

## Improving Access to Opioid Use Disorder Treatment in Kentucky

In March 2021, the Pew Charitable Trusts (Pew) was invited to provide the Commonwealth of Kentucky with technical assistance on its substance use disorder (SUD) programs and policies and provide a set of policy recommendations. To better understand the strengths and gaps in Kentucky's treatment system, Pew met with more than 100 key stakeholders, analyzed available federal and state data, and reviewed the current legal and regulatory landscape.

The scope of this memo is treatment for opioid use disorder (OUD), including expanding access to medications for opioid use disorders (MOUD) and behavioral therapy, particularly for justice-involved individuals who would benefit from diversion from jail to substance use treatment.

By way of this memo, Pew provides 12 policy options categorized by four domains that will build on Kentucky's efforts to address the opioid crisis and may result in measurable improvements in access to MOUD:

### *Create a robust statewide diversion program that links patients with quality treatment*

1. The General Assembly should consider revisions to Kentucky Revised Statutes (KRS) 533.250 to make eligibility for pre-trial diversion more inclusive for people who would benefit from substance use disorder treatment. Access to pre-trial diversion should be automatic to ensure equitable access across the Commonwealth.
2. The General Assembly should consider requiring a pre-trial uniform SUD clinical assessment and referral process for individuals to divert people with SUD to treatment services in the community. This assessment and referral process should be conducted by Medicaid-eligible providers and occur while Medicaid can still reimburse for services prior to booking.
3. The General Assembly should consider funding MOUD pilots in rural and urban jails to include MOUD initiation, maintenance throughout an individual's jail stay, and connection to a community-based provider to upon release.

### *Eliminate barriers to MOUD in community-based treatment*

4. The Department for Medicaid Services (DMS) should revise its Medicaid targeted case management code to support team-based care coordination services among primary care providers and other non-specialty SUD treatment providers for people with moderate to severe SUD.
5. The Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) should revise its Opioid Treatment Program (OTP) regulations to ensure they are no more restrictive than federal requirements.
6. DMS should require all providers billing for SUD services to report payer mix to promote quality and address concerns about the proliferation of cash clinics.
7. DBHDID should revise its licensure requirements for residential treatment facilities that offer services to people with OUD to require that they offer at least one partial or full opioid agonist medication onsite.

*Expand access to treatment for pregnant and parenting people and individuals in rural areas*

8. The Kentucky Board of Medical Licensure (KBML) and Kentucky Board of Nursing (KBN) should revise their regulations to align with federal guidelines and best practices.
9. DMS should extend pregnancy-related Medicaid coverage to 12 months after delivery through either a state plan amendment or an 1115 waiver.
10. DBHDID should begin mobile OTP units and increase the number of mobile buprenorphine units.

*Expand access to wraparound/ recovery support services*

11. DBHDID should extend its existing revolving loan fund to allow access to those funds by any recovery residence, prioritizing residences that serve people with SUD diverted pretrial or with previous criminal justice involvement. Recovery houses participating in this revolving loan fund should be required to meet National Alliance for Recovery Residences (NARR) certification standards and accept people who are on MOUD.
12. Kentucky should distribute naloxone to individuals upon release from jail or residential facilities.

Building off these policy options, Pew has also identified three areas that Kentucky should prioritize for monitoring and evaluation:

1. Reducing jail populations through equitable and effective diversion.
2. Integrating and expanding MOUD through targeted case management.
3. Improving child outcomes and reducing maternal mortality through MOUD and extended Medicaid coverage.

See Attachment 1 for more details on how Kentucky could implement these evaluations.

***Opioid Use Disorder treatment for criminal justice-involved individuals***

The [most effective therapy](#) for people with OUD involves the use of Food and Drug Administration (FDA)-approved medications—methadone, buprenorphine, and naltrexone. Despite evidence that this approach, known as MOUD, reduces relapse and saves lives, [the vast majority of jails and prisons do not offer this treatment](#). Medications are proven highly effective at reducing risk for overdose, illicit drug use, and infectious disease spread.

Data from [2007-2009](#) (the most recent available) showed that more than half of individuals in state prisons or those with jail sentences—compared to 5% of adults in the general population—met the criteria for a non-alcohol and nicotine-related SUD ([drug dependence or abuse](#)).

The criminal justice system provides an opportunity to connect patients with OUD to needed treatment; however, support for MOUD is inadequate. Historically, more emphasis has been placed on drug-free treatment although evidence demonstrating the effectiveness of that approach is limited.

Since SUD is a medical condition and best treated by medical professionals, diverting people with SUD from criminal justice settings to appropriate community-based treatment services is critical to improving health outcomes and reducing overdose and death. When diversion is not available, providing adequate, clinically appropriate treatment in criminal justice settings, as well as ensuring continuity of care for patients moving from these settings to community-based treatment, is also a critical component in addressing a public health crisis that resulted in [more than 49,000 opioid overdose deaths in](#) 2019. For example, a [2010 study](#) found that less than 1% of justice-involved individuals received MOUD while in the criminal justice system.

Upon diversion or reentry from the justice system, factors like discrimination and stigma, treatment access and quality, connection to wraparound services, and availability of MOUD-friendly recovery housing can affect retention and success in treatment.

### ***Kentucky's 1115 waiver and Medicaid coverage for the jail population***

One prominent limitation to treating justice-involved individuals is the Centers for Medicare & Medicaid Services' (CMS) inmate exclusion policy, which prevents jails and prisons from using Medicaid funds for individuals in custody. Pew is closely monitoring the [Medicaid Reentry Act](#), federal legislation which would for the first time allow Medicaid to cover medical care 30 days before release and is under active consideration in Congress.

Additionally, [Kentucky's](#) 1115 waiver proposes that Medicaid reimburse for the SUD care of eligible individuals in custody. Although Kentucky and several other states have asked CMS to waive the inmate exclusion policy, CMS has not previously approved such a waiver. The precedent-setting nature of the waiver may mean that CMS will take additional time to complete its review of Kentucky's waiver, and make changes to the state's request. For this reason, until CMS renders a determination, Pew cautions against making decisions that are predicated on the policies proposed in the waiver taking effect.

### ***Create a robust statewide diversion program that links patients with quality treatment***

**Policy Option 1:** The General Assembly should consider revisions to KRS 533.250 to make eligibility for pre-trial diversion more inclusive for people who would benefit from substance use treatment. Eligibility for pre-trial diversion should be automatic to ensure equitable access across the Commonwealth.

**State Example:** Through [legislation](#), [Louisiana](#) made certain offenses, like drug possession of schedule I or II substances, eligible for diversion.

**Rationale:** [Kentucky statute](#) restricts pre-trial eligibility to people without any felony convictions in any state over the past ten years. Individuals who committed a felony over ten years ago but served probation or parole within the past decade for that offense would also be excluded. This restriction prevents a significant number of people with SUD from accessing diversion to treatment services that could reduce their risk of relapse, overdose, and death, and reduce the chance of recidivism. According to an analysis from the Administrative Office of the Courts (AOC), using 2018 data,

most of the pretrial population is held on nonviolent Class D felony charges, despite low to moderate risk for new criminal activity. Moreover, in 2017, 38% of offenders in Kentucky were sentenced for drug offenses and almost half of all cases were related to drug possession. Diverting individuals with drug possession charges from the justice system could [produce savings](#) for the Commonwealth, reduce jail-overcrowding, and connect individuals with SUD to potentially life-saving care.

DMS submitted a [section 1115 waiver](#) to CMS to allow prisons and jails to bill for treatment services for people with SUD while they are incarcerated. Although this waiver is still being considered by CMS, eligibility for participation is based on KRS 533.250, which would bar many people with SUD in Kentucky's prisons and jails.

**Policy Option 2:** The General Assembly should consider requiring a pre-trial uniform SUD screening, clinical assessment, and referral process for individuals to divert people with SUD to treatment services in the community. This assessment and referral process should be conducted by Medicaid-eligible providers and occur while Medicaid can still reimburse for services prior to booking.

*Rationale:* Kentucky does not have a uniform clinical assessment process for people with SUD that encounter the criminal justice system and use of American Society of Addiction Medicine (ASAM) assessments is limited. The [ASAM criteria](#) is a patient placement tool that is used to determine what treatment is most clinically appropriate for an individual with substance use disorder. The ASAM Criteria is the most widely used and accepted clinical tool for evaluating people with SUD for service needs.

For individuals who are diverted from the criminal justice system based on their SUD, there is no direct connection to clinically appropriate treatment through the use of a clinical assessment such as ASAM. Pre-trial diversion eligibility is not automatic, but is based on the decisions of law enforcement, prosecutors, and judges of each jurisdiction. During Pew's system assessment, stakeholders noted that referrals without a clinical assessment from the justice system to abstinence-based residential treatment were common, even though outpatient treatment is clinically appropriate for most individuals with OUD. Only a small number of residential treatment providers in Kentucky offer agonist or partial agonist medications.

