ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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In This Issue...

Our lead stories this week look at a 1996 federal policy banning health care providers from billing Medicare or Medicaid for 5 years despite being in recovery from prescription drug abuse and practicing medicine in good standing from their medical boards, and at the ever-present need for "beds" — residential treatment — for substance use disorders.
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DEA doubles down on telehealth limits with "special registry"
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Case studies: Formerly addicted doctor and nurse can't bill Medicare or Medicaid

The federal Department of Health and Human Services (HHS) has a policy, called the exclusion program, of banning health care providers from billing Medicare or Medicaid for five years, even if they are in recovery, cooperate with the courts, are abstinent, pass regular drug tests, have their medical licenses back, and have never harmed a patient. Last week, *ADAW* interviewed two such providers —a doctor and a nurse — who agreed to go public with their stories.

ADAW obtained copies of letters sent by the Centers for Medicare & Medicaid Services (CMS) to both providers.

Both were convicted of felonies regarding the prescription and dispensing of controlled substances.

Bottom Line...
Two health care providers went to treatment for prescription opioid addiction, are sober and practicing medicine, but CMS is barring them from billing Medicare or Medicaid for 5 years under "OIG exclusion" policy.

Under HHS Office of Inspector General (OIG) rules, this is the reason they were banned from billing Medicare or Medicaid for five years, long after they complied with the courts and were practicing medicine in good stead in their respective states.

The nurse, Chris Kyzar, developed an addiction to hydrocodone. At one point in his addiction he committed a fraudulent act that

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Leaders say residential care can and must remain integral to continuum

Despite a number of industry trends that would seem to diminish the future role of residential substance use treatment, several leaders in the treatment and research communities still foresee residential care remaining an integral component of the continuum of care.

These leaders told *ADAW* that the importance of residential treatment

Bottom Line...
Initiatives at the national and local level could function to elevate residential substance use treatment at a time when some industry trends have been signaling a move away from residential care.

is playing out in initiatives that range from San Francisco's shift away from a "Housing First" approach to a national outcomes project that is expected to document the value of a full continuum.

Residential treatment is "a critical intervention in the continuum of care that will remain a necessary element of patient care," said Marvin Ventrell, president and CEO of the National Association of Addiction Treatment Providers. NAATP's nonprofit research arm released its first outcomes-monitoring research report in May, as part of an ambitious effort to document how treatment is being delivered and how

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amounted to a felony (a felony is anything that comes with a sentence of more than a year in prison if convicted). He self-reported to the Mississippi board of nursing, got a lawyer, and went to drug court, where he was told that if he went to treatment, his record would be expunged completely. However, because he had self-reported, the nursing board red-flagged him. His record was expunged, and he was never convicted of a crime, but the OIG did not recognize this.

Chris' story

A registered nurse since 2006, Kyzar "never had any issues with substance use, addiction or drugs," he told us last week. However, he was prescribed Norco (hydrocodone) for a dental procedure in 2018, given a prescription for 20 pills, took three or four of them, and then had to go back to the dentist a week later for an abscess. He got another prescription, put both bottles in the medicine cabinet, and didn't think about them until a few months later when he had a planter's wart in his foot that was very painful. "I thought I could fix my pain, and I remembered the pills were there." He took one a day, which turned into two a day, and after the pills ran out, he diverted hydrocodone that was meant for a patient. The patient didn't even know the prescription was there; Kyzar had picked up the pills for the patient. "My drug dealer was work," he told us.

By February 2019, Kyzar realized he was addicted. He reported himself to the board of nursing and was told to go to a "five-day detox." When in treatment there, he was notified that there was a warrant out for his arrest for obtaining narcotics by fraud. "I hired an attorney, went through treatment, eventually went back to the court, and had two years of house arrest. That's what I needed." His license was suspended for the entire duration of drug court supervision — two years, "no missed court dates, no positive drug tests." The conviction was then expunged. But then he got a letter in the mail notifying him that he was excluded from billing Medicare or Medicaid for five years. "But the OIG does not recognize the expungement, or the reversal of those charges." The state of Mississippi did recognize it, and he can now practice, but without being able to bill Medicare or Medicaid, that is difficult.

"I've done everything that was asked of me," Kyzar said. "Having a nursing license is pointless if you can't work anywhere. It's impossible to find a job, once they find this out, they want to err on the side of caution."

