**Introduction**

As the Biden administration assumes office during an accelerating global pandemic, federal policymakers will also confront an additional ongoing crisis of addiction—one that appears to both be worsening in its lethality and evolving as synthetic opioids such as fentanyl, polysubstance use, and stimulants, play a greater role in overdose deaths. The COVID-19 pandemic has contributed both to an alarming increase in drug overdose deaths and has laid bare systemic inequalities that result in poorer health outcomes for communities of color. Unemployment, isolation, and stressors from the pandemic, along with disruptions in access to care, have compounded existing challenges for people with substance use disorders (SUDs). Difficulties in accessing services have been exacerbated by financial pressures on addiction treatment providers even as providers report an increased demand for services.

While immediate action is needed to stem the tide of rising overdose deaths, the administration also has a critical opportunity to take on fundamental reforms for an addiction and behavioral health system that is fragmented, inequitable, and often fails to deliver quality care to those who need it most. Developing a long-term agenda for addressing key drivers of the substance use and addiction crisis will entail working closely with stakeholders to examine and address longstanding disparities and barriers to care, make meaningful investments to the prevention, treatment, and recovery infrastructure, and reorient payment and care delivery approaches to support quality, whole-person care.

To support the Biden administration in addressing these pervasive challenges, the Duke-Margolis Center for Health Policy convened key thought leaders for a December 2020 virtual roundtable with the goal of identifying high-impact action items that the administration could immediately take to address rising overdose deaths as well as priorities for developing a long-term agenda to address the opioid crisis. Taken together, the recommendations presented below reflect a suggested agenda for ending the addiction and substance use crisis based on key priorities and considerations raised by thought leaders across the addiction community, including state and federal officials, academic experts, treatment providers and provider associations, health systems, payers, and addiction advocacy organizations.

To save lives and develop a long-term agenda for addressing the opioid crisis, key priorities for the Administration include:

1. Improve alignment and coordination across federal programs and agencies addressing substance use
2. Identify lessons learned during the pandemic and extend appropriate regulatory flexibilities
3. Center equity and lived experience in the policy-making process
4. Strengthen harm reduction and community-based prevention approaches
5. Reduce regulatory and policy barriers to evidence-based SUD treatment
6. Develop real-time data system information sharing to inform policy efforts
7. Expand investments in prevention, treatment, and recovery workforce capacity
8. Advance payment and delivery reforms that support a whole-person approach to treatment and recovery
9. Reform the criminal justice system and link justice-involved individuals to quality care
Key Priorities and Considerations for Saving Lives and Ending the Addiction Crisis

Improve alignment and coordination across federal programs and agencies addressing substance use

In 2018, the Federal government—primarily through the U.S. Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the Department of Labor (DOL)—allocated over $7.4 billion in time-limited grant programs intended to curb the opioid epidemic. While Medicaid is the largest single payer of SUD treatment in the United States, covering nearly four out of 10 non-elderly adults with opioid use disorder (OUD), supplemental grant programs to states, including State Opioid Response (SOR) grants and Substance Abuse Prevention and Treatment Block Grant (SAPTBG) help to support states with treating uninsured individuals, addressing emerging needs, and supporting wrap-around services, such as housing and social supports not included as a traditional Medicaid benefit. States and local agencies administering opioid funding are challenged by multiple, short-term federal funding streams with differing deadlines, populations, definitions, and reporting requirements as well as lack of incentives for inter-state and local coordination that can further exacerbate in siloed approaches. The Biden administration has an opportunity to assume greater strategic leadership and coordination at the federal level by aligning efforts across agencies and funding streams to unify efforts on criminal justice, employment, health care, education, housing, and other critical issues pertinent to advancing a holistic treatment system.

Opportunities for improving alignment and coordination:

• The Biden administration should consider elevating the National Director of the Office of Drug Control Policy (ONDCP) to a cabinet-level position to integrate addiction policy as part of the broader national policy agenda and to unify efforts across federal departments (e.g., HHS, DOJ, DOI, VA, and DOL) that fund various but siloed treatment and recovery services.

• The Biden administration should appoint an interagency body, potentially modeled after the National Prevention Council, to coordinate and align Federal efforts to address the opioid and substance use crisis. The interagency task force could be convened through ONDCP and include representation from agencies (e.g., CDC, CMS, SAMHSA, HRSA, ASPE, DOL, HUD, DoEd, DEA, FDA, DOJ) across the government and be charged with streamlining and aligning definitions, data requirements, and greater coordination across agencies to ensure that all policies across the Federal government support recovery.

• HHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) should work with Congress to advance multi-year authorization for critical sources of state funding, such as the SOR grant and SAPTBG, which would provide continuity of efforts, enable state-level forecasting and strategic planning, and encourage further long-term investments in treatment infrastructure currently unavailable through time-limited funding. The Biden administration also should work with Congress and relevant agencies to ensure that funding can be applied flexibly to address polysubstance use and emerging needs.

• The Biden administration should encourage a conscious shift from opioid or drug-specific strategies to a more holistic approach to addiction that acknowledges the dominant role of polysubstance use, including the use of stimulants, alcohol, nicotine, and cannabis.
Identify lessons learned during the pandemic and extend appropriate regulatory flexibilities

The COVID-19 pandemic has presented significant challenges for individuals with SUDs, and created pressures on behavioral health systems that further threaten access to critical services. Providers have reported significant revenue losses during COVID-19 with additional costs related to PPE, testing, hazard pay, and COVID-19 mitigation measures—along with cuts to state Medicaid budgets. In September 2020, one association reported that 30 percent of their providers can only survive six months or less in the current environment. Federal and state policymakers, payers, and providers responded to the challenges of the COVID-19 pandemic for medications for opioid use disorder (MOUD) and treatment services in a variety of ways, including expanding payment and eligibility for telehealth services, providing flexibility in prescribing MOUD, offering in-person rates for telehealth services, lifting the number of patients that can be cared for by a DATA 2000-waivered prescriber, increasing flexibility for take-home medications dispensed by opioid treatment programs, and relaxing prior authorization requirements. The Biden administration should consider extending these flexibilities for a predictable time horizon beyond the duration of the current public health emergency to give providers predictability in their staffing and planning, while also studying the impact of these interventions to determine which flexibilities should be sustained beyond the pandemic.

Opportunities for identifying lessons learned and extending appropriate regulatory flexibilities:

• An interagency task force, in coordination with ONDCP and ASPE, should be developed to coordinate across federal agencies, states, payers, and health systems to support the advancement of “virtual models of care” for SUD treatment, including assessing gaps in access to telehealth access across communities and developing resource and training needs for providers facing challenges in adopting telehealth technology. Identifying specific state-based barriers to this care should be included with recommendations for lifting these barriers.

• The Centers for Disease Control and Prevention (CDC) and SAMHSA should work with states to prioritize substance use service providers as frontline health workers for the purposes of vaccine distribution, and highlight the potential role that harm reduction, treatment, and recovery organizations can play as trusted messengers for vaccine administration to communities at high risk of COVID-19.

• HHS and ASPE should lead an effort to study the impact of regulatory flexibilities extended during the COVID-19 crisis on safety, access to evidence-based care (including equity), treatment retention, and other quality measures to determine which flexibilities should be sustained beyond the pandemic. In the interim, SAMHSA, the Centers for Medicare and Medicaid Services (CMS), and the Drug Enforcement Agency (DEA) should extend regulatory flexibilities for 12 months to enable predictability and planning for treatment providers and continue their efforts to be responsive to partner needs.
Center equity and lived experience in the policy-making process

Communities of color in the United States have long faced structural racism embedded in policies within the health and criminal justice systems. Despite rates of substance use roughly equal to white Americans, Black and Hispanic Americans are more likely to face involvement in the criminal justice system, stigma, higher levels of unemployment, and barriers to access for treatment, resulting in poorer outcomes for Black and Hispanic Americans with SUDs. One-sized-fits-all policies to address the opioid epidemic often fail to address differing substance use patterns across age, racial, ethnic, gender, and minority groups or address community needs in a culturally-responsive manner. Going forward, acknowledging the harmful legacy of the “war on drugs” and actively seeking opportunities to overturn its policies, “the Biden administration should find meaningful ways to incorporate the lived experience of communities impacted by these policies, which will be critical to ensuring that federal policies reflect the communities they are intended to heal and recover.

Opportunities for centering equity and lived experience:

- ONDCP and SAMHSA should consider appointing a “lived experience” advisory council with representation from communities of color and sexual minorities and individuals affected by the war on drugs, people who use drugs, individuals in recovery and their families, individuals with difference insurance status (e.g., Medicaid, uninsured, private), and treatment providers to advise ONDCP in all aspects of policy creation. Currently, operating advisory councils should also seek to ensure participation from people in recovery and communities of color.