It is important that the state set up a statewide diversion program for people with SUD that is available equally regardless of jurisdiction to the broadest possible population of people with SUD that encounter the criminal justice system, connects people directly to treatment providers based on a clinically appropriate assessment conducted by a Medicaid-eligible provider, and is sustainable by ensuring Medicaid can pay for the assessment and community-based treatment services. [Research shows](#) prosecutors are more likely to offer less punitive plea offers, like diversion, to white defendants than defendants of color, with all other factors, like prior record or seriousness of offense, being equal. During Pew's system assessment, stakeholders expressed that fees associated with diversion pose a major barrier to treatment and undermine equity. The General Assembly should consider eliminating fees for participating in diversion, since cost and inability to pay deter people from entering treatment.

Standardizing the assessment, having referral occur earlier in the booking process, making diversion eligibility automatic, and reducing or eliminating fees associated with participation in diversion programs could help reduce racial disparities and help people avoid future justice involvement. To ensure that diversion is offered equitably, Kentucky should collect demographic data, such as race, ethnicity, language, gender, and age as part of the screening and assessment process. The AOC should regularly review this data to identify and swiftly address any inequities in the diversion program.

States cannot use Medicaid funds for anyone “held involuntarily through operation of law enforcement authorities in a public institution,” which means that for a person to be Medicaid covered, an ASAM assessment and referral to care would have to occur prior to booking. A clinician, instead of jail staff, would have to conduct the assessment. Kentucky can leverage its certified community behavioral health clinics (CCBHCs) to provide these services and serve as 24-hour access points for care, as well as other community-based providers such as federally qualified health centers (FQHCs) or community mental health centers (CMHCs). Telehealth and mobile services can also be leveraged in situations where there is no nearby community-based provider.

The Commonwealth could offer training to court, law enforcement, and correctional staff to support the implementation of diversion policies in all jurisdictions. These trainings should include education on OUD and MOUD.

Kentucky should also consider providing funding to link data on diversion participation with Medicaid claims to understand and evaluate the long-term treatment outcomes of participants. See Attachment 1 for more detail.

**Policy Option 3:** The General Assembly should consider funding MOUD pilots in rural and urban jails to include MOUD initiation, maintenance throughout an individual's jail stay, and connection to a community-based provider to upon release.

**State Example:**

- **Wisconsin:** In 2019, Wisconsin passed [Act 119](#), which required the Department of Health Services, after consulting with the Department of Corrections, to assess its local jails and state prisons for the availability of behavioral health counseling on premises, the number of rooms available for inpatient withdrawal management, and the availability of MOUD. The Departments identified a facility for a pilot and [submitted a proposal](#) to the budget and appropriations committee.

*Rationale:* During Pew’s system assessment, stakeholders raised the lack of MOUD access in Kentucky’s jails as a significant gap in the treatment system. While MOUD is the standard of care for OUD, regardless of treatment setting, most patients with OUD in Kentucky’s correctional settings do not receive MOUD.

Studies show that patients that receive MOUD in correctional facilities are less likely to be arrested and more likely to continue treatment upon release. A study of OUD patients after release from Washington State Department of Corrections found that this [population is over 10](#)

[times more likely to overdose compared to](#) the general OUD population, and a seamless transition to community care can mitigate heightened overdose risks during reentry.

Most Kentucky jails offer naltrexone, but it's best practice to offer or facilitate access to all three FDA-approved medications onsite. Buprenorphine and methadone initiation are easier and less time-consuming than [naltrexone initiation](#) since neither requires a lengthy withdrawal period. Attachment 3 shows that while many jails offer naltrexone, they still lack access to methadone and buprenorphine.

This recommendation builds on work already occurring in the Commonwealth. As part of the National Institutes of Health's HEALing study, the University of Kentucky is assisting a select number of counties with establishing medication programs in jail settings. Other jails, including Kenton County jail, which utilizes buprenorphine, and Jefferson County jail, which partners with an OTP, have successfully implemented medication programs.

### *Eliminate barriers to MOUD in community-based treatment*

**Policy Option 4:** The Department for Medicaid Services (DMS) should revise its Medicaid targeted case management code to support team-based care coordination services among primary care providers and other non-specialty SUD treatment providers for people with moderate to severe SUD.

#### **State Examples:**

- **Virginia:** In 2016, Virginia's Medicaid program began a process to improve the state's community-based SUD services (see Attachment 5). The state increased the number of buprenorphine prescribers in different settings across the Commonwealth, including primary care, in part by reimbursing for [team-based care coordination services](#).
- **Pennsylvania:** In 2016, Pennsylvania awarded grants to 45 Medicaid-enrolled providers to establish [centers of excellence for OUD](#) (see appendix G in the linked source) meeting specific requirements. In 2020, the state expanded this program to allow any Medicaid-enrolled provider to meet this designation for providing OUD treatment.
- **Vermont:** As part of its Hub-and-Spoke care model, Vermont Medicaid supports primary care practices with [Spoke MAT Care Teams](#) that includes a registered nurse and licensed counselor that provide care coordination services.

*Rationale:* There are significant gaps in access to buprenorphine in parts of Kentucky (see Attachment 2), with [30% of counties](#) lacking even a single buprenorphine prescriber. Buprenorphine can be offered in office-based settings, such as primary care clinics, by physicians, nurse practitioners, and physician assistants who receive a waiver to prescribe the medication. States that have had success expanding access to buprenorphine, particularly in rural or underserved parts of their states, have achieved those gains mostly through engaging primary care providers in the SUD treatment system. This has been done through several reforms addressing primary care provider concerns, including limited resources, expertise, and clinical support. Providing a robust billable code for team-based care coordination services can help



alleviate those concerns by providing funding to sustain the needed clinical and non-clinical support for primary care practices to offer buprenorphine.

Kentucky Medicaid provides a robust billing code for targeted case management services, [codified in 907 KAR 15:040](#), for people with moderate to severe SUD; however, this code is currently limited to a subset of providers that does not include primary care or non-specialty SUD treatment providers like FQHCs and rural health clinics. To close treatment access gaps across the Commonwealth, DMS should permit primary care providers, FQHCs, and other community-based providers to use this targeted case management code to treat people with moderate to severe OUD.

There are two other requirements in 907 KAR 15:040 that limit Medicaid participation among primary care providers, and other non-specialty SUD treatment facilities that have limited experience treating people with SUD. DMS should consider revising:

- Section 3, 4(b) requires documented experience of serving people with behavioral health disorders. This requirement does not support the goal of engaging new providers in community-based treatment settings like primary care practices that have no history of providing SUD treatment services.
- Section 3, 4(f) requires documented programmatic or administrative experience providing comprehensive case management services. This requirement could prevent individual or small group primary care practices from engaging in the SUD treatment system.

DMS, in coordination with DBHDID, the Kentucky Primary Care Association, Kentucky Medical Association, and others, should engage primary care and other community-based providers to educate them on these revisions, provide waiver and other appropriate training support, and encourage their participation in the SUD treatment system.

**Policy Option 5:** The Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) should revise its Opioid Treatment Program (OTP) regulations to ensure they are no more restrictive than federal requirements.

*Rationale:* Highly regulated at the federal level, OTPs are the only care setting that can offer methadone, in addition to other medications that are also available in other settings. Although Kentucky has the discretion to promulgate additional regulations for OTP, some of these policies are not evidence-based and undermine quality of care and the patient experience.

These rules can negatively impact the lives of OTP patients, requiring [daily travel over long distances](#) or having to go to the clinic during times that [may conflict with work schedules](#) and childcare responsibilities.

Pew is encouraged that DBHDID is in the process of reviewing these regulations. Additionally, this action is in line with the [American Association for the Treatment of Opioid Dependence \(AATOD\)](#) and the [American Society of Addiction Medicine \(ASAM\)](#), which [recently recommended](#) states take action to align their regulations with federal requirements.

**Administrative discharge:** [Kentucky regulations](#) allow for OTPs to involuntarily discharge patients for illicit drug use. Evidence shows that involuntary termination from medication treatment puts individuals with OUD at [high risk for overdose](#). Since OUD is a chronic condition, it's common for individuals to return to use during their recovery. Positive drug screens could also indicate that a patient's dose is not high enough, and warrant a discussion between a provider and patient, rather than disciplinary action. Kentucky should amend its regulations to prohibit OTPs from administratively discharging patients for illicit drug use.

**Drug screens:** [Kentucky's OTP regulations](#) require up to 26 observed drug screens per year, while federal regulations mandate [eight without an observation requirement](#). Drug screens can provide valuable insight into patients' ongoing substance use and clinical needs, but frequent drug screens, especially if they're observed, can be demeaning to patients. Kentucky should amend its regulations to align the number of required drug screens with federal requirements and remove the requirement for providers to observe patients producing the sample. According to an [analysis of OTP regulations from 2017](#), only four other states require observed collection of urinalyses.