HHS argument against Kyzar

Kyzar appealed the exclusion, but the appeal was denied. From the appeal denial issued by HHS to Kyzar in December:

1. *Petitioner was convicted of two felony counts of "Obtaining a Controlled Substance by Fraud" pursuant to Miss. Code Ann. § 41-29-144(1).*
2. *Petitioner was a hospice nurse case manager and signed for and picked up controlled substances that were filled for hospice patients.*
3. *Petitioner did not dispense the controlled substances to the hospice patients for whom the prescriptions were filled, but rather, converted the prescriptions for his personal use.*
4. *Petitioner admitted that he willfully, feloniously, and intentionally acquired or attempted to acquire hydrocodone by fraud.*
5. *Petitioner's offenses of "Obtaining a Controlled Substance by Fraud" related to fraud.*
6. *Petitioner's offenses of "Obtaining a Controlled Substance by Fraud" were committed in connection with the delivery of a health care item or service.*
7. *Pursuant to section 1128(a)(3) of the Act, 42 U.S.C. § 1320a- 7(a)(3), Petitioner's*

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felony convictions mandate exclusion from all federal health care programs for a minimum of five years.

Petitioner argues that his convictions were "related to an addiction to a controlled substance, not health care fraud" and that the [inspector general] IG should have imposed an exclusion.

Petitioner may be correct that a second exclusion authority is applicable, but he has not demonstrated that the IG committed any legal error when she chose one applicable exclusion authority over another exclusion authority.

Petitioner argues that he is participating in a drug treatment court program and that his felony convictions "will be vacated and expunged" upon completion of the program.

A state court accepted Petitioner's guilty plea and imposed judgment of conviction, and therefore, Petitioner has been convicted for purposes of an exclusion.

The courts may seek to further rehabilitative goals, but the IG seeks to protect federal funds and Medicare beneficiaries. (see also Kim J. Rayborn, DAB No. 2248 at 7 (2009) (finding that a petitioner had a criminal conviction for purposes of an exclusion, even though the court, following the petitioner's completion of a pretrial diversion program, dismissed her case and explicitly stated there was no criminal conviction).

Petitioner implies that his exclusion is unfair because he has "met many RNs/NPs during [his] recovery that have been convicted of felonies and faced disciplinary action by the [Mississippi] Board of Nursing . . . but none have been contacted by the OIG."

I am not empowered, in the first instance, to impose an exclusion against a practitioner. Rather, my role is to determine whether the IG had a legitimate basis to impose an exclusion against a petitioner who has requested a hearing. Therefore, I cannot remedy any perceived unfairness by excluding another practitioner whom [the] Petitioner believes should have been excluded and who has not been the subject of an IG exclusion. Further, Congress has mandated that the IG "shall exclude" an individual who has an enumerated conviction, and I expect that the IG, upon receipt of probative evidence that an individual has an enumerated conviction mandating exclusion, will take the appropriate action. See 42 U.S.C. § 1320a-7(a).

Finally, Petitioner argues that he has "been sober since February 26, 2019 . . . and completed every form of treatment that has been recommended or required," and that "there should be an amendment to Section 1128(a) of the Social Security Act that allows for a deviation from the mandatory exclusion if the person[']s crimes/disciplinary action are directly related to an addiction." Petitioner argues that crimes stemming from drug addiction should not result in a mandatory exclusion but acknowledges that he has "a better chance of convincing Congress to enact an amendment to this law than this appeal being successful." Drug addiction is not a basis for the imposition of a mandatory exclusion, nor is drug possession that does not involve the felonious manufacture, distribution, prescription, or dispensing of a controlled substance.

The IG did not impose an exclusion because Petitioner struggled with drug addiction or possessed controlled substances; The IG imposed an exclusion because it "shall exclude" an individual, such as Petitioner, who feloniously abused his position as a nurse case manager to fraudulently obtain controlled substances.

Congress has determined that a health care provider who commits felony fraud in connection with providing services must be excluded from federal health care programs. 42 U.S.C. § 1320a-7(a)(3). Petitioner has not identified any legal error in the IG's determination, and I affirm Petitioner's exclusion for a minimum period of five years.

The effective date of Petitioner's exclusion is August 19, 2021.

For the foregoing reasons, I affirm the IG's decision to exclude Petitioner from participation in Medicare, Medicaid, and all other federal health care programs for a minimum period of five years, effective August 19, 2021.