- HHS and the National Institutes of Health (NIH) should increase research to rigorously evaluate existing disparities in access and outcomes for communities of color as well as the impact of policies on communities in real-time.

- HHS should encourage grantees to collect and analyze disaggregated data along race, ethnicity, sexual orientation, gender identity, and other intersections, including their involvement with the justice system, and should direct funding to evaluate programs that have been led by and support marginalized communities.

- The Biden administration should identify opportunities through existing or new initiatives to address stigma, both through education, training, and peer programming as well as modeling appropriate language and de-stigmatizing terminology.
Strengthen harm reduction and community-based prevention approaches

While all racial/ethnic and age groups experienced increases in opioid-involved overdoses deaths between 2015-2017, some of the largest increases occurred among Black Americans aged 45-64 years in large metro areas. During this time, Black Americans also experienced the largest increases in cocaine-involved overdose deaths compared to other racial and ethnic groups. As our insight into the presence of fentanyl in the cocaine supply and in cocaine-involved overdoses continues to sharpen, it is more critical than ever to support harm reduction efforts, such as syringe services programs, that aid communities with reducing the risks associated with drug use. With communities of color, homeless individuals, justice-involved individuals, and other populations already at increased risk of poor outcomes due to COVID-19, there is an urgent need to deliver targeted resources and evidence-based interventions to communities that need it the most. Harm reduction, including naloxone distribution, fentanyl test strips, syringe service programs, and other drug user health programs, are critical evidence-based strategies for reducing overdoses, disease transmission, and other consequences of substance use. In order to save lives, the Biden administration can elevate the importance of culturally and linguistically effective harm reduction as a critical strategy in the prevention-treatment-recovery paradigm, invest in evidence-based and culturally-appropriate programs, and address existing barriers to access these services.

Opportunities for strengthening harm reduction and community-based prevention:

- HHS and CDC should work with Congress to remove the prohibition on the use of Federal funding for the purchase of syringes and work through CDC to support evidence-based harm reduction approaches.

- HHS should expand free naloxone distribution and fentanyl test strips at community sites, harm reduction programs, treatment facilities and pharmacies.

- The FDA should consider exercising their statutory authority under 21 CFR § 310.200(b) to initiate the process of moving at least one naloxone product from prescription to over the counter status, as naloxone has no potential for abuse or misuse.

- HHS, including SAMHSA and in coordination with VA, DOD, and DOL, should identify opportunities to increase access to community-based harm reduction services and support the development of culturally and linguistically responsive interventions, programming, and resources.

- HHS, working across agencies and programs, should prioritize only evidence-based primary prevention programs, such as taking a multi-generational approach to prevent adverse childhood experiences and pay for wraparound and social support services.

- The Internal Revenue Service (IRS) should consider a regulatory update, in coordination with governors, to Opportunity Zones that would prioritize investing in SUD treatment services, including community-based harm reduction services, with a particular focus on spurring economic development and job creation in disproportionately affected communities.
While the pressures of the COVID-19 pandemic have led to a weakening of SUD treatment networks, substantial gaps in access to high-quality treatment far precede the pandemic. At present, nearly 90 percent of individuals with a SUD do not receive treatment and only 36 percent of substance use facilities offer MOUD. To help expand access to and bridge the gap in evidence-based SUD treatment, the Biden administration should examine potential executive actions to address legal and regulatory barriers that inhibit access, while developing long-term strategies that incentivize quality care and build the treatment workforce (addressed in later sections).

Opportunities for reducing regulatory and policy barriers to evidence-based SUD treatment:

• The DEA should finalize the “mobile methadone” rule to allow Opioid Treatment Providers (OTPs) to operate mobile components without a separate registration.

• HHS and DEA should consider opportunities to reduce barriers to OUD treatment, including allowing the permanent initiation of buprenorphine through an audio-visual visit for new patients by quality MOUD providers. SAMHSA should also consider approaches for reducing barriers for methadone induction via telehealth.

• HHS should engage with states and a broad coalition of addiction stakeholders to identify opportunities to reduce barriers to methadone access through regulatory reform and incentives for states.

