

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

Access this content and more online! Go to alcoholismdrugabuseweekly.com/createaccount and log in with your subs ref #, shown on the mailing label.

Volume 27 Number 11
March 16, 2015
Print ISSN 1042-1394
Online ISSN 1556-7591

IN THIS ISSUE...

If there's one group of patients with legitimate cause to object to prescription drug monitoring programs (PDMPs), it's those who must take daily doses of opioids. This includes patients on methadone and buprenorphine, both treatment medications for opioid use disorders. Requiring law enforcement to have a search warrant before perusing the PDMP would go far to protecting those patients, says one group. But another says that it's not necessary. . . . See top story, this page

Recovery Brands, Elements settle lawsuit by Seabrook House . . . See page 3

NAMA comments on Narco Freedom story . . . See page 4

ValueOptions settles with New York AG for parity violations . . . See page 5


Celebrating 25 Years Building Drug-Free Communities
Newsmaker Award
Alison Knopf, Editor


Third Place Winner
Spot News

FIND US ON

adawnewsletter

FOLLOW US ON

ADAWnews

© 2015 Wiley Periodicals, Inc.
View this newsletter online at wileyonlinelibrary.com
DOI: 10.1002/adaw.20465

Should law enforcement be required to obtain search warrants for PDMP data?

We recently reported on a case in which Utah's 17-year-old prescription drug monitoring program (PDMP) had been abused by law enforcement, leading to a bill that would require law enforcement to obtain a search warrant before looking for information (See *ADAW*, Feb. 23). That case led us to wonder about the confidentiality of PDMP information. Can police in every state simply open up a case and look for any information they want about constituents' prescriptions?

The purpose of PDMPs is to prevent doctor shopping, in which patients go from one doctor to another obtaining abusable medications. With the prescription opioid abuse and overdose epidemic, it

Bottom Line...

With PDMPs, law enforcement and public health paths converge, and patients on methadone or buprenorphine may have cause for concern.

was considered a good way to deter prescription drug abuse. However, in most states the PDMP is under the aegis of law enforcement, not the health department.

We talked to Michael Barnes, executive director of the Center for Lawful Access and Abuse Deterrence (CLAAD), and Peter Kreiner, Ph.D., principal investigator with the PDMP Center of Excellence (COE)

See **PDMP** page 2

The Business of Treatment

Seasoned OTP providers have funding opportunity for MAT



Although all states can legitimately claim to be struggling with surging demand for opioid addiction treatment, providers in just over one-third of the states have the inside track to benefiting from a new infusion of federal money to enhance access to medication-assisted treat-

ment (MAT) and recovery support services.

Eligibility for the Center for Substance Abuse Treatment's (CSAT's) Targeted Capacity Expansion: Medication-Assisted Treatment — Prescription Drug and Opioid Addiction grants is limited to the 39 states that have seen the highest per capita rates of primary treatment admissions for heroin and prescription opioid use disorders. In addition, priority for funding will be given to the 18 states that saw the steepest increases in such admissions in the period from 2007 to 2012; this is in

See **TREATMENT** page 6

Bottom Line...

States that have experienced the steepest increase in primary treatment admissions for opioid addiction have an advantage in receiving grants under a new federal initiative to expand medication-assisted treatment.

PDMP from page 1

at Brandeis University, for answers. CLAAD, which is funded by pharmaceutical companies, treatment centers and laboratories, favors a search warrant requirement. The PDMP COE, which is funded by the federal Department of Justice, is more vague on the issue, leaving it up to the states.

Barnes thinks that requiring a search warrant won't hurt public safety. "A standard that requires a search warrant for law enforcement to access PDMP data can respect patient and provider privacy without weakening public health and safety outcomes," said Barnes. For example, PDMPs can utilize "red flag" alerts, which notify health officials when there is a suggestion that a prescriber or a patient might have a problem, he said. "If the health authority reviews the case and concludes that criminal activity is likely taking place, it can then refer the matter to law enforcement," Barnes said. In any other case, law enforcement should be required to have a search warrant to access PDMP data, he said.