The denial was signed by Leslie C. Rogall, an administrative law judge with HHS, CMS' parent agency.

The physician

The other case, Jeffrey Fraser, M.D., involves a physician who developed an addiction to opioid medications after he was diagnosed with prostate cancer. He did have patients filling prescriptions for him. He also complied with the courts, was convicted, went to treatment, became sober, got his license back, and can practice medicine in Nebraska. He is not allowed to bill Medicare or Medicaid because of his felony conviction.

Here is a March letter from the OIG allowing him to bill Medicaid in North Carolina only because the state Medicaid director requested it. However, his employer got nervous, and he was fired.

On July 30, 2021, you were notified by the Office of Inspector General that you were being

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excluded from participation in the Medicare, Medicaid, and all federal health care programs for a minimum period of five years. That action was taken under Section 1128(a)(4) of the Social Security Act (Act) and was based on your felony conviction in the United States District Court, District of Nebraska, of a criminal offense related to the delivery of an item or service under the Medicare or a state health care program. Your exclusion became effective August 19, 2021, and remains in effect.

By letter dated February 20, 2023, Jay Ludlam, Medicaid Director, North Carolina Department of Health and Human Services, requested a waiver of your exclusion. The request for a waiver is based on North Carolina's determination that you are the sole community physician in Cerro Gordo, North Carolina, and that your exclusion would impose a hardship on North Carolina Medicaid beneficiaries in the Cerro Gordo community. Since this request meets the criteria set forth in 42 CFR 1001.1801 and Section 1128(c)(3)(B) of the Act, we are granting the state agency's request for the waiver of exclusion with respect to your enrollment as a provider in the North Carolina Medicaid program.

This waiver only applies to the North Carolina Medicaid program with respect to items and services furnished, ordered, or prescribed as an employee of G&G Healthcare, P.C., in the practice location in Cerro Gordo, North Carolina. Your exclusion remains in effect for all items and services you furnish, order, or prescribe outside of Cerro Gordo, North Carolina, and with respect to any items or services you furnish, order, or prescribe for beneficiaries of other federal health care programs than the North Carolina Medicaid program. As detailed in your exclusion notice, reinstatement to participation in all federal health care programs is not automatic. You must apply to the OIG for reinstatement at the end of your five-year term of exclusion in order to be considered for reinstatement and become eligible to participate in all federal health care programs.

Approval of this waiver request means that, effective with the date of this notice, you may submit claims for payment to the North Carolina Medicaid program for covered items and services furnished, ordered, or prescribed by you as an employee of G&G Healthcare, P.C., in the practice location in Cerro Gordo, North Carolina. This waiver is not retroactive and does not authorize you to claim North Carolina Medicaid program payment for items and services you have previously rendered. If the basis for this wavier ceases to exist, the waiver will be rescinded.

Fraser's story

Fraser said he thinks that Kyzar should definitely not have been excluded — his felony was expunged. "Chris is getting a raw deal," he said.

Of himself, Fraser is not so sanguine. "I'm the king of diversion," he said.

He's a family doctor, owns his own practice, has three children, and doesn't drink alcohol because of his days as an obstetrician when he could have to deliver a baby at any time.

In 2012, he went into treatment for prostate cancer with the gamma knife. He was given a prescription for hydrocodone for back pain and became "immediately addicted." He took about 10-12 pills a day. He said "horrible things" happened to his daughter in 2014 (he didn't elaborate) but they added to his addiction. He wrote a prescription for hydrocodone for one of his employees and asked if he could "have a few." Then, after a few years of that, he had his patients fill prescriptions for him.

On Jan. 2, 2018, six Nebraska state patrol agents went into his office with guns, without a warrant and frisked him (because Fraser had a concealed carry permit). He learned that the Nebraska state officials, along with the Drug Enforcement Administration (DEA) had been trying to catch him. He was under the influence at the time, because when he saw the agents coming, he immediately took 12 pills. "I started talking. I called my wife; she didn't know I was an addict." He went to detox at the local hospital immediately, but the state patrol stayed behind, going through all of his records.

His nurse who had been with him for 18 years would have helped him, but instead, one of his other employees had "ratted me out to Nebraska [Department of Health and Human Services] DHHS," he said. "When you're addicted, you can't stop. I tried to stop about 200 times. I Googled 'self-detox.'"

He had used about 10 patients to fill prescriptions for him; the investigators got four of them to do a videotaped interview saying what Fraser had done.