• CMS in coordination with the Office of Inspector General (OIG), should grant a waiver of the Beneficiary Inducement Civil Monetary Penalty (sometimes referred to as the Anti-Kickback Statute) to allow for Medicare and Medicaid beneficiaries to receive contingency management approaches, which have been proven to be the most effective treatment for SUD. Currently, HHS OIG’s implementation of these rules prohibits Medicare and Medicaid beneficiaries from receiving contingency management services consistent with evidence-based clinical protocols developed under NIH-funded research.

• HHS, DEA, and SAMHSA should work with Congress to pass the TREATS Act, which permanently allows for an audio-video telehealth evaluation exception to the Ryan Haight Act’s in-person exam requirement for purposes of prescribing Schedule III and IV medications and clarifies Medicare’s ability to reimburse for audio-only, substance use disorder telehealth services if an in-person or telehealth evaluation has already occurred.

• DEA, as required by the SUPPORT Act of 2018, should finalize the special registration for telemedicine to enable practitioners to prescribe via telemedicine a controlled substance for OUD, such as buprenorphine, to a patient who has not been medically examined in-person by the prescribing practitioner.
• An interagency task force should examine opportunities to strengthen evidence-based requirements across grant programs (e.g., requiring treatment entities to offer two or more forms of MOUD or prohibiting recovery home grantees from excluding residents taking opioid agonist medications) across entities accepting federal funding to ensure that federal policies do not preclude, penalize, or disincentivize the use of MOUD.

• HHS should work in partnership with Department of Labor (DOL) and state insurance commissioners to enforce behavioral health parity requirements across commercial payers and Medicaid programs.

• The Biden administration should work with Congress to empower DOL to implement civil monetary penalties on employee benefit (ERISA) health insurance plans that do not offer behavioral health services in parity with physical health services.

• HHS should engage with states and a broad coalition of stakeholders to identify opportunities to address the widespread stigma of MOUD through a modern, multimedia national public health campaign (e.g., Choose Change California).

• FDA should release guidance on developing therapeutics for stimulant use disorder.

• FDA should consider new pathways for engagement and guidance to support the development of novel technologies, e.g., mobile applications, to support prevention and/or treatment of SUDs.
Improve the speed and quality of data to inform policy efforts

Data to support the development and evaluation of interventions for substance use, SUDs, and overdose deaths have long been incomplete, siloed, and lagging. In contrast, and in order to respond to the COVID-19 pandemic, the federal government, states, and private stakeholders collaborated at an unprecedented speed to improve data collection approaches and develop tools (e.g., dashboards) to provide real-time visibility of transmission rates, inform policy responses, and evaluate community mitigation and treatment approaches. Applying this same collaborative model and infrastructure to SUD is central to understanding treatment utilization by subpopulations, evolving drug trends, and gaps in access to care that acknowledges the dynamic nature of substance use and can be used to meaningfully improve equitable access and outcomes. To support improved policymaking and responses, the Biden administration should meaningfully invest in the development of behavioral health data systems, reform data collection and information sharing efforts to support consistent definitions, improve the timeliness of mortality data and other reporting requirements, and encourage better sharing of physical and behavioral health data to support integrated approaches.

Opportunities improving data systems to inform policy efforts:

- ONDCP and HHS should seek opportunities to improve the speed, quality, and consistency of data collection and information sharing by:
  - Working with Congress to increase Federal investment in data infrastructure
  - Establishing a Federal data collection framework to understand and track the crisis in real-time to support uniform reporting across states and meaningful quality metrics.
  - Improving data collection from tribal nations to better understand and target resources to this population, in consultation with tribal leaders and American Indian/Alaska Native community stakeholders.
  - Modernizing SAMHSA’s Substance Abuse Prevention and Treatment Block Grant data collection to improve consistency, coordination, and relevance across payers and other federal grants (e.g., State Opioid Response grants).
  - Exploring opportunities for increased standardized reporting of SUD quality measures for the Medicaid program at the national, state, and Medicaid health plan level, such as leveraging the Medicaid Adult Core Set, CMS’ Transformed Medicaid Statistical Information System, federal Medicaid managed care requirements, or other mechanisms.
  - Support state efforts to integrate various public health and public safety data that can be used to develop coordinated risk-reduction strategies tailored to local communities or specific regions.
• The Office of the National Coordinator (ONC) should provide funding to incentivize behavioral health providers to make needed investments in electronic health records and tools for population health, similar to the HITECH program.