Most PDMPs view their role as for both public health and public safety, said Kreiner, noting that only three states — Vermont, Maine and Maryland — require a court order or a subpoena for law enforcement to access the PDMP. "But it's forbidden

for law enforcement or anyone, including providers, to go on a fishing expedition," he told *ADAW*. "To my knowledge it's extremely rare for this to happen."

PDMP data are not admissible in court in most cases, because it's considered "hearsay," said Kreiner. However, access gives law enforcement the chance to get a list of the pharmacies where a patient has had prescriptions filled, he said. "That saves them a lot of time," he said.

New BJA grants

When we talked to Kreiner last month, he was attending a meeting of a new category of Bureau of Justice Assistance (BJA) grantees. BJA has been the main conduit for funding state PDMPs, he noted. Now there is a new category of pilot grants that operates at a county level. "The purpose is to bring together law enforcement, treatment providers, insurers and health departments to talk together for the first time," said Kreiner. They would, in other words, share PDMP data.

"There's a recognition on both sides, law enforcement and public health, that this needs to be done," said Kreiner. "Law enforcement recognizes you can't arrest your way out of the problem, but most states recognize that there are rogue providers who are engaged in criminal activity."

Buprenorphine and methadone

Opioid treatment programs (OTPs), which mainly use methadone, are not required to submit patient information to the PDMP. However, patients treated by office-based physicians with buprenorphine will have that information in the PDMP. Patients are concerned that if other physicians know they are taking buprenorphine for opioid addiction, they won't get adequate pain medication or will be treated badly. Without a PDMP, the OTP director would just talk to a dentist or surgeon about the patient, explaining that the maintenance dose of methadone won't cover pain. What is being done to keep PDMPs from causing discrimination for patients on buprenorphine?

"Only the federal government can enforce federal privacy protections for people on medication-assisted treatment, and it is doing nothing to remedy the violations affecting people who take buprenorphine for opioid dependence," said Barnes. He added that the Substance Abuse and Mental Health Services Administration (SAMHSA) "is actually considering amending rules to permit the reporting to PDMPs of the dispensing of methadone for opioid dependence."

SAMHSA recommends that OTPs query the PDMP about their



Editor Alison Knopf
Contributing Editor Gary Enos
Copy Editor James Sigman
Production Editor Douglas Devaux
Executive Editor Patricia A. Rossi
Publisher Amanda Miller

Alcoholism & Drug Abuse Weekly (Print ISSN 1042-1394; Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Mondays in July and September and the last Mondays in November and December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Print only: \$695 (individual, U.S./Can./Mex.), \$839 (individual, rest of world), \$6135 (institutional, U.S.), \$6279

(institutional, Can./Mex.), \$6327 (institutional, rest of world); Print & electronic: \$765 (individual, U.S./Can./Mex.), \$909 (individual, rest of the world), \$7362 (institutional, U.S.), \$7506 (institutional, Can./Mex.), \$7554 (institutional, rest of the world); Electronic only: \$555 (individual, worldwide), \$6135 (institutional, worldwide). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at (800) 835-6770; e-mail: cs-journals@wiley.com. © 2015 Wiley Periodicals, Inc., a Wiley Company. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden.

Alcoholism & Drug Abuse Weekly is indexed in: Academic Search (EBSCO), Academic Search Elite (EBSCO), Academic Search Premier (EBSCO), Current Abstracts (EBSCO), EBSCO Masterfile Elite (EBSCO), EBSCO MasterFILE Select (EBSCO), Expanded Academic ASAP (Thomson Gale), Health Source Nursing/Academic, InfoTrac, Proquest 5000 (ProQuest), Proquest Discovery (ProQuest), Proquest Health & Medical, Complete (ProQuest), Proquest Platinum (ProQuest), Proquest Research Library (ProQuest), Student Resource Center College, Student Resource Center Gold and Student Resource Center Silver.

Business/Editorial Offices: John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774; Alison Knopf, e-mail: adawnewsletter@gmail.com; (845) 418-3961. To renew your subscription, contact Customer Service at (800) 835-6770; e-mail: cs-journals@wiley.com.



patients, but also that they not input data about their patients. This advice came in a “Dear Colleague Letter” from H. Westley Clark, M.D., then director of SAMHSA’s Center for Substance Abuse Treatment (see *ADAW*, Oct. 24, 2011).