**Set counseling schedule:** [Kentucky's OTP regulations](#) require a set counseling schedule. Kentucky should also remove the set counseling schedule, especially since federal regulations only require OTPs to provide counseling to patients as clinically necessary. [Research](#) shows that strict counseling requirements can reduce retention in treatment, while [medication alone can be effective](#). OTPs should offer counseling based on individual patient needs and desire.

**Take-homes:** [Kentucky's OTP regulations](#) do not allow take-home medications in the first 90 days of treatment and provide a definition of "stability" in order to receive take-home medications, which creates additional barriers to receiving care. Kentucky's OTP regulations should allow for take-home medications in the first 90 days of treatment. Patients must travel to their OTP every day to receive their methadone dose. This poses a barrier to treatment for patients in Kentucky, where there are only 24 OTPs, and most individuals in rural areas live outside of a 30-minute drive time to OTPs (see Attachment 4). Federal regulations allow patients to take home a single dose per week during the first 90 days of treatment. The federal government loosened those requirements as a result of the COVID-19 pandemic. Early [research](#) shows that these increased flexibilities have not led to greater rates of medication diversion. [Only 12 states prohibit take-home medications](#) in the first 30 days of treatment.

**Goal of Treatment:** Kentucky should remove the language from regulations that state discontinuation of medications as the goal of treatment. There is no scientific consensus that long-term use of MOUD is harmful. Research shows that [long-term treatment can lead to better outcomes in employment, health, and criminal justice involvement, while the period immediately after discontinuing treatment poses a high overdose risk](#).

As they stand, these regulations deter and prevent patients from receiving methadone. Revising these regulations could help expand access to treatment and improve quality of care for patients.

**State Examples:**



- **Massachusetts:** [OTP regulations](#) in the Commonwealth state: “Results of drug screening are to be used as a clinical tool and not as the sole factor in the diagnosis and treatment of the client and for monitoring the client's drug-use patterns before and during treatment. The licensee's Medical Director shall ensure that drug screen results are not used to force a client out of treatment but are used as an aid in making treatment decisions.”
- **Ohio:** [Regulations](#) in the state require that each OTP makes SUD counseling available “to every patient as is clinically necessary” and that counselor caseloads allow for counseling to be offered at least weekly during the first 90 days of treatment.

**Policy Option 6:** DMS should require all providers billing for SUD services to report payer mix to improve their understanding of why some providers are not accepting Medicaid.

**State Example:** [Massachusetts statute](#) requires SUD providers offer services to Commonwealth residents with public health insurance on a non-discriminatory basis and report quarterly the facility's payer mix to the department of public health.

*Rationale:* [Kentucky regulations already pose strong penalties](#) for providers that bill patients directly instead of Medicaid for a covered service, terminating providers’ Medicaid program participation if they do not comply. During Pew’s system assessment, however, stakeholders expressed that some providers (both office-based and OTP) still don’t accept Medicaid. This poses a major barrier for access to treatment, since [23.5% of the state’s population has Medicaid](#). Medicaid typically covers a higher percent of people with OUD; for instance, nationally, [Medicaid covers 38% of non-elderly adults](#) with OUD. Providers’ refusal to accept Medicaid also exacerbates racial disparities in access to care, since Medicaid and other public programs are more likely [to insure people of color](#). A requirement to report payer mix would help DMS investigate strategies to get providers to accept Medicaid patients and help providers participating in Medicaid stay accountable to OUD patients and DMS.

**Policy Option 7:** DBHDID should revise its licensure requirements for residential treatment facilities that offer services to people with OUD to require that they offer at least one partial or full opioid agonist medication onsite.

**State Example:**

- **Louisiana:** In 2019, the Louisiana Legislature passed [Act 425](#), requiring all state residential treatment facilities to offer buprenorphine and naltrexone onsite, regardless of payer type, by January 1, 2021 as a condition of facility licensure.

*Rationale:* Abstinence-based treatment is less effective, and there is a higher risk of [relapse](#), overdose, and death for patients who do not have access to MOUD in residential treatment. According to data from SAMHSA’s behavioral health treatment locator, about 20% of residential treatment facilities in Kentucky do not offer any medications, and of those that do use medications in treatment, 20% only offer naltrexone; no residential facilities use methadone in treatment. Although many of Kentucky’s residential treatment facilities offer medications, stakeholders expressed that they are sometimes offered in stigmatizing ways that may discourage

patients from going on medication. Having access to all three forms of MOUD is critical to ensuring high-quality, evidence-based residential care.

In 2018, DMS submitted a waiver to CMS to provide additional coverage for residential treatment for Medicaid patients. This waiver allows DMS to pay for OUD treatment at residential facilities with more than 16 beds. As part of the federal requirements for the waiver, residential providers must offer MOUD onsite or “facilitate access to MOUD off-site.” DMS implemented the waiver with the latter approach, which does not create an incentive for residential facilities to deliver MOUD onsite. Pew’s policy option would take the implementation of the waiver a step further by ensuring MOUD will be offered in these facilities.

This requirement should be phased in over the course of two years. The Commonwealth should offer additional training, practice facilitation, and information on funding support to providers and facilities through the Kentucky Opioid Response Effort (KORE) to support implementation of this requirement. Once it is in effect, Kentucky should collect data from residential treatment providers on the use of medication by patients. This data should include the medication used as well as patient demographic information. Collecting this data will help the state identify inequities in access to medication, and potential inappropriate reliance on antagonist medication.

### ***Expand access to treatment for pregnant and parenting people, individuals in jails, and individuals in rural areas***

**Policy Option 8:** The Kentucky Board of Medical Licensure (KBML) and Kentucky Board of Nursing (KBN) should revise their regulations to align with federal guidelines and best practices.

#### **Example Policy:**

- **Substance Abuse and Mental Health Services Administration (SAMHSA):** The agency’s OUD [treatment guidance for pregnant and parenting people](#) states that as long as a provider is trained to provide agonist therapy, they can treat a pregnant person with OUD.
- **American College of Obstetricians and Gynecologists (ACOG):** Although [ACOG recommends that pregnant OUD patients should be co-managed](#) by an obstetric care provider and a health provider with addiction medicine expertise, there are ways Kentucky can encourage the integration of services and care coordination (see policy option #4) without creating requirements that act as barriers to care.

*Rationale:* There are several [KBML](#) and [KBN](#) regulations that impede and delay access to MOUD for pregnant people. These unnecessary steps exacerbate racial disparities in maternal mortality, restricting access to Black women [who are already at a higher risk of death during this period](#). Both the KBML and KBN require that pregnant people submit a pregnancy test before they begin treatment. Both boards require providers treating pregnant patients with buprenorphine to consult another provider before prescribing. The KBN regulations require advanced practice registered nurses (APRNs) to consult with a psychiatric-mental health nurse practitioner, a physician certified in addiction medicine or psychiatry, or an APRN who is certified in addiction therapy. The KBML regulations require providers who treat pregnant people with buprenorphine to receive a second opinion from another physician who is certified

by the American Board of Addiction Medicine, the American Board of Preventive Medicine, the American Board of Medical Specialties in psychiatry, or an American Osteopathic Association certifying board in addiction medicine or psychiatry. The KBML regulations also require patients to engage in “behavioral modification” to receive treatment.

Opioid agonist pharmacotherapy (buprenorphine or methadone) is the most effective treatment available for pregnant and postpartum people with OUD. Initiating and maintaining patients on these medications produces better maternal health outcomes than supervised withdrawal from opioids, which is more likely to lead to [relapse or overdose](#). Untreated maternal OUD can also lead to [placental abruption, low birth weight, or more severe cases of neonatal abstinence syndrome \(NAS\)](#). Therefore, it’s critical to initiate pregnant patients with OUD on medications as soon as possible.

Policies that delay delivery of treatment raise risk of fatal overdose and could exacerbate racial disparities in maternal mortality. Nationally, [Black women are at least three times more likely to die from a pregnancy-related cause than White women](#). Consistent with national patterns, Kentucky’s maternal mortality rates are higher for Black women than White women. Kentucky can do its part in mollifying the Black maternal mortality crisis through lowering barriers to OUD treatment, [especially since more than 50% of accidental maternal deaths in Kentucky are drug-related](#).

Kentucky is above the national average rate of NAS, and only 35% of substance use treatment facilities in the Commonwealth have special programs for pregnant and parenting people with OUD. Of substance use treatment programs that cater to this population, only half of those offer buprenorphine or methadone despite the medications’ effectiveness (see Attachment 3). It is important that KBML and KBN align its regulations with federal guidelines to encourage more providers to treat pregnant patients with buprenorphine.

