Recommendations
of
Congressman Patrick J. Kennedy
to the
President's Commission on Combating Drug Addiction and the Opioid Crisis

OCTOBER 2017

THE KENNEDY FORUM

Contents

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Executive Summary

Congressman Patrick J. Kennedy was appointed to the President's Commission on Combating Drug Addiction and the Opioid Crisis on May 10, 2017. The concurrent opioid and suicide epidemic is a national emergency demanding a FEMA-like response: collaboration between the government and private sectors, as well as for-profit and nonprofit organizations. Nearly 300 people die every day in this country from drug overdoses and suicides. A siege of this magnitude requires strong thought leadership with a true "all hands on deck" approach. This escalating crisis requires the kind of funding, coordination, manpower, and federal and state commitments commensurate with the level of destruction being inflicted on countless American families. Until we treat brain diseases the same way we treat other diseases, our country will never stem the tide of these deaths of despair. Decimating Medicaid will only escalate the problem. Now more than ever, we need full parity in insurance coverage and comprehensive integrated care. This is impossible if we initiate a race to the bottom by converting all federal health care spending into block grants and allow states to waive essential health benefits. Block grants are fundamentally structured to restrict spending over time, and mental health and addiction coverage will be the first set of essential health benefits on the chopping block for states that choose to opt out.

We must prevent the insurance marketplaces from descending into chaos. The President recently canceled the cost-sharing reduction payments that made it possible for the working poor to access health care without incurring astronomical out-of-pocket expenses. These

payments were not a bailout to insurance companies, but a lifeline to American families of limited means. Senators Patty Murray (D-WA) and Lamar Alexander (R-TN) have devised a bipartisan solution that would fund the cost-sharing reductions for two years and stabilize the individual marketplaces. Without this temporary solution, the markets will plunge into chaos, imperiling access to mental health and addiction treatment. We must solve this epidemic, not make it worse. The President must show true leadership and firmly support this legislation. He must protect those struggling Americans—many of whom voted for him—from the disastrous impact of the complete elimination of the cost-sharing reduction payments.

In his capacity as Commissioner, Congressman Patrick J. Kennedy recommends actions in the following categories:

Declaration of Federal Emergency: The President must declare an emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5121-5208) and the Secretary of Health and Human Services (HHS) must concurrently declare a Public Health Emergency under 42 U.S.C. § 247d.

Insurance Coverage and Treatment: The Administration must not sabotage the Affordable Care Act. This would only serve to exacerbate an already intensifying crisis. The Mental Health Parity and Addiction Equity Act (MHPAEA) must be fully enforced using first-rate tools developed by parity experts. Congress, federal and state agencies, and commercial insurers must substantially increase access to medication-assisted treatment (MAT), and barriers to its uptake must be eliminated. Integration and coordination of care along with alternative payment models must be expanded and improved upon. Congress must remove dangerous limitations to, and exclusions of, care from Medicare and Medicaid. Practitioners and health systems must use technological advancements, evidence-based interventions, and measurement-based care so there is provider accountability and dedication to improving outcomes in a measurable and meaningful way.

Prevention and Early Intervention: Federal agencies, states, localities, and private entities must prioritize and implement evidence-based prevention programs. All medical providers should screen for mental health conditions and substance use disorders in a variety of settings, and Congress must appropriate additional funding for foster care, mental health education in schools, and programs for early intervention. Suicide prevention must be prioritized by the Administration, Congress, and federal agencies in order to reduce the preventable deaths of despair affecting countless American families. Congress must appropriate additional funding for prescription drug monitoring programs and remove barriers to using non-opioid medications to treat post-surgical pain.

Criminal Justice Reforms: We are in dire need of criminal justice reform. There should be an elimination of mandatory minimum sentences. Congress must increase appropriations for mental health courts and drug courts, as well as treatment of inmates in federal prisons. Federal

and state prisons—and county and local jails—must coordinate with social service agencies to ensure those released from incarceration are aligned with proper treatment and other services.

Vulnerable Populations: Native Americans have been disproportionately affected by the opioid and suicide epidemic, which is in part attributable to intergenerational trauma. Congress and the Federal Government must not neglect Native Americans as it addresses this epidemic. Congress must allow sovereign tribes to be eligible for available grants, in the same way as states. Congress must also address the needs of veterans by appropriating additional funding for supportive services and hiring additional mental health professionals within the Veteran's Health Administration. Congress and the Administration must also address the burgeoning crisis of infants born with neonatal abstinence syndrome (NAS) by expanding research and funding programs.

Workforce: Providers who treat patients with pain should utilize the latest training modules, guidelines, and other available resources to properly educate practitioners on how to avoid prescribing in a way that might lead to opioid misuse. Congress must appropriate additional funding for grant programs and other incentives that will increase the mental health workforce capacity.

Research: The National Institute on Drug Abuse—in conjunction with other National Institutes of Health entities—in collaboration with the private sector, must continue to develop alternatives to opioids for treating pain and developing or improving medications to treat substance use disorder.

Grants: Grants must include specific contractual language to ensure appropriated money is tied to measurable data. We must have accountability for outcomes so that federal monies are spent appropriately in a cost-effective manner.

Congressman Kennedy's Full Recommendations to the President's Commission on Combating Drug Addiction and the Opioid Crisis

Declaration of Federal Emergency

- The President must declare an emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5121-5208), which will allow the Federal Emergency Management Agency to provide grants, technical support, and services to states in the form of individual assistance, public assistance, and hazard mitigation.
- The Secretary of HHS must declare a public health emergency (PHE) as authorized under 42 U.S.C. § 247d, which will allow the Secretary to, among other things:
    - Issue grants, provide expense reimbursement, and enter into short-term contracts to address the opioid epidemic.
    - Conduct and support investigations into the cause, treatment, or prevention of a

disease or disorder.

- Allow broader prescribing of buprenorphine through the practice of telemedicine in areas of special need, with the concurrence of the Drug Enforcement Administration (DEA) Administrator, as specified in 21 U.S.C § 802(54)(D).