About half of the PDMPs are allowed by state law to issue unsolicited reports to providers about patients that the PDMP thinks may be engaged in problematic behavior, said Kreisler. Different states use different thresholds for these reports, but typically only a “fraction of 1 percent” of patients meet the threshold for being reported. That, of course, could be patients on buprenorphine — who else gets daily doses of an opioid? However, law enforcement is more interested in providers than patients, said Kreisler.

“Law enforcement sends patient reports to providers and pharmacies and says, ‘We think you should be aware of this,’” he said. “Then it’s up to the provider or pharmacy what to do with the information.” Kreisler said PDMPs have “limited ability to affect what providers do with the information.”

In Massachusetts, the PDMP has been training law enforcement across the state in how to use the PDMP data, said Kreisler. “Then, once they’re trained, investigators [from law enforcement] can log in and query” the PDMP, he said. However, there has to be an active case — the officer cannot open a case, the way they can in Utah.

Barnes agreed that it is rare for law enforcement to use the PDMP for a fishing expedition. “We are

aware of only a few cases of police abuse of PDMPs, and in each case, the offender was properly punished,” he said. Nevertheless, a search warrant requirement provides the best protection for patients, he said.

Missouri

Missouri is the only state without a PDMP. Under that state’s planned version of one, however,

‘A standard that requires a search warrant for law enforcement to access PDMP data can respect patient and provider privacy without weakening public health and safety outcomes.’

Michael Barnes

patients could be turned over to law enforcement.

Mark Stringer, director of the Division of Behavioral Health in Missouri, told *ADAW* that the PDMP is so important he didn’t want to jeopardize it by insisting on confidentiality for patients on buprenorphine or methadone. “Our legislature is extremely conservative, and there’s not

a lot of sympathy for people who have substance use disorders,” said Stringer. “I worry a bit about what impact there would be if there were a protection in the bill for people who are on buprenorphine or methadone — it might actually jeopardize the bill,” he said. “I might work afterward with the Department of Health” to add protections, he said. He added that it is “sad” that there is a bias against methadone and buprenorphine.

CLAAD has encouraged Missouri to amend its PDMP bill “in a way that will provide strong privacy protections as well as the best possible public health outcomes,” said Barnes. “Our approach will yield legislation that is so strong that even the most ardent privacy advocate can feel confident in supporting it.”

He added that a search warrant is the best way to do this. “Individuals must be able to consult with their licensed health care providers and make the decisions that are in their own best interest without fear of unjust government interference,” said Barnes. “A search-warrant standard for PDMPs allows law enforcement to access PDMP data after a judicial determination that access is justified.”

Even without a PDMP, Stringer admitted that Missouri is seeing “unintended consequences” — heroin use — of the crackdown on prescription opioids. “Young people who can’t get prescription opioids for whatever reason are turning to heroin,” he said. “Would a PDMP make that problem worse? I don’t know. But the PDMP is another tool. We need it.” •

Recovery Brands, Elements settle lawsuit by Seabrook House

The lawsuit filed last year by Seabrook House against Recovery Brands and Elements Behavioral Health has been dismissed. *ADAW* broke the news of the lawsuit, which alleged trademark infringement and unfair competition (see *ADAW*, Nov. 3, 2014). Seabrook House, based in

New Jersey, asked for an accounting from both Recovery Brands and Elements of the money they received as a result of people searching for Seabrook or Seabrook House, and for an award of damages.

The only statements made by any party were made by Recovery

Brands and Elements via separate press releases on March 10. Seabrook House did not respond to multiple requests by email and telephone for comment. Sources speculated that given the passion of Ed Diehl, president of Seabrook House, about the

[Continues on next page](#)

Continued from previous page

case, the settlement was confidential.

Jessie Beeber, attorney for Recovery Brands, told *ADAW* that the settlement is not confidential. But the attorney also refused to allow Recovery Brands or Elements to release it to us, although both programs said they wanted to.