"I didn't know anything about addiction; I didn't know the neurobiology," he said. But he knew about Talbott Recovery, a Georgia-based treatment program specializing in treating addicted physicians, and he spent three months there. "I spent 15 days detoxing first in Nebraska — I thought I was going to die," he said (withdrawing from multiple years of heavy opioid use is painful). When he got to Talbott, he was sent to Sunrise Detox for another five days. He went back to Nebraska after treatment. "Nebraska doesn't have a physicians' health program, so during the year I was suspended from practicing, Nebraska did no monitoring

When your license is suspended, you're a non-entity in Nebraska. So I hired an 'addictionologist' and a therapist, I did all the drug testing for a year, I took naltrexone pills" (naltrexone blocks opioids). "My wife stuck with me, my kids stuck with me, my grandkids stuck with me. I didn't have any cravings."

On June 14, 2019, Fraser got his medical license back to practice in Nebraska. But at about the same time, he was indicted for a felony (obtaining the controlled substances illegally). "The U.S. attorney wanted to put me in prison for four years for narcotics and 10 years for prohibited person in possession of firearms." (That U.S. attorney is now the lieutenant governor of Nebraska).

Finally, after he spent $30,000 on two lawyers, the gun charges were dropped and Fraser was placed on probation for four years, which ended in July 2022 (two years early).

"I got my license back, got recruited around the country, easily got my North Carolina license [and] was recruited to a place there," he said. "They put me in a county that had no doctor."

He got his DEA license (allowing him to prescribe controlled medications) back and sold his house in Nebraska. "I bought a brand-new house in a forest, on a lake, on a golf course, and I was practicing for three years. But then I got a letter in the mail from the OIG exclusion office saying [that] I was going to [be] banned from billing Medicare and Medicaid for five years. This was 44 months after I took my last narcotics pill. My employer said not to worry. My lawyer said don't worry about it, since you're working in a small town, don't file an appeal." But then, Fraser's employer fired him. "The CEO said he did not know I was a felon when he hired me. There was a big political thing, with the vice president and other doctors going to bat for me, but he wouldn't change his mind. We had to sell our brand-new house and move back to a little apartment in Nebraska."

Fraser is currently working for the Substance Abuse and Mental Health Services Administration (SAMHSA), helping with advocacy to increase education about addiction in medical schools. "But I want to get back to medicine."

'Punitive and unfair'

Peter Grinspoon, M.D., a primary care physician at Massachusetts General Hospital and instructor at Harvard Medical School, who also was addicted to prescription opioids (he wrote the memoir, *Free Refills: A Doctor Confronts His Addiction*"), knew about the policy, but it did not happen to him, he told us last week. "I was charged with three felony counts, inappropriately prescribing narcotics," he said. He got pretrial probation, had to meet with his probation officer for two years, and it was stressful, he said, but it didn't affect Medicare or Medicaid. He went to abstinence-based treatment first, of course – few physician health programs allow treatment with methadone or buprenorphine, although even without the medications, physicians who are in such programs have very high success rates (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32715). The OIG exclusion policy "terrified me for an eight-month period when I was going through the court system," said Grinspoon.

Grinspoon had a colleague who was in a similar situation, but did not have as friendly a judge, and who lost the right to bill Medicare or Medicaid for five years.

"I could not work if I couldn't bill Medicare or Medicaid," said Grinspoon.

And when told of Kyzar's case, Grinspoon was particularly concerned. "If this happens to you, if you self-report, all that does is discourage people from asking for help," he said.

Grinspoon also crossed the boundary of having patients fill prescriptions for him. "But they didn't give me a five-year ban, they let me go back," he said. "It's not helpful to ban people for five years. Doctors and nurses who are monitored and who are treated, they are safe," he said. "The people who are unsafe are the people who are afraid to get help."

"This is wrong on every level — punitive and unfair," said Grinspoon of the OIG exclusion policy. "It doesn't help addicted doctors and nurses. We have a shortage of doctors and nurses. We have nursing and medical boards."

And Grinspoon said that going through recovery is a process that can make for a better physician. "Physicians who are open about their recovery, they are physicians that patients love. Patients don't feel judged or criticized. The qualities you need to get into recovery are mindfulness, gratitude and humility; qualities that make a good physician."

It's important for everyone with addiction to have social support, good medical care, and people who don't give up on you.