Insurance Coverage and Treatment

Parity and Equality

- As part of the action plan for enhanced enforcement required by Section 13002 of the 21st Century Cures Act, the U.S. Department of Health and Human Services (HHS) should direct all state and federal regulatory agencies with the responsibility of enforcing The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to enforce applicable parity laws through targeted market conduct examinations and pre-market data examinations of issuers of individual and fully-insured health insurance products.
- Regulators need to continue to develop and implement enhanced enforcement strategies by clarifying federal and state parity law requirements (e.g., best practices for health plans to run non-quantitative treatment limitation (NQTL) comparability analyses and establishing clear disclosure requirements).
- Risk management solutions and auditing tools developed by accreditation agencies, advocacy organizations, consulting firms and others should be utilized when appropriate.
- The U.S. Department of Treasury should exercise its existing authority under 26 U.S.C. § 4980D to levy excise taxes on health plans that violate MHPAEA.
- The U.S. Center for Consumer Information and Insurance Oversight (CCIIO) should exercise its authority under 42 U.S.C. § 300gg-22(a)(2) to enforce MHPAEA in the individual market and for fully-insured, non-federal governmental plans when a "State has failed to substantially enforce" the law; failure to "substantially enforce" shall include solely relying on consumer complaints to determine if there is non-compliance and refusing to investigate all complaints involving behavioral health denials of coverage for possible MHPAEA violations.
- When jurisdiction permits, state attorneys general and other applicable regulatory agencies must launch parity investigations of health insurance issuers similar to those performed by the New York State Attorney General's Office.
- All states that may enforce MHPAEA should pursue parity implementation training from the leading parity experts, as identified by the U.S. Department of Labor (DOL), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and CCIIO.

- Congress must amend 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-26 to require all health plans and issuers to document their NQTL analyses in advance of the plan year, and make the analyses available to plan participants, beneficiaries, and regulators via hyperlink from the summary of benefits and coverage.
- Through Executive Order, the President should require within 180 days that HHS identify and evaluate clinical guidelines on an ongoing basis to create a database of what accepted current medical practice is, to inform NQTL analyses, in consultation with DOL.
- Congress should amend the Employee Retirement Income Security Act (ERISA) to authorize the Department of Labor to impose a civil monetary penalty on a group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan by adding a new 29 U.S.C. § 1132(c)(13), similar to 29 U.S.C. § 1132(c)(10), which applies for violations of the Genetic Information Nondiscrimination Act (GINA).
- Congress should amend ERISA to authorize the DOL to enforce against health insurance issuers by removing 29 U.S.C. §1132(b)(3).
- Congress must appropriate recurring funds for the DOL to increase capacity to perform audits of group health plans.
- Congress must amend a section of the Americans with Disabilities Act found at 42 U.S.C. § 12114 so that individuals with substance use disorders are afforded the same protections as those with other medical conditions, regardless of whether they are currently using illegal drugs or alcohol.

Medication Assisted Treatment

- The President and key federal agencies should take the following steps to expand Medication-Assisted Treatment (MAT):
  - The Centers for Medicare and Medicaid Services (CMS) should send a state health official letter requesting that state Medicaid programs cover all U.S. Food and Drug Administration (FDA)-approved MAT drugs for opioid use disorder without prior authorization.
  - CMS should create enhanced reimbursement rates for CPT billing codes that indicate the provision of (either directly or by referral) maintenance pharmacotherapy as part of an OUD treatment service.
  - CMS must create an expedited application process for assigning Healthcare Common Procedure Coding System (HCPCS) codes for medications used to treat opioid use disorder.
  - The President, through Executive Order, should require that the Federal Bureau of Prisons eliminate its exclusion of MAT in federal prisons.
  - The Health Services and Resources Administration (HRSA) should ensure all Federally Qualified Health Centers (FQHCs) offer MAT, including the associated wraparound and counseling services.

- HRSA should require all federally qualified health centers (FQHCs) to mandate that their staff physicians, physician assistants, and nurse practitioners possess DATA 2000 waivers to prescribe buprenorphine.
- The DEA must finalize regulations implementing the Ryan Haight Act, as required by 21 U.S.C. § 831(h)(2), in order to create a special registration pathway for state-licensed community mental health and addiction treatment providers who utilize telemedicine to treat people with addiction or other mental illness.
    - If the DEA does not finalize these regulations and a public health emergency is declared by the Secretary of HHS, the Secretary of HHS shall establish the registration process for all providers who are authorized to engage in the practice of telemedicine as authorized by 21 U.S.C. § 802(54)(D) during a public health emergency.

- Congress should amend the DATA 2000 Act in the following ways:
    - There should be no cap on the number of eligible patients to whom qualified practitioners can prescribe medication maintenance treatment or detoxification treatment— amend 21 U.S.C. § 823(g)(2)(B)(iii).
    - Make permanent the designation that nurse practitioners and physician assistants are qualified practitioners by amending 21 U.S.C. § 823(g)(2)(G)(iii)(II).
- Congress should enact the following insurance protections for MAT as a new section within 42 U.S.C. § 300gg et seq:
    - Health plans and issuers may not exclude coverage of any FDA-approved medication for the treatment of substance use disorders, if such medication is medically necessary according to most recent *National Practice Guideline on the Use of Medications for the Treatment of Addiction Involving Opioid Use* established by the American Society of Addiction Medicine (ASAM).
    - All FDA-approved medications for the treatment of substance use disorders should be placed on the lowest tier of a health plan or issuer's prescription drug formulary.
    - Health plans and issuers may not impose step therapy requirements before MAT is approved.
    - Health plans and issuers may not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Integrated Care

- CMS should establish enhanced reimbursement rates for the existing behavioral health integration (BHI) and collaborative care model (CoCM) G-codes (G0502, G0503, G0504, G0507) to increase the use of integrated care, which generates strong return on investment and successful outcomes.[1]
- CMS should establish a new G-code for a "consultation" fee. When primary care initiates the consultative relationship with a psychiatric professional, the consultant could

receive a supplemental G-code for providing decision supports and ad hoc eConsults for a patient population under their shared care, as well as any telepsychiatry payments.
- Congress should expand the use of certified community behavioral health clinics (CCBHCs) beyond the current eight-state pilot.[2]