• CDC, working in close partnership with states, could leverage and apply data collection and reporting “dashboard” approaches adopted during the pandemic to rapidly identify trends in real-time to

• HHS should consider further changes in the interpretation of 42 CFR Part 2 to better integrate substance use data across physical health, behavioral health, and other payers while protecting the data of individuals receiving SUD treatment and develop strategies for assisting states and providers with implementation of future changes.
Expand investments in prevention, treatment, and recovery workforce capacity

In 2018, approximately 2.4 million people aged 12 or older received substance use treatment at a specialty facility, roughly 11.1 percent of the people who needed treatment. The 2019 National Drug Control Strategy cites “critical shortages in trained and professional addiction service providers” as a key factor contributing to the “treatment gap.” A lack of adequate infrastructure, has inhibited the expansion of evidence-based care and has prevented states from maximizing SAMHSA grant funding. Specific factors contributing to the current inadequacy of the addiction and behavioral health workforce is its insufficient size, frequent turnover, relatively low compensation, minimal diversity, and limited training. While regulatory reforms to increase the number of physicians authorized to prescribe MOUD may help reduce critical barriers to access for these therapies, significant investment and payment reform are needed to meaningfully grow and sustain the behavioral health workforce.

Opportunities for Investing in treatment workforce capacity:

• The Biden administration should work with Congress to increase the number of residency positions eligible for graduate medical education payments under Medicare in hospitals that have addiction medicine, addiction psychiatry, or pain medicine fellowship programs or consultation services.

• SAMHSA should issue SUPPORT Act guidance for integrating substance use and addiction education into health professional school and residency curricula to expand the functional knowledge of substance use services and ensure all graduates and trainees are DATA 2000 waivered to prescribe buprenorphine.

• The Biden administration should consider working with Congress to amend the Social Security Act to recognize substance use treatment facilities and harm reduction providers as an independent provider type to qualify for Medicare reimbursement.

• The Biden administration should work with Congress, HHS, and DEA to eliminate the need for DATA 2000 waivers for DEA-registered prescribers, including advanced practice clinicians such as nurse practitioners and physician assistants, while ensuring all prescribers of controlled substances receive adequate training in treating pain and in recognizing and treating addiction.

• HHS should work with public and private payers, health systems, and addiction treatment providers to facilitate sustainable reimbursement levels for behavioral health services through value-based payment approaches that incentivize quality care.

• HHS and CMS should work with Congress to expand access to additional states for capacity-building planning grants and demonstration projects authorized under Section 1003 of the SUPPORT Act.
Advance payment and delivery reforms that support a whole-person approach to treatment and recovery

Individuals with substance use disorder often have complex physical, behavioral, and social needs that are poorly served in the current fragmented health system, resulting in poor outcomes and significant healthcare costs. Medical costs for individuals with comorbid medical and substance use disorders or mental health conditions are estimated to be two to three times higher than individuals without behavioral health conditions. Integrated care models for SUDs can improve outcomes and reduce health care costs by treating the underlying factors and comorbidities contributing to an individual’s substance use condition. These coordinated care models can help advance a whole-person approach to treatment and recovery, including psychosocial and supportive services to address co-occurring social determinants of health such as a lack of housing and transportation, food insecurity, and joblessness. Medicaid, Medicare, and commercial payers all play a critical role in ensuring access to evidence-based care. The Biden administration can take a significant leadership role in helping to reform and strengthen the behavioral health treatment system through efforts to identify meaningful quality metrics and standards for treatment across the continuum of care, encouraging and supporting value-based payment and meaningful risk sharing for outcomes, encouraging coordination between health systems and community social supports such as safe and stable housing and supported employment, and supporting the scaling of innovative models of care.

Opportunities for advancing payment and delivery reforms:

• Through CMS, increase coverage of evidence-based practices and incentivize improved SUD treatment and recovery outcomes in Medicaid by:

  - Issuing guidance to implement and reimburse for a SUD Collaborative Care Model in Medicaid, which would allow states to uniformly reimburse for care coordination and integrated behavioral health services needed to support an individual’s recovery.

  - Working with Congress to add a behavioral health category specifically requiring treatment of addiction to the existing list of mandatory benefits in federal Medicaid statute to allow services to be covered consistently across states and to ensure that individuals continue to receive services to maintain their recovery.

  - Issuing guidance that would empower states to establish bundled payments or case rates that are aligned with levels of care and tie payments to performance on one or more quality metrics.

