] Appendix A outlines a list of potential partnerships that ONDCP might facilitate.

## 8. Guide Agencies to Provide States with Technical Assistance

States and federal agencies can better collaborate so that federal agencies can better administer technical assistance. BPC recommended that SAMHSA, for example, strengthen their Division of Services Improvement and the Division of State and Community Assistance within its Center for Substance Abuse Treatment (CSAT) to better serve state departments of health by reintroducing these processes and structures. ONDCP could guide federal agencies to offer more individualized attention to states, giving grantees an opportunity to provide continuous feedback on the training and technical assistance that they receive. Federal agencies would be able to offer expanded training, technical assistance, and program management capacity; and states would thus be able to provide input on programmatic direction and receive customized guidance from agency leaders, and share state-level best practices.[106 107,108,109,110,111,112]

ONDCP could also guide agencies to provide technical assistance to direct opioid settlement funding. Recently, states have begun to receive billions of dollars in additional funding through the various opioid settlements from drug manufacturers. Although state recipients are thinking proactively about how to effectively use these settlement funds, there is still a need for some regular guidance to help ensure funded efforts do not produce stagnant or worsened health outcomes. In 2021, ONDCP did release a model law for state legislatures to help ensure opioid litigation settlement funds address addiction and overdose to avoid missed opportunities from past tobacco settlements.[113] State and local entities would need to identify ways to use settlement funds without duplicating any federal grant funding, both through using funds for evidence-based programs and to ensure that states and localities have the infrastructure to bring in additional funding sources after the settlement periods conclude. Technical assistance that federal agencies provide may help states determine where funds are already being used, how they could use settlement funding to supplement federal funding, and how they could use settlement funding to build an infrastructure to strength states' ability to bring in more federal grant funding.

## COUNTERNARCOTICS STRATEGY

### Barriers to Counternarcotics Activities

In recent years, a likely rise in fentanyl supply has inspired lawmakers to focus heavily on regulation of fentanyl inside the U.S. and interdiction of fentanyl, particularly with respect to fentanyl trafficking from other countries. In 2022, the U.S. Commission on Combating Synthetic Opioid Trafficking released recommendations to enhance policy coordination and implementation, reduce supply, reduce demand and promote public health, encourage international cooperation, and promote research and monitoring efforts.[114] This bipartisan report demonstrates that there is an urgent need for addressing the opioid crisis by targeting supply, and to prevent it from continuing to increase. Partisan politics have divided lawmakers on the Hill and in the Biden Administration on potential solutions that target the fentanyl supply with international origins.

A barrier to counternarcotics activities include:

1. **Border migration management and drug interdiction efforts are intermingled, harming solutions-oriented discussions for both.** As the U.S. has responded over the last decade to the unprecedented arrival of millions of asylum-seeking migrants, pressures on the government to address that crisis as well as the fentanyl and broader drug crisis have muddied the debate to a point where understanding solutions needed for either are missing.[115] Federal officials know that the majority of fentanyl and most other drug seizures happen at ports of entry along the Southwest border, and most indictments and convictions for border drug smuggling are of U.S. citizens, not migrants. Asylum-seeking migrants who turn themselves in to border agents are often not smuggling drugs.[116,117] However, border agents must still take them into custody and transport them for processing, which has pulled agents away from border surveillance and interdiction. Even with increased resources provided to border operations, the significant increase in migration has resulted in allocation of personnel and resources toward migration management and away from other border law enforcement efforts.[118]

### Recommendation

1. **Border interdiction efforts need to be separated, rhetorically and operationally from migration management.** As currently configured, migration at the U.S.-Mexico border is not known to be a significant vector for the smuggling of drugs to the U.S. Yet, Congress and the public are merging these issues together, frustrating the search for solutions to both. To address the rhetorical issue, ONDCP could pointedly clarify these dual roles and the needs of both, without further exacerbating the intermingling of these important missions.

BPC recommended managing these two issues separately, both to improve humane management of migration flows, but also to allow border agents to return to their law enforcement missions.

- By moving migration management efforts for asylum seekers away from Border Patrol after encountering migrants, especially those who pose no security or smuggling threat, it frees up Border Patrol agents to focus on specialized tasks.
- While acknowledging the important role that Border Patrol plays in counternarcotics enforcement at the border, the biggest "bang for the buck" is to improve detection and interdiction capabilities at the border by investing in personnel, technology, infrastructure, in particular at ports of entry and border patrol checkpoints, where most seizures occur.
- Finally, CBP needs to expand the resources devoted to processing asylum-seekers and migrants at ports of entry while it is expanding nonintrusive inspection technology at ports of entry to ensure that the two missions do not interfere with each other.

As new fentanyl detection technologies are deployed, CBP must monitor the potential health effects both on the drivers and passengers in vehicles, but also the potential to impact smuggled migrants in commercial vehicles while agents deploy these technologies to search for contraband narcotics.

## FINAL THOUGHTS

While there are designated federal leaders to guide aspects of the opioid crisis response, executive branch-wide governance and leadership to foster coordination could be improved. ONDCP is uniquely positioned to inform federal funding priorities through the National Drug Control Strategy by operating as a "center of excellence."

**There is no standard congressional or executive branch process for determining opioid-related program effectiveness.** With federal opioid-related discretionary spending at an all-time high, Congress does not have processes for revising, replacing, and/or eliminating programs that are not demonstrating positive impacts on health outcomes. Meanwhile, executive branch departments that must implement congressionally authorized and funded programs would benefit from a regular, standardized process to help them determine overall program effectiveness.