Medicaid and Medicare Improvements

- Congress must eliminate the Medicaid Institutions for Mental Disease exclusion found at 42 U.S.C. § 1396d(a)(29)(B) and allow federal financial participation for treatment in inpatient substance use disorder and mental health treatment facilities without reducing expenditures for outpatient services within Medicaid.
- Congress must eliminate the Medicare 190-day lifetime inpatient limit on treatment in a psychiatric hospital found at 42 U.S.C. § 1395d(b)(3).
- Congress must amend 42 U.S.C. 1395w-102(e)(1) so that Medicare Part D allows for coverage of medications administered or dispensed in an opioid treatment program, which will allow for the coverage of methadone in the outpatient setting.
- Congress should pass the Mental and Behavioral Health Care Bump Act, which requires Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states' certain spending.[3]
- Congress must extend Medicaid coverage to cover evidence-based housing support programs and other supportive services.[4]
- CMS should require state Medicaid programs to cover all ASAM Criteria levels of care and all FDA-approved medications for opioid addiction.
- CMS should establish that the Federal Medical Assistance Percentage (FMAP) is 100 percent for outpatient mental health and substance use disorder services, and states should establish reimbursement rates to providers equal to the Medicare fee schedule.
- CMS should encourage the use of the Patient-Centered Opioid Addiction Treatment (P-COAT) alternative payment model, which is designed to improve outcomes and reduce spending for opioid addiction by using three bundled payments:
    - Patient Assessment and Treatment Planning bundle
    - Initiation of MAT bundle
    - Maintenance of MAT bundle [5]
- CMS should encourage the use of case rates for substance use disorder care that set a predetermined rate for each level of care once prior authorization has been approved, thereby eliminating the need for further utilization review as the patient progresses through detoxification, rehabilitation, partial hospitalization, and intensive outpatient services.[6]
- CMS should modify its Comprehensive Primary Care Plus pilot program to include a mental health component—adapting the payment model so that risk adjustment and performance-based incentives are tied to use of mental health and substance use disorder screening tools, with full capitation of mental health services.[7]
- CMS should create a demonstration project with one or more accountable care organizations in which they screen for all common mental health and substance

use disorders, including depression, anxiety disorders, psychoses, bipolar disorder, schizophrenia, and various addictions, and track outcomes for all of these conditions by using a quantifiable and standardized symptom rating scale.[8]

Temporary Regulatory Relaxations

- The Secretary of the Department of Health and Human Services (HHS) should use the waiver process established by Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) to:
  - Temporarily modify Medicare, Medicaid, and Children's Health Insurance Plan (CHIP) requirements to augment treatment capacity.
  - Loosen the Health Insurance Portability and Accountability Act of 1996 (HIPAA) restrictions to allow notification to families of persons who have overdosed and been revived.

Care Coordination

- Congress should pass the bipartisan Overdose Prevention and Patient Safety Act in the House (H.R. 3545) and Protecting Jessica Grubb's Legacy Act (S. 1850) in the Senate, which will allow for the appropriate sharing of substance use treatment information among providers and health systems for the purposes of treatment, payment, and health care operations without the prior written consent of the patient—thereby improving care coordination and preventing inappropriate prescribing of opioids to patients with substance use disorders.
- Congress should address co-morbid mental illness and psychological distress among those with substance use disorders by drafting legislation that would create Programs of Excellence that are successful in coordinating systems and service delivery across the continuum: between prevention workers, health care professionals/prescribers, clinical counselors, and recovery support services providers.
- HRSA should update the Uniform Data Set and other data systems, including all substance use disorder treatment providers and services, to collect information about treatment services being provided by non-addiction-specific providers, such as psychologists, social workers, counselors, and nurse practitioners

Supportive Services and Recovery

- Congress should amend 42 U.S.C. § 1437f(f)(5) so that the Housing Choice Voucher Program does not bar applications from persons with non-violent, non-distribution drug arrests or convictions by specifying that "drug-related criminal activity" does not include simple possession or drug use.
- Congress should increase HUD vouchers for supportive housing for people in recovery.
- Congress should amend 42 U.S.C. § 290ee-2 to increase funding authorization for recovery community organizations created under the Comprehensive Addiction and Recovery Act (CARA).
- Congress should amend 42 U.S.C. § 423(d)(2)(C) and 42 U.S.C. § 1382c(a)(3)(J) so

eligibility for supplemental security income and supplemental security disability income is available to people with SUDs.[9]

- States and localities should expand other supportive services such as peer support, community integration, job and skill training, recovery coaches, education services, and 12-step programs—and both commercial and public payers should reimburse for these services.
- ONDCP, CNCS, and SAMSHA should work with nonprofit recovery organizations to lead a Recovery Services Work Group to include key leaders in recovery living, recovery coaches, life skills programs for young adults, drug courts, Collegiate Recovery, Recovery High Schools, other community-based organizations such as the YMCA, and anti-poverty organizations piloting or running programs targeted to people in recovery. This group will work to develop recommendations supportive to long-term recovery such as:
  - How to develop infrastructure in the government and private sectors to support long-term recovery and prevent relapse.
  - How to identify and support accreditation models that evaluate programs providing recovery support services, including the guiding principles, practice standards, and evaluation criteria of such models—and provide incentives for accreditation of all entities providing peer recovery support services to meet and adhere to national standards.
  - How to identify model recovery support programs and evaluate outcomes of services offered, such as recovery coaching, sober living standards, and life skills training for job reentry and career building that can be models for local communities.
  - How to unite Government agencies and the nonprofit sector to map the continuum of services needed through the first five years of long-term recovery, and create incentives and funding mechanisms for state and local communities to adopt and implement services.
- Hospitals, emergency medical services organizations, and police departments should develop formal relationships with recovery coaches and supportive service providers who can consult with those who have overdosed and been revived.
- Identify and promote parent and family support systems for those whose loved ones are experiencing opioid use disorder.

Quality of Care and Provider Accountability

- HHS should support:
  - Dissemination of clinical practice guidelines for addiction treatment, such as the ASAM *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*.
  - Development and validation of quality measures for addiction treatment.
  - Provider certification programs that provide patients, families, and payers with a reliable indicator that providers are delivering a certain quality or level of care.