“Without seeing the settlement agreement, it is difficult to know the full extent of what has been resolved,” Jeffrey Lynne, a lawyer with Weiner, Lynne, and Thompson in Florida, told *ADAW* in an email. “It is very common for legal matters to resolve themselves with a confidential settlement agreement, assuming in this case, the settlement is confidential. However, to the extent that there has been an amicable resolution, it would be my guess, and this is simply an experienced and educated guess, that both sides have merit to their arguments, but neither side has evidence of such strength so as to force the other one’s hand.”

Press releases

Both Elements and Recovery Brands, which operates a website in which patients are directed to treatment programs, stated in their press releases that the lawsuit was dismissed with prejudice, meaning only that Seabrook can’t refile it, and without a financial settlement.

“Through our online marketing campaigns, continuing education programs, publications and community events, we are committed to providing consumers the information they need to make important treatment decisions,” said David Sack, M.D., CEO of Elements, in the March 10 press release. “We believe it is time for all members of our industry to move beyond rushing to conclude that something unethical has occurred just because a treatment center has developed robust online advertising campaigns that reach a broad audience of potential clients and their families.”

According to the Elements press release, the treatment program is

NAMA comments on Narco Freedom story

Last week we reported on the Narco Freedom opioid treatment program story in which the state Office of Alcoholism and Substance Abuse Services (OASAS) was planning for contingencies in case the New York City-based program would be shut down in the wake of indictments from the state attorney general (see *ADAW*, March 9). The story was spurred by a press release from the National Alliance for Medication Assisted Recovery (NAMA Recovery), but the contact on the press release, NAMA Recovery Executive Director Joycelyn Woods, did not get back to us in time to be quoted in the story. She has since sent this comment:

“I have always been proud of New York’s state agency. A number of times programs have closed and the state has always stepped in and taken on the responsibility of making sure that every patient is able to continue treatment. I expect no less of OASAS to insure that every patient can continue treatment with as little disruption as possible. And I know they can and have the will to do it.”

Diplomatic as this comment is, there is nevertheless resentment and suspicion on the part of patient advocates as to whether OASAS can be trusted, as can be seen from Walter Ginter’s comments last week. At issue is whether patients in medication-assisted treatment will be involved in decisions that involve them. Stay tuned for more on Narco Freedom.

“disappointed that Seabrook House chose to file this unsuccessful lawsuit rather than work with” them on their concerns. “We have the greatest respect for Seabrook’s programs and have strongly supported Seabrook over the last several years through charitable contributions to the Seabrook Foundation and the numerous referrals we’ve made to their programs,” said Sack in the press release.

Although nobody, including Seabrook’s lawyer, would make the settlement available to *ADAW*, the press release from Elements disclosed that part of the agreement states that “neither party will include a listing of the other in any websites owned or operated by the other.” The Elements press release suggests that this may “impact this support” (referrals) in the future. “With this lawsuit put to rest, it is our hope that we can gradually return to a mutually respectful and beneficial relationship,” said Sack in the press release.

Lack of proof

In the Recovery Brands press release, company co-founder Abhilash Patel said that Seabrook’s “complaint

was based on a fundamental misunderstanding of what Recovery Brands does, and how our third-party consumer websites function to provide people who need help with the best possible information about all of their treatment options.”

As Lynne speculated, the problem appeared to be that Seabrook House couldn’t prove its case. Patel stressed that the allegations — that Recovery Brands misdirected patients searching for treatment from Seabrook to other providers — “were never proven.” He added that they “could never have been proven because we don’t use those tactics with anybody.” He added: “It also was never proven that we infringed on any of Seabrook House’s rights or violated any laws.”

At the same time, Patel asked the industry to “work with us to establish better standards for digital marketing and launch an industry-wide education effort about the power of the web to support people with addictions.”

Recovery Brands operates Rehabs.com and Recovery.org, which are supported by advertising. From

the press release: “Recovery Brands adheres to the highest standards of ethics for digital marketing. All sponsored content is clearly marked, while free listings include phone numbers and links that point directly to the intended facilities. The company does not pre-qualify callers for advertisers and strictly prohibits any direct referral arrangements.”

Recovery Brands co-founder Jeff Smith said, “We believe our websites fill a critical void by providing honest, useful resources similar to how Google, Yelp and Angie’s List provide utility to other kinds of consumers.” He added, “Consumer review portals have been a big part of the web for years, and their blend of sponsored and publicly-available content does not violate the law.”