  - Issuing a CMCS Informational Bulletin, or a State Medicaid Director letter, highlighting various approaches to financing care coordination, such as turning on specific SUD care coordination codes as a component for covered services (e.g., Virginia OBOT reimbursement model), or using managed care directed payments (e.g., Pennsylvania’s Centers of Excellence).
• The Center for Medicare and Medicaid Innovation (CMMI) should identify opportunities to support value-based payment models that incentivize a whole-person approach to recovery and integrate physical, behavioral, and social needs by:

  - Incorporating social risk factors into risk adjustment payments to incentivize providers to care for medically complex patients that helps people move through the treatment continuum as their needs fluctuate.

  - Developing and testing innovative alternative payment models for SUD treatment using performance-based incentives tied to meaningful processes and outcome measures to accelerate movement towards a recovery-oriented system of care that integrates behavioral health, physical health, and social needs and produces equitable outcomes.

  - Recognizing SUD is a chronic, relapsing disease requiring ongoing care management (including self-care), and therefore payment should be condition-specific as opposed to episodic.

• HHS should work with stakeholders to move toward consistent quality metrics for SUD treatment and recovery across levels of care to support improved consistency and quality across the treatment system.

• HHS should engage with states, public and private payers, health systems, treatment providers, harm reduction providers, and community-based organizations to shift toward payment strategies that link payment to evidence-based practices and provide linkage to services and supports at the appropriate level of care.
Reform the criminal justice system and link justice-involved individuals to quality care

Echoing the Biden Plan to End the Opioid Crisis, roundtable participants raised the urgent need to critically rethink the punitive role of the justice system, address racism within the health and criminal justice systems, and invest in robust prevention and treatment systems that can address untreated addiction and prevent justice involvement. While the Biden administration will need to address more comprehensive criminal justice reform efforts, there is also a need to support improved pre-arrest diversion strategies that can link individuals to treatment, improve community supervision approaches, and expand access to evidence-based care for those already involved in the justice system. Individuals in criminal justice settings bear a disproportionate burden of SUDs and have a 12.7-fold increased risk of fatal drug overdose compared with the general public during the first 2 weeks post-release. Despite the availability of MOUD, it is estimated that fewer than 1 percent of jails and prisons in the U.S. provide access to all three forms of these medications. Strategies are needed to connect individuals reentering the community to the critical treatment and supports needed to support sustained recovery.

Opportunities linking justice-involved individuals to care:

- As required by the SUPPORT Act, CMS should issue guidance to states on 1115 waiver demonstrations for Medicaid coverage 30 days pre-release.

- CMS should approve pending 1115 waiver demonstrations that increase coverage and access of MOUD and evidence-based SUD treatment services for incarcerated populations using Medicaid funds.

- CMS, DOJ, ONDCP, and SAMHSA should collaborate to enhance, augment, and accelerate the exchange of secure information sharing between public health and public safety.
Conclusion and Next Steps

Although significant progress has been made in reorienting from a “war on drugs” approach to a public health emphasis on prevention, treatment, and recovery, the incoming Biden administration will face an ongoing addiction crisis exacerbated and made more challenging by the COVID-19 pandemic. To respond to rapidly increasing overdose deaths in the short term, the recommendations outlined in this report offer a substantial opportunity for immediate executive and regulatory action to reduce barriers to evidence-based care, deliver sorely needed resources to vulnerable populations, and link justice-involved populations to quality treatment and support services. Beyond the pandemic, the Biden administration—working in partnership with Congress, state and local leaders, payers, health systems, providers, and community organizations—has the opportunity to fundamentally reshape our nation’s approach to addiction by consciously integrating the lived experience of individuals and communities of color into policymaking, leveraging data to identify and address health disparities, supporting whole-person approaches that meaningfully address social determinants and individual needs, and advancing health system reforms that support quality and evidence-based SUD treatment across the continuum of care.