  - Infrastructure development in government and nonprofits that support long-term recovery and prevent relapse.
  - Identification of accreditation models that evaluate programs providing recovery support services, including the guiding principles, practice standards, and evaluation criteria of such models—and provide incentives for accreditation of all entities providing peer recovery support services to meet and adhere to national standards.
  - Identification of model recovery support programs and evaluate outcomes of services offered, such as recovery coaching, sober living standards, and life skills training for job reentry and career building that can be models for local communities.
  - Unification of Government agencies and the nonprofit sectors to map the continuum of services needed through the first five years of long-term recovery, and creation of incentives and funding mechanisms for state and local communities to adopt and implement services.
- HHS should work through CMS, the Center for Medicaid and Medicare Innovation (CMMI), CDC, the Agency for Healthcare Research and Quality (AHRQ), and its other agencies to develop and evaluate performance measures for adoption of the CDC *Guideline for Prescribing Opioids for Chronic Pain* through annual Medicare and Medicaid payment rules, in Accountable Care Organizations (ACOs), and in other innovative value-based payment pilots.
- CMS should make Medicaid and Medicare reimbursement contingent upon the use of measurement-based care by 2022.[10]
- As the Research Domain Criteria (RDoC) research framework uncovers higher-level domains of human behavior and functioning that reflect contemporary knowledge about major systems of emotion, cognition, motivation, and social behavior, CMS should develop billing codes that reflect RDoC instead of the DSM for reimbursement of mental health treatment.
- Congress should appropriate federal funding to the CDC to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region.[11]
- State, federal, and local authorities, as jurisdiction dictates, should investigate, prosecute, and shut down fly-by-night SUD treatment facilities, while identifying best practices for SUD inpatient treatment, such as integration of MAT into inpatient treatment protocols and mandatory discharge planning that includes direct linkages to outpatient care.
- Substance use disorder providers should use the following tools to implement measurement-based care:
  - The Alcohol Use Disorders Identification Test (Audit-C)
  - The Drug Abuse Screening Test (DAST-10)
  - The Substance Abuse Outcomes Module
  - The Brief Intervention Monitor
  - The CRAFFT Screening Test (youth and adolescents)[12]

Evidence-based Standards

- Public and private sector partnerships should identify and recommend funding to replicate or scale promising evidence-based practices that incorporate:
  - Discharge planning and a warm handoff to treatment, immediately after revival from an overdose
  - Other brain fitness interventions that mitigate or prevent opioid abuse risks[13]
- HHS, DOJ, The Office of National Drug Control Policy, and the White House Office of Science and Technology Policy (OSTP) should work to create a national set of standards for medical examiners to follow when investigating overdose deaths, including recommendations for detecting poly-drug interactions and accuracy of coded "intent" for overdose deaths when determining cause of death (unintentional vs. suicide/ intentional).

Promoting Technology-Assisted Treatment

- Congress must amend the HITECH Act to extend Medicaid financial incentive eligibility for electronic health record use to non-physician mental health and addiction treatment providers (42 U.S.C. § 1396b(t)).
- CMS, FDA, and the US Preventive Services Task Force (USPSTF) should implement a fast-track review process for any new evidence-based technologies supporting SUD treatments.
- Commercial insurers and CMS must do a better job reimbursing for emerging technology-assisted SUD treatments, which would include the creation of additional HCPCS codes for technology-based treatments, digital interventions, and biomarker-based interventions.
- Payers and health systems should increase the use of predictive modeling and data analytic tools that include clinical data, claims data, demographic data, actively captured patient-reported data, and passively captured patient-reported data so treatment is best tailored for the patient and as an additional means to prevent opioid misuse.
- Behavioral health advocacy organizations should work with EHR and other technology vendors to develop tools that transmit findings from smartphones directly into the medical record.
- Governmental, for-profit and nonprofit organizations must develop a coordinated approach to evaluating behavior modification apps for those with SUD, so individuals have a better sense of which of the many available apps are actually effective.
- There is emerging research indicating transcranial magnetic stimulation (TMS) may be useful for treatment of pain. TMS and other alternative pain treatments should be encouraged and replicated through grants from NIH.

Prevention and Early Intervention

Evidence-Based Prevention

- SAMHSA's Center for the Application of Prevention Technologies (CAPT) should examine the National Registry of Evidence-based Programs and Practices (NREPP) to identify the most effective evidence-based prevention programs and practices (EBPP)—and recommend those programs and practices that should be replicated and scaled.
- All SUD and mental health prevention programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through adherence to clearly identified goals.
- The Federal and state governments should:
    - Invest resources in scaling EBPPs and customizing them for specific priority audiences such as youth, veterans, and persons with chronic pain.
    - Congress should increase mandatory substance use prevention funding through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and amend 42 U.S.C. § 300x-22(a)(2) to make receipt of primary prevention program funds contingent on the use of best EBPPs identified by CAPT.
    - In coordination with the Federal Government and the Partnership for Drug-Free Kids, tech giants such as Google, Amazon, Facebook, and others should contribute $500 million in pro-bono advertising across multiple platforms, in addition to partnering with SAMHSA or a public-private partnership solution to overhaul and modernize the SAMHSA treatment finder.
    - A public-private partnership should create an education program that informs the public about modes of treatment that have been shown to be effective.

Screening and Early Intervention

- The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses.[14] This includes changes in drug use patterns, including heroin, fentanyl, and carfentanil increases in communities—and related harms including hepatitis C and HIV.
- CMS and commercial payers should always reimburse for screening, brief intervention, and referral to treatment (SBIRT) services when provided by any qualified practitioner.
- Primary care professionals conducting preventive services should receive adequate education and training on substance use disorders and information on effective screening and assessment tools. This includes not just providers in traditional primary care settings, but also those in schools, juvenile justice facilities, and other primary care settings where prevention services related to substance use disorders are especially needed.
- All facilities that receive federal funding should be required to train all providers in

substance use disorder and misuse screening.