In April 2021, SAMHSA [changed its practice guidelines](#) to exempt providers serving under 30 patients to acquire the buprenorphine waiver, yet the KBML still maintains this outdated requirement. SAMHSA changed its buprenorphine waiver guidelines in response to rising overdose deaths, which emphasized the need for expanded access for this medication. Loosening waiver requirements could allow a greater variety and spread of physicians, particularly primary care providers, emergency department physicians, and providers in rural areas who may serve a smaller set of OUD patients, to prescribe buprenorphine. By not aligning with federal requirements, the Commonwealth is perpetuating stigma associated with the buprenorphine waiver by incorrectly implying that OUD should be treated differently from other health conditions and that buprenorphine is more risky than other medications.

**Policy Option 9:** Department for Medicaid Services (DMS) should extend pregnancy-related Medicaid coverage to 12 months after delivery through either a state plan amendment or an 1115 waiver.

**State Examples:** [Indiana](#) and [Virginia](#) submitted 1115 waiver applications to CMS, and [West Virginia](#) passed a law to extend coverage to one year postpartum. CMS also approved [Georgia’s](#)

[waiver](#), which covers up to six months after birth. These states join [sixteen others](#) that have either passed legislation to extend coverage, proposed waivers, or had waivers approved.

*Rationale:* Kentucky's pregnancy-related Medicaid coverage ends at the federal minimum requirement of 60 days postpartum. Volatile insurance status makes it harder for pregnant and parenting people to remain stable in OUD treatment. Overdose risk heightens during the postpartum period, with one [2012-14 study from Massachusetts](#) showing that the highest level of risk occurs 7-12 months after delivery.

States can extend postpartum Medicaid coverage through an 1115 waiver. The American Rescue Plan also allowed states to extend postpartum Medicaid through a state plan amendment, with matching funds becoming available by April 2022. ACOG, the American Medical Association, and the Medicaid and CHIP Payment and Access Commission have all made recommendations to states to extend postpartum coverage up to 12 months post-delivery.

Postpartum Medicaid extension could meaningfully improve access to care after delivery for people whose incomes are above the Medicaid expansion population's income threshold. In Kentucky, those who qualify for Medicaid based solely on income are at or below 138% of the federal poverty level (FPL), while beneficiaries who qualify for Medicaid based on pregnancy and income are at or below 200% of the FPL. This means that 60 days after delivery, OUD patients who qualified for and received Medicaid based on their pregnancy would lose their coverage. Extending postpartum Medicaid to one year will also ensure continuity of care and providers. Pew is encouraged that DMS is in the process of creating a state plan amendment to extend postpartum coverage to 12 months after delivery.

**Policy Option 10:** DBHDID should begin mobile OTP units and increase the number of mobile buprenorphine units.

**State Example:**

- **Colorado:** The Colorado Department of Human Services and the Office of Behavioral Health used money from their State Opioid Response (SOR) grant to provide startup funding to six mobile health units specializing in MOUD with the goal of improving access in rural and underserved areas. Over time, funding for these projects has transitioned to Medicaid reimbursement for provided services.

*Rationale:* During Pew's system assessment, stakeholders listed transportation as a major barrier to care, particularly OTPs. There are 24 OTPs across the state, with many concentrated in the "golden triangle" of Lexington, Louisville, and Cincinnati. Many people in rural areas are outside a 30 minute-drive to OTPs (See Attachment 3). A regional study of OTP locations, including in Kentucky, found that OTP patients typically have to [travel farther](#) to receive methadone than they do to access other medical care facilities (e.g., FQHCs). Furthermore, daily in-person visits to [OTPs can interfere](#) with patients' other obligations such as employment and childcare. This evidence indicates that the burden of travel to brick-and-mortar OTP facilities can interfere with treatment retention and recovery.

Alternatively, studies show that [mobile treatment effectively engages](#) typically hard-to reach individuals, such as those in rural areas who do not have convenient access to treatment. A recently finalized rule from the Drug Enforcement Administration allows states to develop mobile OTP units as part of the registration for a stationary OTP. Additionally, SAMHSA recently released [updated guidance](#) clarifying the range of services, such as counseling, that could be offered on a mobile OTP. Kentucky should take advantage of these new rules to implement mobile OTP units that can reach people who would otherwise lack access to an OTP for treatment.

Although start-up costs for mobile clinics can range from \$200,000-\$300,000, (see Attachment 6) Kentucky can utilize short-term funds, like opioid settlement funds, SOR, the mobile crisis planning grant, and the Substance Abuse Prevention and Treatment Block Grant to outfit the vans before they begin operating and become Medicaid-reimbursable. Regulatory changes proposed in policy option 5 would also make it easier for patients to access care through mobile units.

### ***Expand access to wraparound/recovery support services***

**Policy Option 11:** DBHDID should extend its existing revolving loan fund to allow access to those funds by any recovery residence, prioritizing residences that serve people with SUD diverted pretrial or with previous criminal justice involvement. Recovery houses participating in this revolving loan fund should be required to meet National Alliance of Recovery Residences (NARR) certification standards and accept people who are on MOUD.

#### **State Examples:**

- **Missouri:** The Missouri Department of Mental Health, Division of Alcohol and Drug Abuse offers [financial support](#) for NARR-certified recovery residences using federal grant funding. Eligibility for this funding is determined using a survey to assess support for residents on MOUD, and those deemed unsupportive are ineligible.
- **Ohio:** The state sets [standards for recovery housing](#) (beyond those set by the state NARR affiliate) that specify residents may be permitted to receive MOUD. The state also developed a [searchable database](#) of residences that can filter for MOUD acceptance and used SAMHSA grant funds to provide [training and support](#) to operators on how to accommodate MOUD.
- **Wisconsin:** [Legislation](#) created a recovery housing registry that does not include residences that reject residents solely on the basis of MOUD.

**Rationale:** Housing is a crucial component of recovery people with OUD who [have stable housing](#) are [less likely to overdose and relapse](#). [Recovery residences](#) are a vital part of recovery supports. Stakeholders identified limited certification standards and a lack of residences that accept people on MOUD as the two primary barriers people with OUD face while trying to access recovery housing in Kentucky. According to a 2020 report by the Kentucky Injury Prevention and Research Center (KIPRC) at the University of Kentucky, there are also recovery housing shortages in the eastern and western regions of the Commonwealth. In fact, the study found that 77% of counties in Kentucky appeared to lack a single recovery house.

According to the [KIPRC study](#), 37% of recovery houses do not allow people on MOUD, place harmful restrictions such as forced tapering policies on their residents, or only allow people on Vivitrol. Additionally, 34% of houses surveyed have a zero-tolerance policy for residents that relapse. These MOUD restrictions could impact an individual's ability to remain in treatment, and—especially in parts of Kentucky with limited availability—eliminate the only existing housing options.

There is a significant need for recovery housing that is available to people that have encountered the criminal justice system. According to the KIPRC study, only 7% of recovery houses in Kentucky house people exiting jail or prison and less than 20% will accept people with a criminal justice history.

Expanding the current revolving loan fund could support the growth in availability of recovery housing, while ensuring quality through NARR certification and acceptance of people on MOUD.

**Policy Option 12:** The General Assembly should consider requiring jails and residential facilities to distribute naloxone to individuals upon release from jail or residential facilities.

*Rationale:* People recently released from correctional settings who have a history of opioid use are at [high risk of experiencing an overdose](#), likely due to a lower drug tolerance after a period of abstinence. Similarly, [people exiting drug treatment programs may also have a lower opioid tolerance](#) than when they entered that puts them at risk for overdose, especially if treatment is abstinence-based or does not include medications for OUD. Given this risk, all people departing these settings should receive naloxone, or a prescription for it.

The Commonwealth should permit such corrections-based naloxone distribution through their naloxone access laws and purchase the naloxone using state or federal opioid response grant funds and local opioid overdose prevention funds or obtain it by partnering their corrections agencies with community organizations that provide naloxone. The General Assembly should amend the Commonwealth's naloxone access laws, if necessary.

The General Assembly should also require treatment facilities that receive public funding to prescribe or dispense naloxone upon discharge without affecting program budgets; the cost of naloxone [may be covered by the patient's insurance](#) as part of treatment. Existing prison discharge planning regulations or policies should be amended to include this requirement.

As a result of the COVID-19 pandemic, [the University of Kentucky HEALing study provided naloxone to jails to give to individuals upon release](#).