**BPC recommends that ONDCP operate as a "center of excellence" for drug control policy and federal coordination.** ONDCP is well-positioned to provide policy guidance to Congress, the executive branch, and federal Departments and agencies. To fulfill its leadership role, ONDCP should collect information from various sources to catalogue evidence-based opioid-related programs that merit continued federal support.[119,120] ONDCP should model its process of providing evidence-based recommendations to OMB on that used by the Office of Science and Technology Policy (OSTP), which advises the White House on the scientific and technological aspects of numerous policy areas. ONDCP should help synthesize information about program effectiveness and assist agencies in providing guidance to states as they use this information to identify and fill service/coverage gaps. Furthermore, based on this process and their understanding of both federally funded opioid-related programs and emerging evidence, ONDCP and HHS should incorporate relevant, proven evidence-based program approaches into a new data set/registry to serve as a "menu" for evidence-based practices which could eventually be implemented by federal grantees.[121]

**We also recommend Congress leverage the National Drug Control Strategy for congressional oversight.** Congress should use the National Drug Control Strategy that ONDCP develops as a stencil for establishing funding priorities. The Constitution grants congressional committees the authority to conduct oversight, meaning that Congress has the responsibility to monitor and change actions of the executive branch and federal agencies in order to prevent fraud, waste, and abuse; maintain a degree of accountability; and protect the rights and civil liberties of the American people. The National Drug Control Strategy uses evidence from the research field in the final product, which gives Congress opportunities to weigh evidence-based and stakeholder-driven priorities in their funding decision-making.

BPC is grateful for the opportunity to respond to this critical request. We applaud ONDCP's efforts to develop the 2024 National Drug Control Strategy and expect Congress to leverage it as a stencil for establishing future federal funding priorities.

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## APPENDIX A: POTENTIAL FEDERAL PARTNERSHIPS TO ENHANCE TREATMENT CAPACITY

| | Federal Partnership | Synergies |
|---|---|---|
| *HHS Interagency Partnership* | SAMHSA and CDC | SAMHSA should collaborate with the CDC to design and implement behavioral health surveillance programs; and coordinate harm reduction services (e.g., syringe service programs). |
| | SAMHSA and CMS | SAMHSA should partner with CMS to identify additional services that could be covered by insurance and tracked, especially those which focus on harm reduction (naloxone; syringe services; fentanyl test strips, etc.); and determine clinical effectiveness for various SUD treatments. |
| | SAMHSA and HRSA | SAMHSA should partner with HRSA to expand and improve the behavioral health workforce; coordinate behavioral health services in outpatient settings such as Federally Qualified Health Centers (FQHCs); and bolster the community networks necessary for SAMHSA's Certified Community Behavioral Health Clinics (CCBHCs). |
| | CDC and CMS | CMS should partner with the CDC (and state health departments) to further identify state-level trends in patient outcomes and evaluate SUD clinical activities (including health care costs); and build more cohesive working relationships to fill coverage gaps. |
| | SAMHSA and IHS | IHS and SAMHSA should work together to ensure that culturally appropriate behavioral health services (e.g., expanding CCBHCs to tribal jurisdictions) are accessible to Tribal populations, a traditionally hard-to-reach and underserved population. |
| | SAMHSA and NIH | SAMHSA should collaborate with the NIH (primarily but not exclusively NIDA, NIAAA and NIMH) to both integrate emerging research findings into OUD/SUD programs and offer access to real-world settings in order to study the scalability of promising and finalized evidence-based interventions. |

| | |
|---|---|
| FDA and CMS | CMS should work with the FDA to monitor prescribing activity through claims data. This process should be viewed through the lens of newly released CDC opioids prescribing guidelines. |
| CMS and HRSA | HRSA should partner with CMS to ensure that there is a sustainable pipeline of health care professionals and expand Medicaid coverage in FQHCs by aligning FQHC incentives with SBIRT billing codes. |
| FDA and CMS | CMS should work with the FDA to monitor prescribing activity through claims data. This process should be viewed through the lens of newly released CDC opioids prescribing guidelines. |
| IHS and HRSA | The IHS and HRSA should partner to expand access to outpatient settings such as FQHCs, bolster the health care workforce within IHS facilities, including through tailored recruitment, retention, and training programs, and reach Native Americans living with jurisdictional barriers unique to Tribal Nations. |
| IHS and DOJ | IHS and DOJ should work together to ensure that culturally appropriate behavioral health services are accessible to Native populations under justice supervision. This work should be informed by and possibly integrated with collaborative work undertaken within HHS, between IHS and SAMHSA. |
| CMS and DOJ | DOJ should work with CMS to adjust to new prescribing guidelines as the COVID-19 PHE concludes; ensure that incarcerated individuals receive high-quality SUD treatment services while institutionalized; and expand Medicaid coverage to potential beneficiaries once released. |
| DHS and CDC | DHS and the CDC should partner to design and conduct fentanyl surveillance to monitor international trafficking and epidemiological trends. DHS should be able to alert the CDC of supply shifts geographically tied to morbidity and mortality; while the CDC should be able to identify additional risk factors and opportunities for intervention. It is important to note that **there is not a causal link** between immigration activities and overdoses, but this partnership would promote more comprehensive surveillance. |

*Interdepartmental Partnership*

| | |
|---|---|
| HRSA and VA | The VA and HRSA should partner to expand patient access to outpatient SUD services, through providers such as FQHCs. This is especially important in areas located far away from VA clinics, and could yield significant increases in overall patient access to quality services. |
| DOJ and ACF | The DOJ and ACF should partner to assess potential overlaps in the populations their programs are designed to reach. This review can identify and address risks in these populations and enhance prevention efforts that support at-risk youth. |

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