- CMS and commercial payers should require providers to use substance use screening and remission measures to quality measurement initiatives, such as the CMS-AHIP Core Quality Measures Collaborative.
- Congress should substantially increase annual appropriations for the Foster Care Program under Title IV-E of the Social Security Act (42 U.S.C. § 670-679c) to provide adequate support for the children who have been subjected to trauma and adverse childhood experiences (ACEs), which are inclusive of being separated from parents and living in a house with active substance misuse.[15]
- Congress should amend the Public Health Service Act to require all practitioners provide, and all health plans reimburse, for evidence-based mental health and SUD screening during annual well-child exams and adult annual physical exams, including an ACE screening.[16]
- Congress should amend the Elementary and Secondary Education Act at 20 U.S.C. § 6311 through 42 U.S.C. § 6315 to require teacher and principal training, and professional development on mental health conditions in children[17].
- Congress should increase appropriations authorized under 42 U.S.C. § 12340 disbursed by the Administration for Children, Youth, and Families for grants to states for the specific purposes of ensuring high quality mental health care, as directed by 42 U.S.C. § 12333(1)(B).
- States and localities should modernize child welfare systems, which includes meeting the increased needs related to the opioid epidemic by supporting comprehensive case manager approaches and differentiated response strategies that help keep families together to reduce the trauma of separation when possible and appropriate.
- School districts and private schools should invest in:
    - Evidence-based social-emotional learning and life/coping skill programs
    - Widespread use of modern evidence-based substance misuse prevention programs
    - Expanding availability of school counselors and mental health personnel and increasing school services and coordination across health, education, and social services
    - School-based suicide prevention plans, including training for personnel

Methods to Reduce Opioid Availability and Monitor Opioid Prescribing

- CMS should not provide any reimbursement through Medicaid or Medicare to providers or facilities who do not participate in and/or use the PDMP available in the provider's state.
- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding from the Bureau of Justice Assistance (BJA) Harold Rogers PDMP Grant Program.
- Congress should significantly increase authorizations and appropriations for the BJA Harold Rogers PDMP Grant Program.
- Congress should authorize and appropriate funding for a national PDMP coordination

and standardization system that would allow providers in every state to have real-time access to information from each PDMP throughout the country.

- Government agencies that administer PDMPs should rely upon the Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) at Brandeis University.
- Government agencies that administer PDMPs should implement the recommendations of *Prescription Drug Monitoring Programs: Evidence-based practices to optimize prescriber use*, created by the Pew Charitable Trusts and the Institute for Behavioral Health, Heller School for Social Policy and Management at Brandeis University.
- CMS should unbundle and provide separate Medicare reimbursement for non-opioid postsurgical pain management drugs administered by the healthcare provider and establish separate recognition and reimbursement for those drugs. Currently, 42 CFR § 419.2(b)(16) unconditionally packages payment for all drugs "that function as supplies when used in a surgical procedure" for purposes of Medicare's hospital outpatient prospective payment rates, which inhibits the use of non-opioid postsurgical pain medications and leads to increased opioid prescribing.
- HHS should establish new billing code(s) to reimburse healthcare practitioners for additional time spent providing pre- and postsurgical evaluations and consultations related to low or no opioid postsurgical pain management strategies.
- States and localities should create education about safe storage, disposal, and take back programs to inform patients about safe use and storage, and reduce the availability of unused medicines in the community.
- Payers and Prescription Drug Monitoring Programs (PDMPs) should provide feedback to providers on prescribing metrics, focusing on providers with high-risk prescribing histories.

Harm Reduction

- All federal agencies involved in providing or reimbursing SUD treatment should prioritize public health interventions, including syringe exchange programs, which increase access to health care and decrease blood-borne disease transmission.
- States that have criminal laws that prohibit or inhibit access to syringe exchange programs should not receive any type of federal funding for substance use disorder care.
- All federal, state, and local law enforcement officers should be equipped with naloxone and training on how to administer by 2019.
- Congress must create a grant program that will enable workplaces, libraries, community centers, airports/train and metro stations, universities, schools, public libraries, and other non-medical locations to have naloxone on hand and receive proper training in its administration for staff.
- States and localities should expand naloxone availability, Good Samaritan laws, and other policies that make naloxone more widely available—so people may be able to respond to overdoses and limit liability for helping.

Suicide Prevention

- The Administration should convene key national experts and other stakeholders to reach consensus on, establish, and promote comprehensive standards of care (for primary care, behavioral health, and emergency department settings) for the prevention and treatment of opioid use disorder and related suicidal behavior.
- The VA should fund and support treatment interventions for veterans.
- The DoD, VA, Education, HHS, DOJ, and DOL should sign MOU's with behavioral health advocacy organizations and networks such as the American Foundation for Suicide Prevention and the National Action Alliance for Suicide Prevention to collaborate on suicide prevention, education, and mental health programs at the federal, state and local levels.
- The Director of the National Institutes of Health (NIH) should prioritize suicide prevention research, as well as substance use disorder research, from current appropriations or discretionary funds.
- Availability of evidence-based information about means restriction should be included in medical schools, nursing schools, and all other types of medical education programs.
- States and localities should implement policies to encourage the safe storage of prescription drugs, potentially poisonous household chemicals, and firearms.
- All federally-administered health systems and facilities should follow the latest protocols of the Zero Suicide model put forth by the National Action Alliance for Suicide Prevention, the Suicide Prevention Resource Center, and supported by The Substance Abuse and Mental Health Services Administration (SAMHSA).[18]
- The National Violent Death Report System (NVDRS) should be expanded to every state to allow for better tracking of suicide patterns and risks in order to develop stronger, targeted suicide prevention strategies. Currently Arkansas, Florida, Idaho, Mississippi, Montana, North Dakota, South Dakota, Tennessee, Texas, and Wyoming do not participate in the NVDRS.
- All states should develop suicide prevention plans that focus on building effective support systems within key institutions, training "gatekeepers" or people in positions that have high contact with tweens, teens, and adults (educators, community and faith leaders, human resource and social service providers, etc.) to help identify those at risk, and provide crisis services for those in need. Special focus should be dedicated to school-based efforts and supporting Veterans, Native American/Alaska Native, LGBT, and other higher risk communities.
- All states should require health professionals to receive training in suicide assessment, treatment, and management.

Utilizing the Poison Control Centers to Respond to the Epidemic

- Congress, the Office of Management and Budget, and HRSA should appropriate funding for poison control centers at their fully authorized level (42 U.S.C. § 300d-71; 42 U.S.C. § 300d-72; 42 U.S.C. 300d-73).