## Attachment 1: Recommendations for Monitoring and Evaluation

This attachment provides initial logic models and suggested metrics for three priority areas:

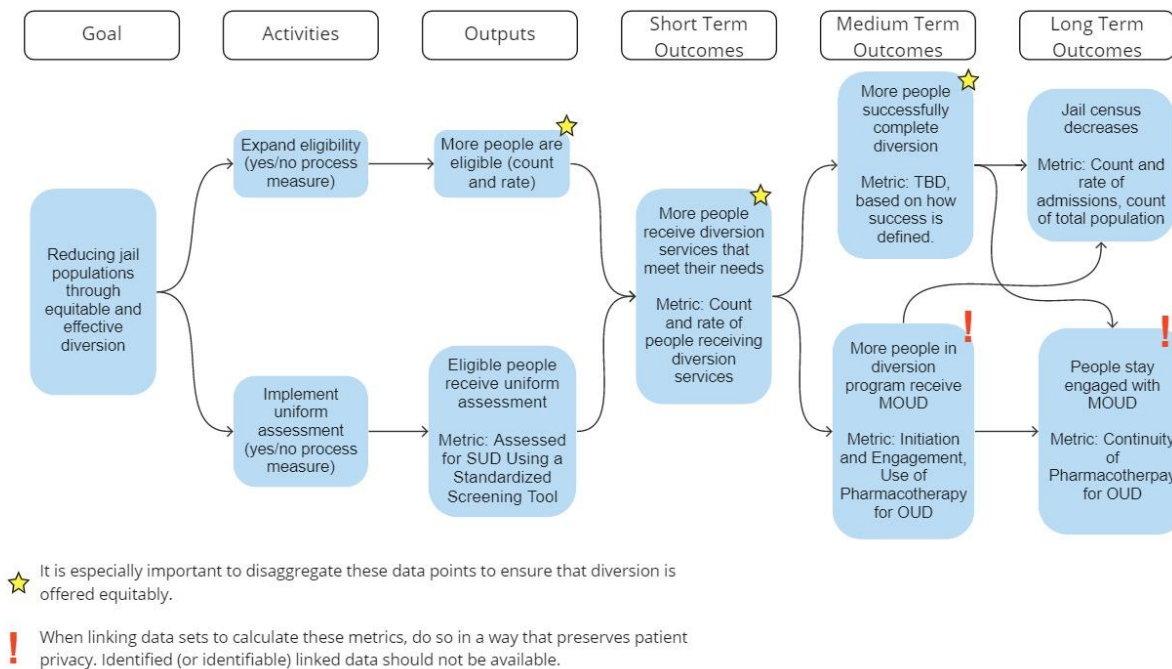
1. Reducing jail populations through equitable and effective diversion.
2. Integrating and expanding MOUD through targeted case management.
3. Improving child outcomes and reducing maternal mortality through MOUD and extended Medicaid coverage.

The activities and outputs in the logic models are drawn for the policy options made in this memo. Where the logic models use established health quality measures, they provide the relevant National Quality Forum number or HEDIS title. Following each logic model are additional considerations for implementing the monitoring and evaluation plans.

To finalize these plans, the Office of Health Data and Analytics should convene data owners and stakeholders across the relevant agencies to refine the metrics based on data availability and agency priorities.

When implementing metrics, it is important to disaggregate data based on race, ethnicity, geography, and other factors so that inequities can be identified and addressed. This is especially important for monitoring and evaluating the jail diversion and maternal and child health policies, as these are areas with long-standing racial inequities.

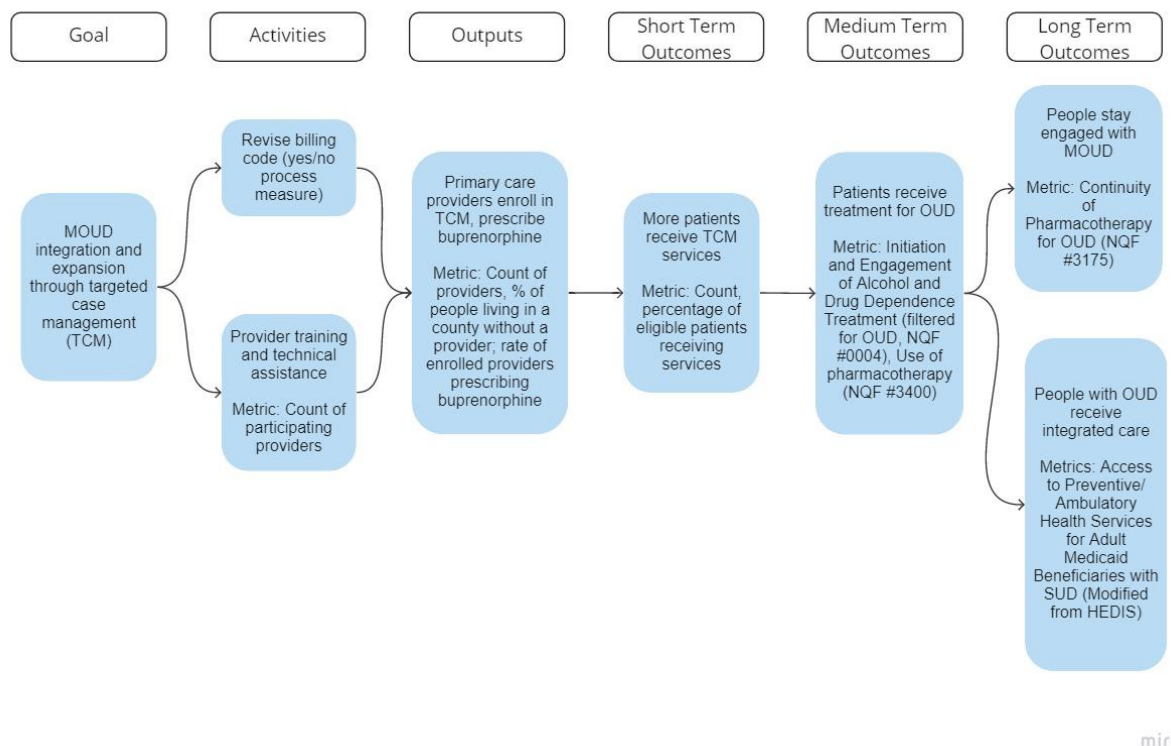
### Reducing jail populations through equitable and effective diversion



### Implementation considerations:

- To evaluate whether people in the diversion program are receiving MOUD, it is necessary to link AOC and Medicaid data. The Office for Health Data and Analytics has the capacity to analyze the linked data; however to date there has not been funding support to create the data linkage. Legislation reforming the diversion program could include such funding.

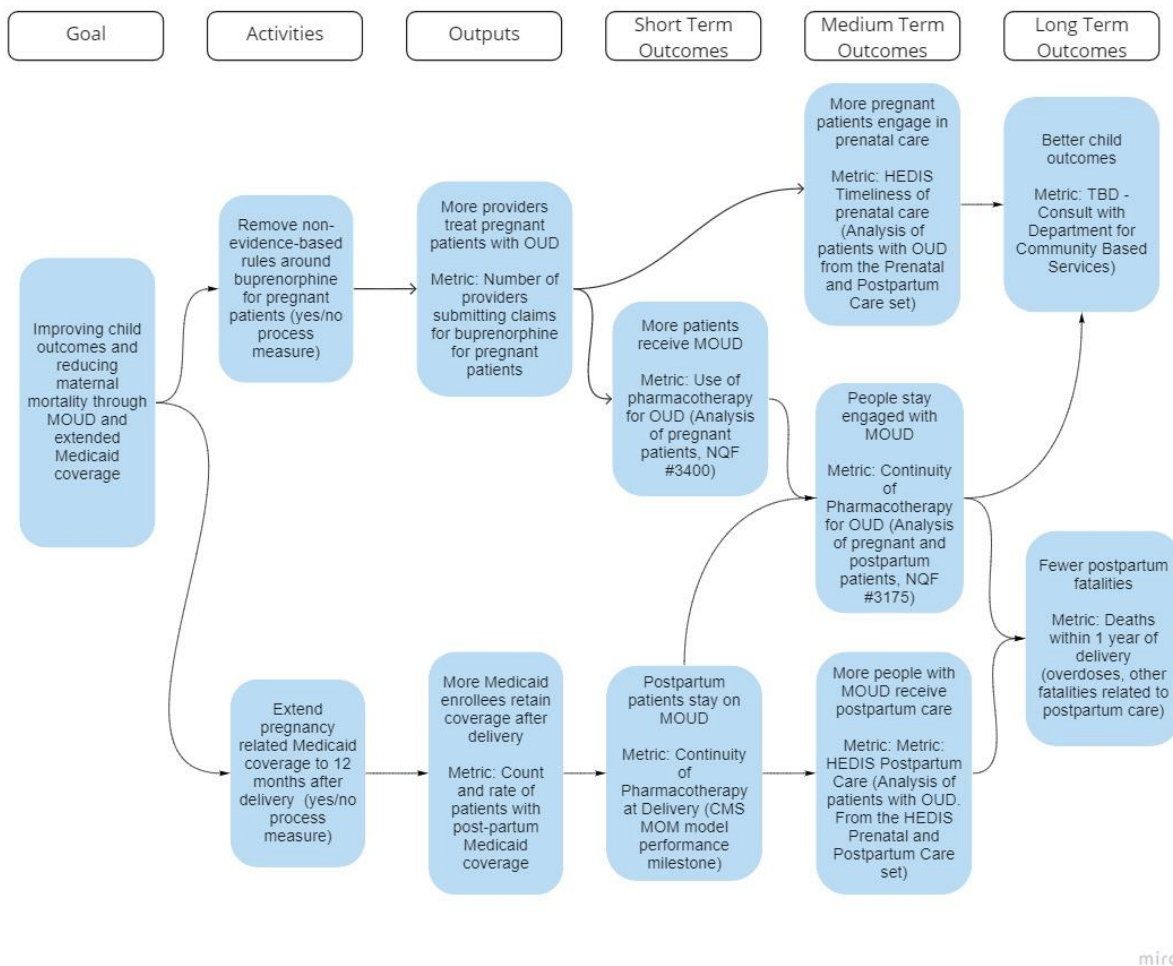
### *MOUD integration and expansion through targeted case management*



### Implementation considerations:

- Due to federal reporting requirements for the 1115 SUD waiver, the Department of Medicaid Services is already collecting and reporting on access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD. of Kentucky's 1115 SUD Waiver.