To Kyzar and Fraser, Grinspoon said this: "I applaud the fact that you've gone public; grateful that you're working to change this unfair policy."

Federal non-response

Two weeks ago *ADAW* asked the CMS press office to respond to questions about the policy. They asked us for copies of the letters to Kyzar and Fraser. We sent them. They promised to respond by last week. Then, they demurred, saying it was the job of HHS to respond. We sent three emails to all the press officials at HHS. There was no response. We also contacted SAMHSA asking if they had a response. SAMSHA press office said it was CMS' responsibility.

We commend SAMHSA for bringing in Fraser. As for the non-response from HHS and CMS, *ADAW* contends that those agencies are not proud of this policy. •

For more on the policy, go to https://oig.hhs.gov/exclusions/.

DEA doubles down on telehealth limits with "special registration"

The Ryan Haight Act, long a thorn in the side of buprenorphine prescribers, requires prescribers to conduct an in-person examination before prescribing any controlled substance to a new patient. That rule was suspended temporarily during the COVID-19 pandemic, but that public health emergency ended in May of this year.

Last spring, the Drug Enforcement Administration (DEA) proposed new limits on telehealth for buprenorphine (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33712); apparently in response to comments, the agency is now holding a "listening session" next month. However, in the Aug. 7 announcement of the listening session, the DEA added a new possible restriction: a "special registration" for physicians who prescribe buprenorphine via telehealth.

The notice of proposed rulemaking (NPRM) issued in March called for patients to see a doctor within 30 days of a new telehealth prescription.

The NPRM was needed because the public health emergency for COVID-19, which included many exemptions for methadone and buprenorphine, ended in May. However, on May 11, the exemptions were extended until November 11 to allow for "continuity of care."

At the same time that the DEA issued the NPRM for buprenorphine, it issued an NPRM requiring the same thing (being seen by the prescribing physician) for all new controlled substances patients. This particular proposal aroused ire among commenters.

The comment period was only 30 days; yet the DEA received more than 38,000 comments, which is why they are holding the "listening session." More than 35,000 of the comments were about the NPRM regarding all controlled substances. Fewer than 3,000 were on the buprenorphine NPRM.

Methadone is a Schedule II drug, along with morphine and many other prescription opioids. Buprenorphine is Schedule III. This information will be helpful in understanding the below information from the DEA announcement:

> *The Drug Enforcement Administration (DEA) is conducting public listening sessions to receive additional input concerning the practice of telemedicine with regards to controlled substances and potential safeguards that could effectively prevent and detect diversion of controlled substances prescribed via telemedicine.*
>
> *DEA received a total of 38,369 public comments in response to the NPRMs — 35,454 comments on the General Telemedicine NPRM and 2,915 comments on the Buprenorphine NPRM. When combined, these were among the highest number of public comments received on an NPRM in DEA's history. DEA thanks all commenters for their input and has been considering the comments carefully. On May 10, 2023, DEA and HHS temporarily extended the telemedicine flexibilities in place during the COVID-19 PHE to permit further consideration of the comments and avoid lapses in care.*
>
> *Among the 38,369 comments submitted in response to the NPRMs, a significant majority expressed concern, with respect to at least some controlled substances, that the proposed regulations placed limitations on the supply of controlled substances that could be prescribed via telemedicine prior to an in-person medical evaluation. In addition, several hundred comments specifically raised the possibility of a separate Special Registration for those practitioners who seek to prescribe controlled substances without conducting an in-person medical evaluation of patients at all.*
>
> *DEA is open to considering — for some controlled substances — implementation of a separate Special Registration for telemedicine prescribing for patients without requiring the patient to ever have had an in-person medical evaluation at all. DEA also observes that making permanent some telemedicine flexibilities on a routine and large-scale basis would potentially create a new framework for medicine that fundamentally expands access to controlled substances in a way that warrants a new framework for accountability based, in part, on increased data collection and visibility into prescription practices in order to ensure patient safety and prevent diversion in near-real-time.*

Among the questions DEA is posing:

> *If telemedicine prescribing of schedule III-V medications were permitted in the absence of an in-person medical evaluation, what framework, including safeguards and data, with respect to telemedicine prescribing of schedule III-V medications do you recommend to help DEA ensure patient safety and prevent diversion of controlled substances?*
>
> *Should telemedicine prescribing of schedule II medications never be permitted in the absence of an in-person medical evaluation? Are there any circumstances in which telemedicine prescribing of schedule II medications should be permitted in the absence of an in-person medical evaluation? If it were permitted, what safeguards with respect to telemedicine prescribing of schedule II medications specifically would you recommend to help DEA ensure patient safety and prevent diversion of controlled substances?*

Former official comments

The special registry concept actually originated from the Ryan Haight Act itself; Congress required the DEA to create a special registry for all prescribers of controlled substances who prescribe by telemedicine. The DEA never proposed this registry, and in fact didn't even mention it in the NPRMs. However, apparently, some commenters had the idea, and now the DEA wants to hear about it.