- Opioid manufacturers should voluntarily work with the American Association of Poison Control Centers to establish an ongoing fund (funded by opioid sales) to help defray cost of operating the nation's poison control centers.

Criminal Justice Reforms

Jail Diversion

- Local jurisdictions should connect those in custody to crisis intervention centers, community-based substance use or mental health treatment, or other evidence-based services at every early justice-system intercept:
  - Before arrest
  - Before charging or booking
  - Before a guilty plea or conviction
- The DOJ should promote model programs, such as the Police Assisted Addiction and Recovery Initiative, which originated in Gloucester, Massachusetts.
- Congress should increase appropriations for drug court programs established by 34 U.S.C. § 10611.
- Congress should increase appropriations for mental health and drug treatment alternatives to incarceration programs established by 34 U.S.C. § 10581.
- Congress should increase appropriations for mental health courts established by 34 U.S.C. § 10471 and amend that section to remove the 100-program limit currently in place.

Treatment for Inmates

- All Federal Bureau of Prisons medical staff should be trained to recognize and treat substance use disorders and withdrawal symptoms.
- The Health Resources and Services Administration (HRSA) should work with SAMHSA to incorporate MAT competencies and accreditation standards into academic curricula across medical, social service, and criminal justice disciplines.
- CMS should decrease federal financial participation for all Medicaid services to any state that terminates rather than suspends Medicaid eligibility for those incarcerated.
- Congress should increase appropriations for the Residential Substance Abuse Treatment (RSAT) program established by 34 U.S.C. § 10421 and amend 34 U.S.C. § 10422 so grant awards are contingent upon the use of MAT.
- Congress should amend 42 U.S.C. § 1396d(a)(29) so federal financial participation is permitted for inmates enrolled in Medicaid for mental health and substance use disorder treatment.
- Federal prisons should provide every person leaving their custody with a reentry plan that includes initial appointments and contact information for substance use and mental health treatment services and supportive housing.
- State and local courts and corrections facilities should coordinate and collaborate with

other state and local government agencies, community-based treatment providers, and supportive services to meet the health needs of people in transition without unnecessarily disrupting care they are receiving or delaying care they need.
- States should pursue Medicaid health home options to ensure people with complex, varied health needs receive care and support in a coordinated way that is well designed to meet the health needs of formerly incarcerated people and others involved in the criminal justice system.
- State and local courts, as well as probation and parole agencies, should refer individuals with substance use disorders to whatever treatment is most appropriate, including MAT, rather than incarceration whenever possible.
- No judge, probation or parole officer, or other law enforcement official should be allowed to forbid any person under his or her supervision from receiving appropriate addiction treatment, including MAT, as recommended by a medical professional.

Collateral Damage from Drug Arrests

- Criminal records should be expunged after successful reintegration into society and recovery have been achieved by those with non-violent, non-distribution drug convictions.
- Congress must amend 20 U.S.C. § 1091 so any conviction for drug possession without intent to distribute, does not suspend federal student loan eligibility for any amount of time.

Vulnerable Populations

American Indians and Alaska Natives

- The CDC and National Center for Health Statistics should provide Indian Country with real-time access to data involving opioids and suicides.
- Congress must appropriate additional funding to address the need for on-reservation treatment centers, supportive housing for those in recovery, child care resources for the children of those with active substance use disorder, enhanced law enforcement resources, preventive addiction programs such as peer mentoring so that not only the siege of opioids is addressed, but also the siege of the suicide epidemic in Indian Country.
- Grants provided to Indian Country must be structured similarly to how they are for states.
- Reinforce execution of the CDC's Guideline for Prescribing Opioids for Chronic Pain within the Indian Health Service.
- With regards to a Presidential Disaster Declaration, the Stafford Act allows American Indian Tribes to apply directly to the President through the Federal Emergency Management Agency (FEMA), without application through their respective states. Indian Tribes should be clearly granted similar authority when it comes to declaring a state of emergency

related to the opioid epidemic. Federal resources stemming from a Presidential national emergency declaration must be made available directly to Indian tribes and tribal organizations in order to implement culturally appropriate treatment and prevention programs.

- Tribal governments need parity with state and local governments. Direct funding should be made available to Indian tribes as they seek to combat the opioid crisis in their communities.
- Future federal legislation should include set-asides for Indian tribes and ensure that tribes are able to access all resources and funding opportunities.
- Tribal representatives must have the opportunity to serve on federal task forces or commissions seeking to address the opioid epidemic. The Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force (HHS Task Force) and the National Committee on Heroin, Opioid, and Pain Efforts (HOPE) must both include tribal representation.
- Collaboration and coordination among federal agencies is needed in order to pool together the resources to address the opioid epidemic available to Indian tribes.
- Congress must provide fast-track methods for supplying the Bureau of Indian Affairs and Tribal first responders with naloxone.

Issues Concerning Veterans

- Congress should amend 42 U.S.C. § 254e(a)(2) to extend the National Health Service Corps (NHSC) to include Veterans' Health Administration facilities and clinics, by explicitly including those facilities and clinics under the definition of the term "medical facility."
- Congress should authorize and appropriate additional funding to the Department of Veterans Affairs in order to increase the number of behavioral health professionals in the Veterans Health Administration.
- Congress should authorize and appropriate additional funding for the Department of Veterans' Affairs Supportive Housing (HUD-VASH) program found at 42 U.S.C. § 1437f(o)(19).
- Congress should increase appropriations to the Department of Veterans Affairs Special Therapeutic and Rehabilitation Activities Fund, and the Secretary of the Veterans Administration should allocate those additional monies to the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs established by 38 U.S.C. § 1718 to expand the following programs for veterans with substance use disorders, mental illness, traumatic brain injury, and those who are homeless:
    - Incentive Therapy Program
    - Sheltered Workshop Program
    - Transitional Work Program
    - Supported Employment Program
    - Transitional Residence Program

Pregnant women, new mothers, and newborns with opioid dependence

- Pregnant women with opioid use disorder who present at FQHCs should be connected with appropriate MAT during pregnancy and remain in treatment after they have given birth.[19]

- Congress should utilize tax credits and grant programs to fund new (or existing) newborn intensive care units in all hospitals that are equipped to care for infants with neonatal abstinence syndrome (NAS), so mothers do not have to be separated from their children after birth.
- The NIH should fund research into non-pharmacologic interventions for children born with NAS, such as creating a low-stimulation environment, swaddling, feeding on demand, and ensuring that the mother is at the bedside with the infant as often as possible.
- NIH should fund further research comparing the health outcomes for infants whose mothers used different MAT therapies during pregnancy to develop a plan for best efficacy.