Provider, NAATP respond

David Lisonbee, president and CEO of Twin Town Treatment Centers in California and an outspoken critic of what he views as unethical marketing tactics, told *ADAW* that few treatment listings on the Internet list addresses of geographic locations, and many don’t even list a company name. This works against

small programs like Seabrook House. “The little guys need to find their niche and brand so as to carve out a piece of the market,” Lisonbee told *ADAW* last week. “If I called two places for help and one was a couple of miles away and the other was in a different part of the country, I would choose the one closer as long as it sounded trustworthy,” said Lisonbee, who said that accreditation and “honest outcome measures” are also important features to publish.

The bottom line, said Lisonbee, is that the consumer must be made aware of unethical marketing tactics. “The vulnerable population of people we serve need to beware of deceptive business practices,” he said. “It’s our responsibility to inform potential consumers about availability of affordable and viable treatment options in the communities where they live. It’s also our responsibility to demonstrate that there exist honest and trustworthy providers of quality treatment services.”

Finally, Lisonbee said that third-party payers have become increasingly aware of insurance abuses and will take more drastic measures to reduce excessive expenses for them-

selves and their membership. If the treatment industry is unable to police itself, regulatory agencies will do so, he said.

Meanwhile, the main industry association is looking closely at ethics and Internet marketing. Ken Gregoire, chairman of the board of the National Association of Addiction Treatment Providers (NAATP), told *ADAW* that the organization is “tackling the issue of ethics in our field directly and with energy and commitment.” Bob Ferguson, head of NAATP’s ethics committee, is putting together presentations for the association’s May conference on topics like Internet marketing, Gregoire told *ADAW*. He said he couldn’t comment on the Seabrook case because he wasn’t familiar with the complaint. Emails to Ferguson were not returned by press time, but both Ferguson and Gregoire explained to *ADAW* earlier this year how they are approaching the issues surrounding Internet marketing (see *ADAW*, Jan. 12). •

Editor’s note: *ADAW* subscribers can download a copy of the original complaint at <http://bit.ly/1wASukH>.

ValueOptions settles with New York AG for parity violations

Beacon Health Options, formerly known as ValueOptions, has settled with New York Attorney General Eric T. Schneiderman in the case in which the company had been charged with violating federal and state parity laws. On March 5, the attorney general announced a settlement requiring Beacon to reform its claims review process and pay a \$900,000 penalty. The settlement resolves allegations made after the attorney general found that ValueOptions issued denials twice as often for behavioral health claims, and four times as often for substance use disorder claims, as medical insurers did for medical or surgical claims.

Because the company was operating as ValueOptions during the

period of the alleged violations of parity laws, the attorney general refers to the company by the former name. ValueOptions and Beacon agreed to merge last year.

A year ago, the attorney general announced a settlement with MVP Health Care, which contracted with ValueOptions for behavioral health services (see *ADAW*, March 31, 2014). Under the terms of that settlement, MVP paid a \$300,000 fine and was required to refund as much as \$6 million to plan members whose claims were denied. MVP was also to cover residential treatment. In addition to settling with MVP, the attorney general last year settled with EmblemHealth, which also used ValueOptions.

Previously denied claims

In the agreement with ValueOptions, which administers behavioral health benefits for about 2.7 million New Yorkers in fully funded or state and local government health plans and 45 million customers around the country, the attorney general stressed that ValueOptions must submit previously denied MVP and Emblem mental health and substance use disorder treatment claims to an independent appeal process. This could result in millions of dollars being returned to members, he said.

“Insurance claims for mental health care should be treated just the same as insurance claims for physical health care, and my office

[Continues on next page](#)

Continued from previous page

will continue to ensure full compliance with our state's mental health parity laws," said Schneiderman. "The millions of New Yorkers who need mental health and addiction services should never feel shame or stigmatized, and my office will remain committed to eliminating barriers to patients getting the care they need."

ValueOptions must cover residential treatment and charge the lower, primary care co-payment for most outpatient visits to mental health and substance use disorder treatment providers.