Appendix: Glossary of Acronyms

**ASPE**: Assistant Secretary for Planning and Evaluation

**BJA**: Bureau of Justice Assistance

**CDC**: Centers for Disease Control and Prevention

**CMCS**: Center for Medicaid and CHIP Services

**CMMI**: Center for Medicare and Medicaid Innovation

**CMS**: Centers for Medicare and Medicaid Services

**DEA**: Drug Enforcement Administration

**DATA**: Drug Addiction Treatment Act

**DoED**: Department of Education

**DOI**: Department of Interior

**DOJ**: Department of Justice

**DOL**: Department of Labor

**FDA**: Food and Drug Administration

**HHS**: Department of Health and Human Services

**HITECH**: Health Information Technology for Economic and Clinical Health Act

**HRSA**: Health Resources and Services Administration

**HUD**: Department of Housing and Urban Development

**MOUD**: Medications for Opioid Use Disorder

**NIH**: National Institutes of Health

**OIG**: Office of the Inspector General

**ONC**: Office of the National Coordinator

**ONDCCP**: Office of National Drug Control Policy

**OTP**: Opioid Treatment Providers

**OUD**: Opioid Use Disorder

**SAPTBG**: Substance Abuse Prevention and Treatment Block Grant

**SAMHSA**: Substance Abuse and Mental Health Services Administration

**SOR**: State Opioid Response

**SUD**: Substance Use Disorder

**VA**: Veterans Affairs
Acknowledgements

The following experts participated in the roundtable discussion “Next Steps in Responding to the Opioid Crisis: Priorities and Considerations for a Federal Response,” hosted by the Duke-Margolis Center for Health Policy on December 15, 2020. The priorities and considerations in this paper reflect ideas generated during the discussion and subsequent feedback from participants, but does not necessarily reflect a formal consensus of the group, nor the endorsement of any specific participant or their organization.

Eric Bailly  
Business Solutions Director, Substance Use Disorder Strategy  
Anthem

Jay Bhatt  
Chief Clinical Product Officer, Medical Home Network  
Founder and Principal, JDB Strategies, LLC

Erin Booker  
Vice President for Community Health and Engagement  
Christiana Healthcare

Michael Botticelli  
Former Director  
Office of National Drug Control Policy

Robert Califf  
Former Commissioner  
Food and Drug Administration

Kelly Clark  
Immediate Past President,  
American Society of Addiction Medicine  
Founder, Addiction Crisis Solutions

Wilson Compton  
Deputy Director  
National Institute of Drug Abuse  
National Institutes of Health

Beth Connolly  
Project Director, Substance Use Prevention and Treatment Initiative  
The Pew Charitable Trusts

Kelly Corredor  
Chief Advocacy Officer  
American Society of Addiction Medicine

Gabby de la Gueronniere  
Director of Policy  
Legal Action Center

Tom Hill  
Vice President  
National Council for Behavioral Health
Erin Holve  
Director, Health Care Reform and Innovation Administration  
Department of Health Care Finance  
Government of the District of Columbia

Van Ingram  
Executive Director  
Kentucky Office of Drug Control Policy

Chris Jones  
Deputy Director, Injury Center  
Centers for Disease Control and Prevention

Kate Knutson  
Chief Executive Officer  
Optum Behavioral Health

Regina LaBelle  
Program Director, Addiction and Public Policy Initiative  
Georgetown O’Neill Institute

Amanda Latimore  
Director, Center for Addiction Research and Effective Solutions  
American Institutes for Research

Jeffrey Locke  
Program Director  
National Governors Association

John O’Brien  
Senior Consultant, Human Services Group  
Technical Assistance Collaborative

Andrey Ostrovsky  
Managing Partner  
Social Innovation Ventures

Sudha Raman  
Assistant Professor  
Department of Population Health Sciences  
Duke University School of Medicine

Kevin Roy  
Chief Public Policy Officer  
Shatterproof

Josh Sharfstein  
Former Deputy Commissioner  
Food and Drug Administration

Brad Stein  
Director, Opioid Policy Center of Research Excellence  
RAND Corporation
ACKNOWLEDGEMENTS CONTINUED

Kima Taylor  
Nonresident Fellow  
Urban Institute

Marti Taylor  
President and CEO, OneFifteen  
Verily

Christina Tsafoulias  
Legislative Director  
Representative David Trone

Vikki Wachino  
Chief Executive Officer  
Community Oriented Correctional Health Services

Sarah Wattenberg  
Director of Quality and Addiction Services  
National Association for Behavioral Healthcare

Greg Williams  
Managing Director  
Third Horizon Strategies

Contributing Authors

Katie Greene  
Visiting Policy Associate

Kirk Williamson  
Senior Policy Analyst

Hemi Tewarson  
Visiting Senior Policy Fellow

Mark McClellan*  
Director

* Disclosure as of 10/20/2020

Mark B. McClellan, MD, PhD, is an independent director on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and PrognoMiq; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Arsenal Capital Partners, Blackstone Life Sciences, and MITRE.

This publication was made possible by a gift from the Margolis Family Foundation.