Workforce

- Providers who treat patients with chronic pain or those patients who traditionally might be prescribed opioids should consider the following options:[20]
    - Complete the *Minimizing the Misuse of Prescription Opioids in Patients with Chronic Nonmalignant Pain* module created by the University of Massachusetts Medical School.
    - Use the *Screener and Opioid Assessment for Patients with Pain Revised* (SOAPP-R) screening instrument to detect patients who might be at risk for opioid misuse.
    - Read the *Assessment and Management of Chronic Pain Guideline Summary* from the Institute for Clinical Systems Improvement to learn about general recommendations for assessing and managing chronic pain and also use the DIRE Score contained within, which predicts patient suitability for long-term opioid analgesic treatment.
    - Read and utilize the tools available in *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders* developed by SAMHSA.
    - Read the *Guidelines for the Chronic Use of Opioids* created by a multidisciplinary expert panel convened by the American College of Occupational and Environmental Medicine.
    - Complete the *SCOPE of pain* (Safe and Competent Opioid Prescribing Education) continuing medical education activities created by Boston University to increase knowledge of how to safely and effectively use opioid medications, only when necessary, for patients with chronic pain.
    - Use the CDC Opioid Guideline mobile app.

  - Rely upon the CDC checklist for prescribing opioids for chronic pain.
  - Read *The Role of a Prescription Drug Monitoring Program in Reducing Prescription Drug Diversion, Misuse, and Abuse*, created by CMS.
  - Complete the *CO*RE/ASAM Opioid Prescribing Safe Practice, Changing Lives* training course developed by The Collaborative for REMS Education (CORE) and the American Society of Addiction Medicine (ASAM).
  - Read the *Clinician Summary: Clinical Practice Guideline for Opioid Therapy for Chronic Pain* created by the Department of Defense and Department of Veterans Affairs.
  - Download and keep on hand the *Pocket Guide: Clinical Practice Guideline for Opioid Therapy for Chronic Pain* created by the Department of Defense and Department of Veterans Affairs.
  - Watch the video created by the Drexel University School of Medicine titled *Administering a Narcotic Contract*, which demonstrates how to implement a narcotic contract with a patient.
- All federally-supported medical, nursing, and other clinician training programs should be required to incorporate a curriculum regarding the diagnosis and treatment of addiction.
- Federal agencies that employ prescribing clinicians should disseminate and implement the CDC's *Guideline for Prescribing Opioids for Chronic Pain*.
- The FDA and DEA should require clinicians who apply for a registration to prescribe controlled substances demonstrate competency in safe prescribing, pain management, and substance use disorder identification.
- CMS should incorporate the CDC *Guideline for Prescribing Opioids for Chronic Pain* into the Conditions of Participation (CoPs) for the Medicare and Medicaid programs.
- CMS should require all prescribers associated with Medicare Part D plans be required to take training on pain prescribing that follows the CDC *Guideline for Prescribing Opioids for Chronic Pain*.
- The CDC *Guideline for Prescribing Opioids for Chronic Pain* must be updated or supplemented to address prescribing practices for non-primary care prescribers.
- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program (42 U.S.C. 254l; 42 U.S.C. 254l-1; 42 U.S.C. 254q; 42 U.S.C. 254-q-1) to increase the supply of behavioral health professionals. [21]
- Congress should appropriate additional funds to the Minority Fellowship Program (42 U.S.C. 290ll) designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations.[22]
- Congress should increase authorizations and appropriations for SAMHSA, HRSA, and CMMI grant programs that support behavioral health care and/or integration models—particularly increasing grants that focus on underserved areas/populations.
- Congress should create additional substance use education, training, and initiatives to attract and maintain a diverse and culturally competent addiction workforce prepared

for changes to the health care system.

- The FDA should incorporate the CDC's *Guideline for Prescribing Opioids for Chronic Pain* into its Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting Opioid Analgesics.
- HRSA should create distinct categories for addiction health professional shortage areas (HPSAs) that are different from mental health HPSAs.
- Congress should pass the bipartisan S. 1453, which would make providers who serve in facilities that provide SUD specialty treatment eligible for the National Health Service Corps Program.
- States should adjust practice scope/licensing requirements to broaden behavioral healthcare workforces to include more kinds of providers, and enable non-physician providers to deliver a wider range of service.

Research

- Congress should substantially increase appropriations to NIMH, NIDA, and NIAA.
- NIDA should continue its partnership with private pharmaceutical companies in order to:
    - Develop and further test long-acting injectables of both buprenorphine and naltrexone.
    - Develop and test additional medications to treat substance use disorders generally, and opioid use disorders, specifically.
    - Develop and test versions of naloxone that can effectively revive those who have overdosed on powerful versions of fentanyl and carfentenil.
    - Develop and test alternative interventions against opioid-induced respiratory depression, such as wearable devices that can monitor physiological markers to detect signs of an overdose and notify emergency personnel while delivering a reversal agent concurrently.
    - Further test Lofexidine—which is used in the United Kingdom—for use in detoxification.
    - Develop and test opioid vaccines that could prevent opioids in the bloodstream from crossing the blood-brain barrier.
    - Further develop and test conjugate vaccine that produces high levels of antibodies to protect against fentanyl and numerous analogue overdoses.
    - Further develop and test non-addicting pain medications that do not act on the mu-opioid receptor in a way that activates the rewarding and respiratory-arresting effects of current opioid agonist medications.
    - Collaborate with the Blueprint Neurotherapeutics Program within NIH to further develop and test kappa-opioid antagonists for both treatment of stress-induced pain and for potential treatment of opioid used disorder.
    - Collaborate with other Institutes within NIH to further develop and test a

dopamine D3 antagonist that reduces morphine tolerance and dependence without sacrificing analgesic effect.
- Collaborate with other Institutes within NIH to further develop and test $Na_v1.7$ antagonists for use as analgesics.
- Collaborate with other Institutes within NIH to further develop and test gene therapy that applies a powerful anti-inflammatory protein to treat pain.[23]