New York's parity law, called Timothy's Law, only applies to mental health. The federal Mental Health Parity and Addiction Equity Act applies to both mental health and substance use disorders.

Changes required

ValueOptions has agreed to overhaul its behavioral health benefits process by:

- Removing visit limits for almost all behavioral health services, and removing preauthorization requirements for outpatient behavioral health services.

- Covering services provided by mental health practitioners, such as mental health counselors, licensed under Article 163 of the New York Education Law.
- Ensuring that its provider networks and online provider directory are accurate, and assisting members in transitioning providers where necessary.
- Conducting full and fair reviews for services that require preauthorization, such as inpatient substance use disorder treatment.
- Providing detailed oral and written explanations for denied claims, so that members can exercise their appeal rights, and providing up-to-date information about alternative treatment providers.
- Classifying claims correctly so that reviews are done expeditiously and members are afforded full appeal rights.
- Removing the requirement that members "fail" outpatient substance use disorder treatment before qualifying for inpatient rehabilitation treatment.
- Basing the number of treatment days or visits approved

on members' needs, rather than arbitrary limits.

- Integrating medical and behavioral health claims review staff, which will facilitate the coordination of members' care.
- Continuing coverage of treatment pending the completion of appeals, so that treatment is not interrupted.
- Reimbursing coverage of treatment for most diagnoses listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association*, including gender identity disorders.
- Reimbursing members for out-of-network services at the usual, customary and reasonable rate for the relevant behavioral health service, without arbitrarily applying lowered rates for non-M.D. providers.
- ValueOptions will also post parity disclosures on its website, file regular compliance reports with the attorney general and pay a \$900,000 penalty. •

Consumers with questions or concerns about this settlement or other health care matters may call the attorney general's Health Care Bureau Helpline at 1-800-428-9071.

Treatment from page 1

keeping with the direction set by Congress when it appropriated the \$11 million in funding available for this grant program.

"This is an age-old issue of 'Should you rank states based on higher need?'" Robert Morrison, executive director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), told *ADAW*. "We've struggled with that. I don't know of any state that can raise its hand and say that it has addiction licked."

But Morrison added that the most important factor in this new grant announcement remains Washington's acknowledgment of the importance of supporting the effort to

combat opioid dependence, made even clearer by the fact that the proposed fiscal 2016 federal budget would increase funding for this Targeted Capacity Expansion grant program to \$25 million.

Interest in states

The 18 states that are in the group most likely to receive grants under this initiative are Alaska, Arizona, Colorado, Florida, Indiana, Iowa, Kentucky, Minnesota, Missouri, Nevada, North Carolina, South Carolina, South Dakota, Tennessee, Vermont, Washington, Wisconsin and Wyoming. The single state agency (SSA) for substance abuse is the required applicant for each state. Given the present demand for ser-

vices in these states, interest in pursuing this money likely will be keen.

"Our providers are just crushed by the demand for treatment," Mark Stringer, director of the Division of Behavioral Health at the Missouri Department of Mental Health, told *ADAW*. "Waiting lists are pretty long. If you don't get treatment when you're ready for it, you could really be in trouble again later."

Stringer indicated he is fairly sure that the state will apply for this grant; up to 11 awards of a maximum of \$1 million per year will be available, for a project period of three years (there is no matching fund requirement for states under this program).

CSAT's parent Substance Abuse

and Mental Health Services Administration (SAMHSA) outlines its goals for the program as increasing the number of individuals receiving one of the three federally approved medication treatments for opioid addiction; increasing the number of patients receiving integrated care; and reducing illicit drug use at six-month follow-up. Stringer sees these goals as being a good match with his state's.

"The main benefit for us would be in being able to serve more people," he said. "We're already using medication-assisted treatment in opioid programs as well as in our publicly funded system."

He said that if the state were awarded a grant, it likely would spread the funding across numerous existing initiatives. One area that has been prioritized in Missouri involves the provision of monthly Vivitrol (injectable naltrexone) doses for justice-involved clients. In separate state-funded programs for St. Louis drug court clients and for state prison inmates, individuals receive Vivitrol shortly before release from custody and then continue to receive the monthly injections in the community. For the program involving the state Department of Corrections, the Gateway Foundation in St. Louis

American Association for the Treatment of Opioid Dependence (AA-TOD), told *ADAW* that the inclusion of proprietary OTPs as part of the grant program represents a "marked departure" for SAMHSA grant initiatives, which nearly always require that funded entities be publicly supported nonprofit organizations. Parrino said the limited funding options for MAT delivered in OTP settings remains a highly misunderstood aspect of the treatment system.