Rob Kent, formerly counsel for the New York state Office of Addiction Services and Supports, and until this spring, counsel for the federal Office of National Drug Control Policy, told *ADAW* last week that a special registry was "completely unnecessary." With more than two years' experience of telehealth buprenorphine prescribing, the "world didn't fall apart," he said.

"They [the DEA] could have put the special registry forward in the March proposal, but they chose not to," said Kent.

Kent noted that even with the COVID-19 public health emergency over, the buprenorphine rule could have been extended under the opioid public health emergency, which still exists.

A special registry would have a chilling effect on prescribing, both from the view of the prescriber and the patient, said Kent.

"We always hear about diversion, but how much buprenorphine which is prescribed for [opioid use disorder] OUD is actually being diverted?" asked Kent.

"This is a step backwards, and it raises legal issues about whether something like this can even be done."

Details on listening sessions

The listening sessions will be held on Tuesday, Sept. 12, 2023, and Wednesday, Sept. 13, 2023, can be found at https://www.federalregister.gov/documents/2023/08/07/2023-16889/practice-of-telemedicine-listening-sessions. •

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patients are responding (see "Inaugural outcomes study released by NAATP," *ADAW*, May 22, 2023; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33780).

A key element to maintaining the role of residential treatment, Ventrell contends, involves an accurate assessment of need conducted by professional staff. He compared the importance of maintaining multiple levels of care for substance use disorder to the diversity of possible responses around a diagnosis of prostate cancer, ranging from surgery at the most intensive to vigilant monitoring on the opposite end of the spectrum.

"Our [outcomes] project will validate the different interventions," Ventrell said.

So while advances in treatment technology and medication interventions for addiction might signal that fewer individuals will need a residential level of care, the complexity of the illness would still suggest the importance of access to the most intensive level of service, industry leaders have said.

San Francisco's shift

In San Francisco, where decay and despair reflected in rampant open drug use on the streets have led in recent months to a public outcry for change, a transformation in addressing the needs of the marginalized is taking shape. At the center of this shift is a comprehensive effort by The Salvation Army to establish a continuum of support that includes a heavy dose of residential care for substance use disorders.

The organization's "The Way Out" initiative (thewayoutsf.org) is led by two individuals (one of whom has a substance use history) who formerly worked together to pioneer several treatment-focused programs in San Francisco's adult probation operation. Initiative executive director Steve Adami, who himself was paroled to a residential program after release from incarceration, said he knows few people who have been in his shoes and did not need residential care at some point as part of their recovery journey.

The Way Out embodies a shifting paradigm away from a "Housing First" mindset that Adami and others have said has failed to address the core issues contributing to chronic homelessness. Its leaders describe their mission as one of creating a recovery-focused system of care that includes residential treatment, transitional housing and other supports (see "S.F. seeks improved recovery programs amid a philosophical tug-of-war," *ADAW*, Nov. 14, 2022; https://onlinelibrary.wiley.com/doi/10.1002/adaw.33615).

Adami and The Way Out deputy director Destiny Pletsch explained that a combination of city grants and private funds allows the initiative to operate outside the bureaucratic hurdles to care brought on by the Medi-Cal health plan requirements. This allows The Salvation Army to guarantee treatment on demand within a campus location that houses a social model detox program, residential treatment beds and a family shelter.

Adami said that at present, the detox program has a bed capacity of 40, half of which are being funded by the city. The residential treatment component currently has 96 beds, 56 of which are city funded. Leaders said they expect to scale the initiative over the next two years, hoping to reverse a trend that has seen substance use treatment admissions in San Francisco decline by more than 30% since the mid-2010s, Adami said.

The overall vision calls for duration of client participation in the continuum to range anywhere from weeks to up to three years. "We believe that treatment should be based on need, not on funding," Adami said.