Federal Grant Accountability

State and Other Federal Grant Recipient Accountability

- Federal grants for the treatment and prevention of mental health conditions and substance use disorders must be structured as contracts that require certain outcome measures be met by grant recipients, including but not limited to:
    - Increased uptake and use of screening tools for all mental health conditions and substance use disorders
    - Improvements in follow-up screening scores on tools such as the Patient Health Questionnaire (PHQ-9)
    - Increased use of evidence-based practices
    - Percentage of people receiving mental health and substance use disorder treatment
    - Percentage of population reporting a willingness to seek treatment for a mental health condition or substance use disorder
    - Percentage of individuals transitioning from detox to outpatient treatment
    - Prevalence of suicide attempts
    - Prevalence of suicide attempts among individuals receiving mental health and addiction treatment
    - Prevalence of total overdoses
    - Prevalence of overdose deaths
    - Percentage of overdoses that result in death
    - Prevalence of overdoses among those receiving mental health and addiction treatment
    - Prevalence of alcohol and drug dependency

- Improvements in public literacy about mental health conditions and substance use disorders and treatment options available
- Percentage of primary care providers participating in integrated care
- Percentage of mental health professionals participating in integrated care
- Improvements in the eligible population enrolled in health insurance

Endnotes

[1] See The Kennedy Forum's Issue Brief "Fixing Behavioral Health Care In America: A National Call for Integrating and Coordinating Specialty Behavioral Health Care with the Medical System" (2015 43 pages). *http://thekennedyforum.org/wp-content/uploads/2017/06/KennedyForum-BehavioralHealth_FINAL_3.pdf.*

[2] See The Kennedy Forum's Guide for the 115th Congress, page 25 for Senate, page 31 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[3] See The Kennedy Forum's Guide to the 115th Congress, page 23 for Senate, page 30 for House *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[4] See The Kennedy Forum's Guide for the 115th Congress, page 28 for Senate, page 34 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[5] See the whitepaper of the Thomas Scattergood Behavioral Health Foundation, The Kennedy Forum, and Peg's Foundation, *Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples,* Page 13. *https://thekennedyforum.org/wp-content/uploads/2017/09/Payment-Reform-and-Opportunities-for-Behavioral-Health-Alternative-Payment-Model-Examples-Final.pdf*

[6] See the whitepaper of the Thomas Scattergood Behavioral Health Foundation, The Kennedy Forum, and Peg's Foundation, *Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples,* Page 11. *https://thekennedyforum.org/wp-content/uploads/2017/09/Payment-Reform-and-Opportunities-for-Behavioral-Health-Alternative-Payment-Model-Examples-Final.pdf*

[7] See the whitepaper of the Thomas Scattergood Behavioral Health Foundation, The Kennedy Forum, and Peg's Foundation, *Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples,* Page 16. *https://thekennedyforum.org/wp-content/uploads/2017/09/Payment-Reform-and-Opportunities-for-Behavioral-Health-Alternative-Payment-Model-Examples-Final.pdf*

[8] See the whitepaper of the Thomas Scattergood Behavioral Health Foundation, The Kennedy Forum, and Peg's Foundation, *Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples,* Page 17. *https://thekennedyforum.org/wp-content/uploads/2017/09/Payment-Reform-and-Opportunities-for-Behavioral-Health-Alternative-Payment-Model-Examples-Final.pdf*

[9] See The Kennedy Forum's Guide for the 115th Congress, page 27 for Senate, page 34 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[10] See The Kennedy Forum's Issue Brief "A national Call for Measurement-Based Care in the Delivery of Behavioral Health Services" (2015 37 pgs). *http://thekennedyforum.org/wp-content/uploads/2017/06/KennedyForum-ResourceGuide_FINAL_2.pdf.* See also Measurement-Based Care Supplement at *http://thekennedyforum.org/wp-content/uploads/2017/06/MBC_supplement.pdf.*

[11] See The Kennedy Forum's Guide to the 115th Congress, page 26 for Senate, page 32 for House.

http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf

[12] See The Kennedy Forum's Issue Brief, A Core Set of Outcome Measures for Behavioral Health Across Service Settings. *https://thekennedyforum.org/wp-content/uploads/2017/06/MBC_supplement.pdf*

[13] See The Kennedy Forum's Issue Brief "Promoting Brain Health and Brain Fitness: A National Call for Action" (2015 54 pgs). *http://thekennedyforum.org/wp-content/uploads/2017/06/issue-brief-Brain_Fitness_160725.pdf.*

[14] See The Kennedy Forum's Guide to the 115th Congress, page 28 for Senate, page 34 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[15] See The Kennedy Forum's Guide to the 115th Congress, page 26 for Senate, page 32 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[16] See The Kennedy Forum's Guide to the 115th Congress, page 24 for Senate, page 31 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[17] See The Kennedy Forum's Guide to the 115th Congress, page 24 for Senate, page 31 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[18] See Suicide is a Significant Problem, a white paper from the Thomas Scattergood Behavioral Health Foundation and Margaret Clark Morgan Foundation written by Dr. Michael F. Hogan. *http://www.scattergoodfoundation.org/sites/default/files/Suicide_Is_a_Significant_Health_Problem_033017.pdf*

[19] See The Kennedy Forum's Guide for the 115th Congress, page 26 for Senate, Page 32 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[20] These all came from AHQR source, will properly cite later *https://integrationacademy.ahrq.gov/sites/default/files/MAT_for_OUD_Environmental_Scan_Volume_2.pdf*

[21] See The Kennedy Forum's Guide to the 115th Congress, page 26 for Senate, page 33 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[22] See The Kennedy Forum's Guide to the 115th Congress, page 27 for Senate, page 33 for House. *http://thekennedyforum.org/wp-content/uploads/2017/06/The_New_Frontier_CongressGuide.pdf*

[23] From the National Institute on Drug Abuse (N.D.V.), and the Office of the Director (F.S.C.), National Institutes of Health, Bethesda, MD. *http://www.nejm.org/doi/full/10.1056/NEJMsr1706626#t=article*


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