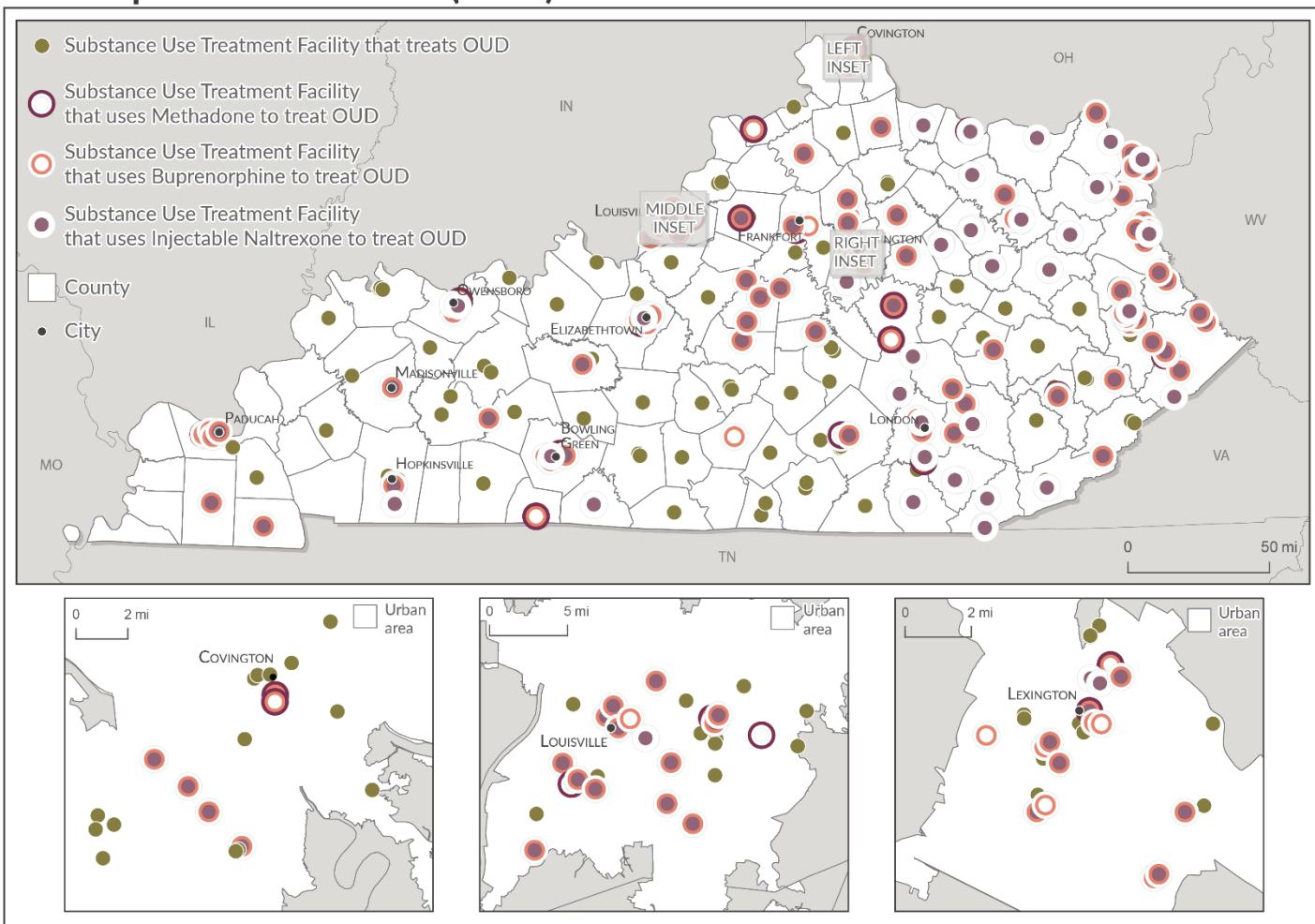
### *Improving child outcomes and reducing maternal mortality through MOUD and extended Medicaid coverage*



Implementation considerations:

- To finalize measures, the Office of Health Data Analytics should collaborate with the Perinatal Quality Collaborative, the Division of Maternal and Child Health, and the Department for Community-based services.
- Given [racial disparities in maternal deaths](#), it is critical to disaggregate data when monitoring and evaluating these changes.

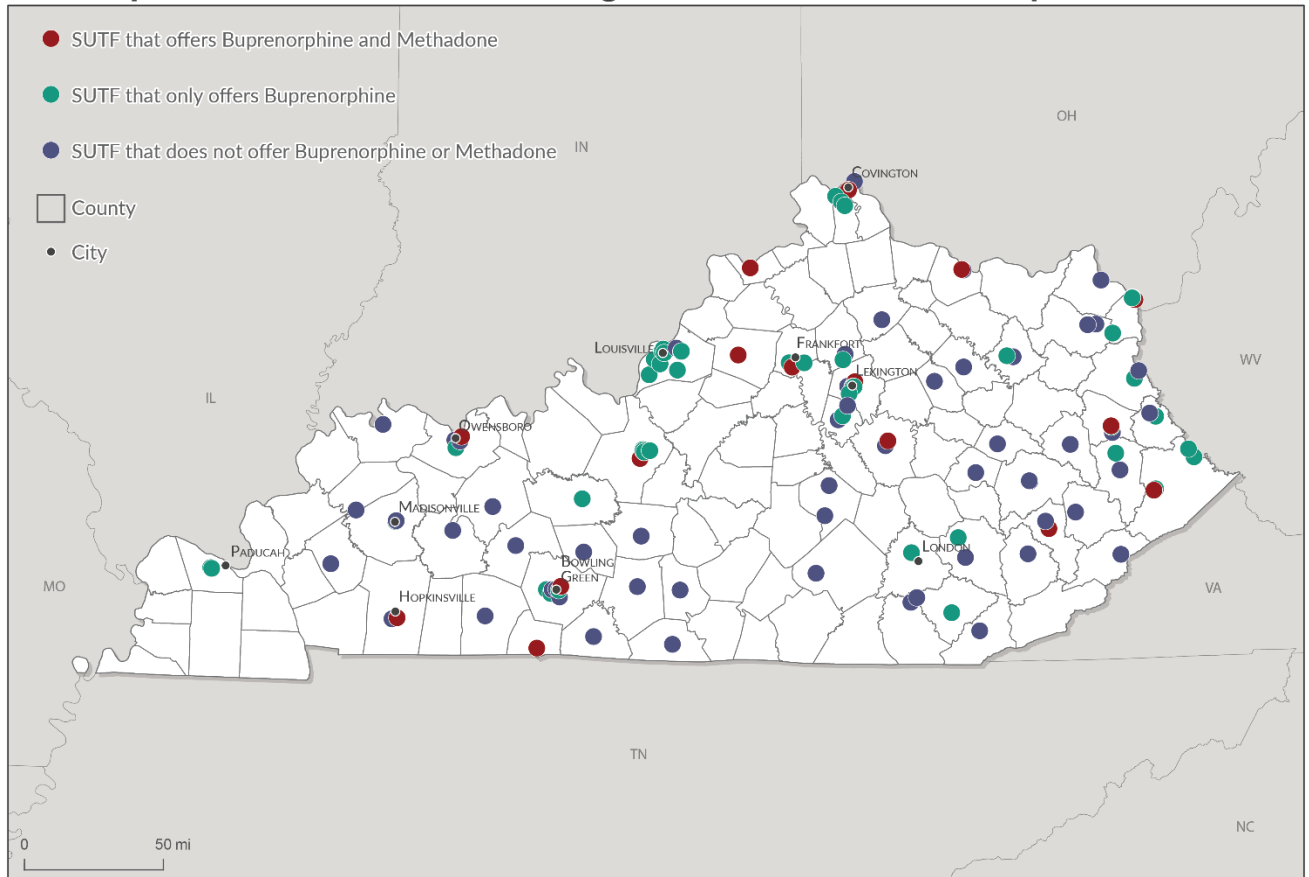
# Kentucky Substance Use Treatment Facilities that Use Medication to Treat Opioid Use Disorder (OUD)