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"What residential treatment does is give you a sense of community," he said. "The message people have been hearing on the streets is that people just need housing. Housing is not an evidence-based solution to addiction," he said, as housing alone does not address the drivers of chronic homelessness.

The Way Out's leaders see the tide gradually turning in the city, even with messaging from city government that has appeared to shift from a safe-use message to one promoting recovery. "We're pushing the narrative that people can recover," Pletsch said. "The Salvation Army is stepping into a leadership role."

The Way Out also includes a transitional housing component that currently serves 36 individuals and is expected to expand to a capacity of 100 by January 2024.

Overcoming obstacles

"Due to higher levels of addiction severity, complexity, chronicity and a high risk for adverse events, 'medical necessity' will dictate that residential treatment stays are sometimes clinically necessary," said leading national researcher John F. Kelly, Ph.D., the Elizabeth R. Spallin Professor of Psychiatry in Addiction Medicine at Harvard Medical School and director of the Recovery Research Institute at Massachusetts General Hospital.

"The duration of those residential stays for which government or insurance pays will depend on that medical necessity, but in other instances, both individuals, as well as their families, may elect to pay out-of-pocket for residential treatment to provide a more prolonged and uninterrupted focus that such a protected environment can give," Kelly said.

The NAATP's Ventrell said he agrees that payer determinations will remain critical to preserving the residential level of care. Without payer buy-in, a full continuum can't be supported. This is why it remains crucial for the industry to arrive at a set of generally accepted standards of care, which in turn would lead to genuine value-based contracting in substance use treatment, he said.

One of NAATP's current priorities in messaging to its members has involved encouraging more broad-based assessment of patient need based on the high prevalence of co-occurring mental health disorders. Programs need to consider in these cases the options of "treat it, refer it, or braid it," Ventrell said, with the latter referring to coordinating care with a second treatment provider. A need for coordinated care to address the complexities of co-occurring disorders speaks to the importance of the availability of residential levels of care, he said.

"For some individuals, a residential stay can be a lifesaver and a turning point," Kelly said. "Family members too, who can often become severely ill themselves through the chronic stress of a loved one suffering from addiction, are often helped immensely and gain great relief from the protection that a residential setting can provide for their loved one." •

Coming up...

The **California Society for Addiction Medicine (CSAM) State of the Art Addiction Medicine Conference** will be held **August 30 - September 2** in San Diego, California. For more information, go to https://csam-asam.org/

The **Contemporary Drug Problems Conference** will be held **September 6-8** in Paris, France. For more information, go to **https://www.latrobe.edu.au/arcshs/events/contemporary-drug-problems-conference**

The **Cape Cod Symposium on Addictive Disorders** will be held **September 7-10** in Hyannis, Massacchusetts. For more information, go to **https://www.capecodsymposium.com/**

The **NAADAC annual conference** will be held **October 6-12** in Denver, Colorado. For more information, go to **https://www.naadac.org/annualconference**

In case you haven't heard...

Netflix has released a new series, called *Painkiller*, which professes to detail the guilt of the Sackler family going back to the 1950s, when Purdue Pharma, along with nearly all other pharmaceutical companies, learned that the best way to sell medications to physicians was to sell them directly to physicians. Complete with dramatic music and commentary by people who have lost loved ones to the opioid epidemic —which the series blames on Purdue, OxyContin and the Sacklers — the series sounds like a documentary with an agenda. Judy Berman of Time magazine wrote this in her Aug. 10 review: "Based on Keefe's *New Yorker* exposé, "The Family That Built an Empire of Pain," and the book *Pain Killer* by Barry Meier, *Painkiller* presents a prismatic view of the devastation wrought by OxyContin over the past quarter-century." But Berman added that these accounts, as well as many others she names, are much more enlightening. "Neither as moving nor as informative as any of the above nonfiction accounts, *Painkiller* is a flawed vehicle for a vital message about lethal corporate malfeasance in health care and our government's failure to protect us from it. The best it can do is entice us to seek out better information." We heard the producer on National Public Radio last week gloating that he expected Richard Sackler to be much more hurt by his name being removed from the museums and concert halls he donated money to than by the $8 billion he paid to avoid any future civil lawsuits — a deal that has yet to be sealed by the courts. If you want to see *Painkiller*, go to https://www.netflix.com/title/81095069.