Source: SAMHSA; NaturalEarth, US Census. Updated 4/2021

### Attachment 3

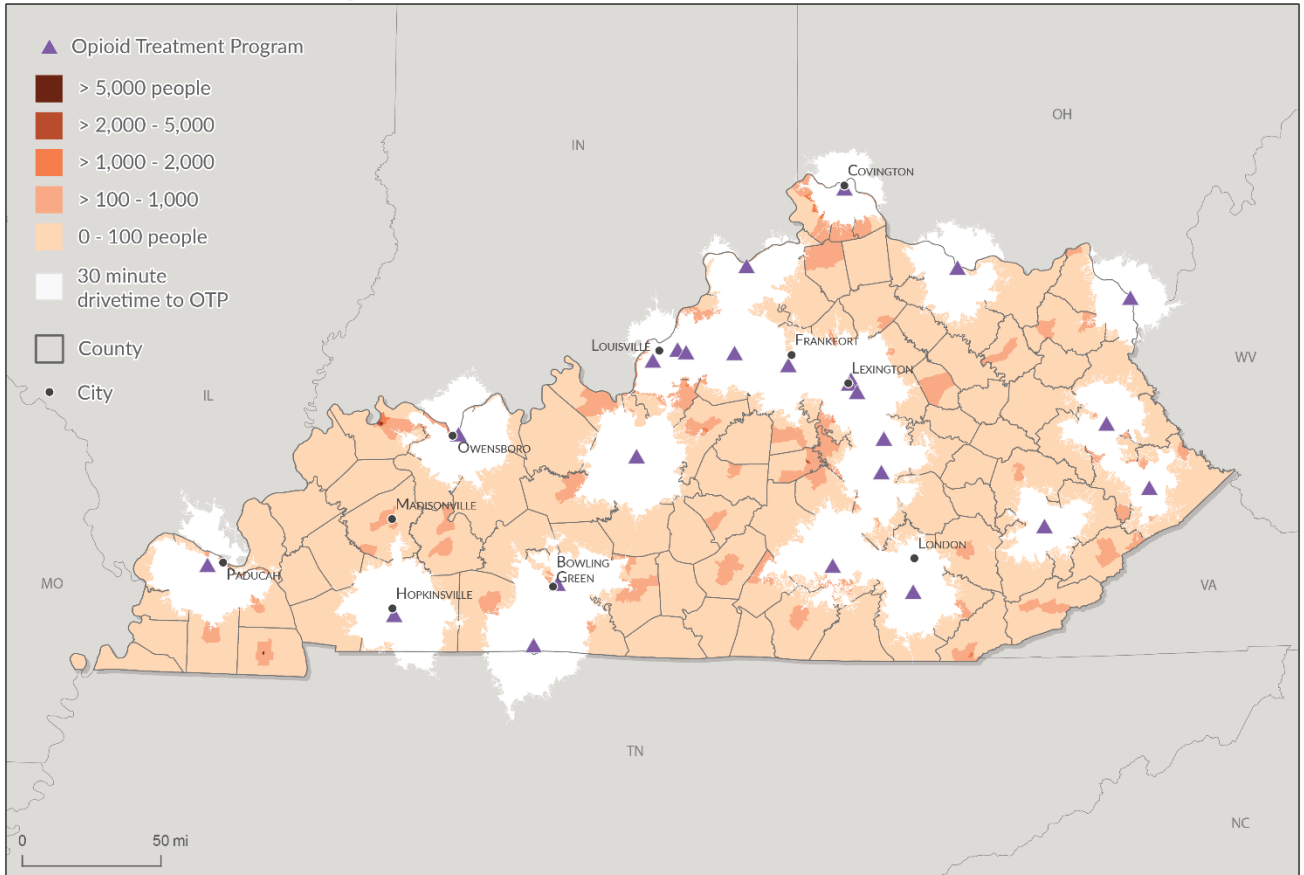
## Kentucky Substance Use Treatment Facilities (SUTF) that Use Medication to Treat Opioid Use Disorder in the Pregnant and Post-Partum Population



Source: SAMHSA; NaturalEarth, US Census. Updated 4/2021

## Attachment 4

### Kentucky Population Density Outside 30 Minutes Driving of Opioid Treatment Program (OTP) Locations



Source: Drive times calculated with Esri; SAMHSA; NaturalEarth, US Census. Updated 4/2021



### ***Attachment 5: Addiction and Recovery Treatment Services Benefit***

The Addiction and Recovery Treatment Services (ARTS) benefit, which redesigned Virginia's Medicaid program to improve access to care for people with OUD, originated from a recommendation from the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse. [The Governor established the Task Force in 2014](#) to identify immediate steps to address prescription opioid and heroin misuse and improve access to treatment for people with OUD. To implement the benefit, Virginia's Medicaid program—working closely with the Department of Behavioral Health and Developmental Services—submitted an amendment to the state's Medicaid plan, known as the Section 1115 Demonstration Waiver. The Governor included the new benefit in the [proposed budget for FY 2017](#), and it passed the General Assembly in March 2016 with strong bipartisan support.

The ARTS benefit:

- Expands short-term SUD inpatient detoxification to all Medicaid members.
  - Expands short-term SUD residential treatment to all Medicaid members.
  - Increases reimbursement rates for existing Medicaid SUD addiction and recovery services.
  - Pays for peer support services for individuals with SUD and/or mental health conditions.
  - Provides provider education, training, and recruitment activities.
- [Gives the state's Medicaid Managed Care Organizations responsibility for community-based SUD treatment services](#) to promote full integration of physical health, mental health, and addiction treatment services (known as a “carve-in”).

The ARTS benefit provides access to addiction treatment services for all enrolled members in Medicaid, Family Access to Medical Insurance Society (FAMIS, Virginia's health insurance program for children of eligible families), and FAMIS MOMS (Virginia's health insurance program for uninsured pregnant women). Additionally, the ARTS benefit required Medicaid health plans and providers to organize patient assessment and service delivery around one single set of criteria. Implementing [a nationally-recognized standard](#) across care settings helps health care providers and payors communicate around patient needs to make objective decisions about patient care that are individualized, clinically-driven, and outcome-informed. [Virginia](#) selected use of the [ASAM Criteria](#) as the standard criteria for assessment of patient need and to standardize service delivery settings. To design and implement a strategic plan for the ARTS benefit, and ensure its alignment with the ASAM Criteria, Virginia created the [ARTS Core Workgroup](#), comprised of representatives from all key state health agencies. The ARTS benefit took full effect in April 2017 and represents a significant redesign of Virginia's Medicaid benefit for individuals with SUD.

Notably, the ARTS benefit included [significant reimbursement rate increases](#) to align Medicaid rates with, or exceed, commercial reimbursement rates. This was done to address [concerns from providers](#) who had expressed unwillingness to provide SUD treatment services due to low reimbursement rates.

Table 1 presents the benefit's major changes to service coverage and reimbursement rates.

*Table 1. Changes under the Virginia ARTS benefit passed by the Governor and General Assembly in March 2016*

Addiction and recovery treatment service	Children < 21	Adults*	Pregnant women
Traditional services			
Inpatient (ASAM level 4.0)	P	New	New
Outpatient (ASAM level 1.0)	P	P	P
Medication-assisted treatment (MAT) - medication component	P	P	P
Non-traditional services			
Residential (ASAM levels 3.1, 3.3, 3.5, and 3.7)	P	New	50% rate increase
Partial hospitalization (ASAM level 2.5)	400% rate increase	400% rate increase	400% rate increase
Intensive outpatient (ASAM level 2.1)	400% rate increase	400% rate increase	400% rate increase
Opioid treatment - counseling component of MAT (ASAM level 1.0)	400% rate increase	400% rate increase	400% rate increase
Crisis intervention	P	P	P
Case management	50% rate increase	50% rate increase	50% rate increase
Peer recovery coaching (DBHDS certified peers)	New	New	New
Key: P = Service was previously covered New = ARTS benefit newly-covered service as of April 1, 2017. Rate increases were also included in the ARTS benefit. * = Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare			

*Table 2 illustrates appropriations for the ARTS benefit in FY17 and FY18.*

*Table 2. Funds for the ARTS benefit appropriated in 2016 budget*

Fiscal Year	General Fund	Non-general Fund (federal match)	Total ARTS Benefit Expenditures	Virginia's Total Medicaid Expenditures
17	\$2.6 million	\$2.6 million	\$5.2 million	<a href="#">9.8 billion</a>
18	\$8.4 million	\$8.4 million	\$16.8 million	<a href="#">9.6 billion</a>

[Table 3 presents outcomes from the first year after ARTS implementation:](#)

*Table 3. Outcomes from the first year of ARTS implementation*

	<b>Before ARTS (Apr 2016- Mar 2017)</b>	<b>After ARTS (Apr 2017- Mar 2018)</b>	<b>% Change</b>
<b>Access to care</b>			
Members with OUD receiving treatment	10,092	14,917	↑ 48%
Total number of OUD outpatient providers	570	1,352	↑ 137%
<b>Outcomes</b>			
ED visits related to OUD	5,016	3,756	↓ 25%
Hospitalizations related to OUD	3,520	3,315	↓ 6%
Total number of prescriptions for opioid pain medications	549,442	399,678	↓ 27%

To see additional outcomes measured in the first year after ARTS implementation, please refer to a presentation titled, “[Outcomes from the First Year](#),” created by the Virginia Department of Medical Assistance Services in September 2018. For a list of outcomes observed during the first five months of the ARTS benefit implementation, please see the independent evaluation conducted by the Virginia Commonwealth University School of Medicine in December 2017 titled, “[Addiction and Recovery Treatment Services: Access, Utilization, and Spending for the Period of April 1 – August 31, 2017](#).”

## Mobile Methadone and Medication Units: Federal Requirements and Implementation Factors

Researched and Written by Joanna Jackson, Ph.D., MSN, RN, Assistant Professor, Healthcare Management, Winthrop University  
Current as of November 15, 2021

Considerations	Mobile Unit	Medication Unit
<b>Federal Approval Requirements</b>	<ul style="list-style-type: none"> <li>➤ No separate Drug Enforcement Administration (DEA) registration requirement.<sup>1</sup></li> <li>➤ Substance Abuse and Mental Health Services Administration (SAMHSA) <i>Notification of Program Changes</i> SMA-162 must be completed.<sup>2,3</sup> (SMA-162: As of 10/17 there is no place to select “mobile unit.” Facilities should select “medication unit” when completing the notification.)</li> <li>➤ State approval by State Opioid Treatment Authority (SOTA) needed before submitting SAMHSA application.<sup>4</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Separate and unique DEA registration required.<sup>1</sup></li> <li>➤ SAMHSA <i>Notification of Program Changes</i> SMA-162 must be completed.<sup>2,3</sup></li> <li>➤ State approval also needed.<sup>1</sup> <ul style="list-style-type: none"> <li>○ While not required, many states issue authorizing regulations for medication units. These states include: <a href="#">CA</a>, <a href="#">FL</a>, <a href="#">KY</a>, <a href="#">MA</a>, <a href="#">ND</a>, <a href="#">NV</a>, <a href="#">OH</a>, <a href="#">OK</a>, <a href="#">SC</a>, <a href="#">TX</a>, <a href="#">WI</a></li> </ul> </li> </ul>
<b>Costs</b>	<ul style="list-style-type: none"> <li>➤ Startup costs range between \$200,000-\$300,000, depending on type of vehicle (e.g., RV, passenger van, or bus) and customization. Cost includes medical equipment, basic office supplies, a compliant alarm system, and a safe.<sup>1,5,6,8</sup></li> <li>➤ Maintenance costs vary by mobile unit type and age.<sup>5,6,7</sup></li> <li>➤ Annual maintenance costs for <i>new</i> units range from \$6,000-\$10,000.<sup>5</sup></li> <li>➤ Units over ten years old may have annual maintenance costs exceeding \$20,000.<sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Costs vary depending on collaboration agreements with community partners.<sup>1,5</sup></li> <li>➤ A conservative estimate for annual rent for office space is \$46,000.<sup>1</sup></li> <li>➤ Cost of a separate DEA registration is \$296 per year.<sup>1</sup></li> </ul>
<b>Required Services</b>	<ul style="list-style-type: none"> <li>➤ Mobile units must follow all applicable federal and state Opioid Treatment Program (OTP) regulations.<sup>1,3,4,5</sup></li> <li>➤ All clients must receive federal- and state-required OTP services.<sup>1,4,5</sup></li> <li>➤ Services may be provided in the mobile unit if space allows.<sup>4</sup></li> <li>➤ Any required services (e.g., medical, counseling, education) not provided in mobile units must be conducted at the OTP.<sup>4</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Medication units must follow all applicable federal and state OTP regulations.<sup>1,3,4</sup></li> <li>➤ All clients must be offered federal- and state-required OTP services.<sup>1,3,4,5</sup></li> <li>➤ Services may be provided at the medication unit if space allows.<sup>4</sup></li> <li>➤ Any required services (e.g., medical, counseling, education) not provided in medication units must be provided at the OTP.<sup>4</sup></li> </ul>

<b>Prohibited Services</b>	<ul style="list-style-type: none"> <li>➤ Mobile units can provide any required OTP service as long as there is appropriate privacy and adequate space.<sup>4</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Medication units can provide any required OTP service provided there is appropriate privacy and adequate space.<sup>4</sup></li> </ul>
<b>Staffing Requirements</b>	<ul style="list-style-type: none"> <li>➤ Nurse, clinical staff, security officer, driver (may need a commercial license).<sup>1,3,5</sup></li> <li>➤ State regulations vary and determine the ultimate number and type of staff.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Nurse, clinical staff, security officer, and medical office staff.<sup>1,3,5</sup></li> </ul>
<b>Common Partner Organizations &amp; Examples</b>	<ul style="list-style-type: none"> <li>➤ <a href="#">Correctional facilities</a>, <a href="#">government health departments</a>, Federally Qualified Health Centers (FQHCs), outpatient mental health and substance use treatment facilities not offering MAT, <a href="#">residential treatment facilities</a>, sober living, and recovery houses, and <a href="#">harm reduction outreach programs</a> (e.g., syringe exchange programs).</li> </ul>	<ul style="list-style-type: none"> <li>➤ <a href="#">Correctional facilities</a>, FQHCs, outpatient mental health, <a href="#">behavioral health agencies</a>, and <a href="#">substance use treatment facilities</a>.</li> </ul>
<b>Geographic Reach</b>	<ul style="list-style-type: none"> <li>➤ OTPs can only operate a mobile component in the state in which they hold a DEA registration.<sup>4</sup></li> <li>➤ No explicit distance requirements.<sup>4</sup></li> <li>➤ Mobile units are required to return their registered location at the end of each day.<sup>1</sup> <ul style="list-style-type: none"> <li>○ Facilities with exceptional circumstances may apply for a DEA exception waiver of this requirement.<sup>1</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>➤ N/A</li> </ul>
<b>Time to Deployment</b>	<ul style="list-style-type: none"> <li>➤ Customized mobile units can take 4-6 months to deploy (time includes DEA application approval, SOTA approval [time varies by state], and delivery of customized vehicle).<sup>1,5,8,9</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Weeks to months depending on the location and need for construction and renovations.<sup>1</sup></li> </ul>
<b>Insurer Limitations</b>	<ul style="list-style-type: none"> <li>➤ Medicare will reimburse Medicare-enrolled OTPs to deliver services.<sup>10,11</sup></li> <li>➤ Mobile methadone providers report that there are no specific mobile methadone CMS billing codes.<sup>2,5,10,11</sup></li> <li>➤ All states must cover OTP services (including those provided in mobile units) in their Medicaid programs.<sup>11</sup></li> <li>➤ Reimbursement may not cover total costs of operation.<sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Medicare will reimburse Medicare-enrolled OTPs to deliver covered services.<sup>10,11</sup></li> <li>➤ All states must cover OTP services (including those provided in medication units) in their Medicaid programs.<sup>11</sup></li> </ul>

<b>Additional Insights</b>	<ul style="list-style-type: none"> <li>➤ State/federal funding sources may ease financial burden.<sup>5</sup></li> <li>➤ <i>Factors to consider in selecting unit:</i> number of patients served, expected travel distance, parking availability, type of driver/driver's license.<sup>5</sup></li> <li>➤ Plan for potential service interruptions resulting from vehicle maintenance, weather, and equipment failures. DEA requires a contingency plan to ensure dosing if van is incapacitated.<sup>5</sup></li> <li>➤ Collaborate with multiple agencies that allow mobile units to serve more than one location per day (<i>e.g., unit serves county jail in the a.m. and FQHC in the p.m.</i>).<sup>5</sup></li> <li>➤ States may require commercial driver's license depending on the type of van. Drivers required to have a commercial driver's license may command a higher salary.<sup>5</sup></li> <li>➤ Depending on unit size, one employee may serve as both security officer and driver.<sup>5</sup></li> </ul>	
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