"I believe that more people will be able to access care because of these treatment grants, and it may help offset the fact that 17 states still do not provide Medicaid funding for the use of the three federally approved medications to treat opioid addiction through OTPs," said Parrino.

'I believe that more people will be able to access care because of these treatment grants, and it may help offset the fact that 17 states still do not provide Medicaid funding for the use of the three federally approved medications to treat opioid addiction through OTPs.'

Mark Parrino

Stringer added, "We try to make all of the FDA-approved medications (methadone, buprenorphine and injectable naltrexone) available. It should be just as is the case with mental health, where all of the anti-psychotics are available. People have different preferences, different levels of social support. It frustrates me that some states focus on one medication over another."

SAMHSA's request for applications specifically defines MAT as encompassing methadone, buprenorphine formulations and naltrexone products. Stringer indicated that while some opioid treatment programs (OTPs) in Missouri still use methadone only, others have begun to expand to the other medications as well.

provides the ongoing treatment post-release, Stringer said.

Provider partners

The grant application specifies that state applicants must designate at least one experienced (at least two years of relevant services) provider organization to offer direct services pertinent to the grant. The program requires that MAT be provided in combination with comprehensive services that may include counseling, behavioral therapy and, in some cases, medication for an alcohol use disorder. These providers can be an OTP, a substance abuse treatment facility, or a community health or mental health center, and the inclusion of OTPs on this list is noteworthy.

Mark Parrino, president of the

Other requirements

The RFA also specifies that state applicants must:

- Identify at least two high-risk communities within the state and partner with other organizations to address the specific needs of those communities.
- Ensure and document that evidence-based practices are used for screening, assessment and interventions.
- Not use funding for MAT for detoxification services.
- Collect and report on data at intake, six months post-intake and discharge, covering areas such as abstinence, retention in treatment, social connectedness, and housing and employment status. •

The application deadline is May 8. Inquiries about programmatic issues should be directed to Anthony Campbell at (240) 276-2702 or tony.campbell@samhsa.hhs.gov.

If you need additional copies of *ADAW*, please contact Customer Service at 800-835-6770 or cs-journals@wiley.com.

BRIEFLY NOTED

Acadia buys Quality Addiction Management OTPs in Wisconsin

Acadia Healthcare Company has bought another treatment program, the company announced in a March 2 press release. Quality Addiction Management (QAM), which operates seven opioid treatment programs utilizing methadone in Wisconsin, was purchased by Tennessee-based Acadia for \$53 million, according to the press release. Acadia, a publicly traded company, last year acquired CRC Health Group for \$1.18 billion (see *ADAW*, Nov. 3, 2014) and in 2012 acquired Timberline Knolls in Chicago for \$90 million (see *ADAW*, Nov. 5, 2012). QAM serves 2,600 patients per day, according to the press release. QAM's CEO Michael S. Goldstone, M.D., will join Acadia as chief medical officer. "We believe this transaction is consistent with our growth strategy of acquiring behavioral health services that serve a community need and complement our existing base of services," said Joey Jacobs, chairman and CEO of Acadia, in the release. "QAM has a proven track record and long history of providing quality behavioral treatment services, and we look forward to working with QAM's caring and qualified staff. We also look forward

Coming up...

The national conference of the **American Association for the Treatment of Opioid Dependence** will be held **March 28–April 1 in Atlanta, Georgia**. Go to www.aatod.org/national-conference/2015-aatod-conference-atlanta for more information.

Innovations in Recovery will hold its conference **March 30–April 2 in San Diego, California**. For more information, go to www.foundationsrecoverynetwork.com/events/conferences.

The **National Prescription Drug Abuse Summit** will be held **April 6–9 in Atlanta, Georgia**. Go to <http://nationalrxdrugabusesummit.org> for more information.

to working with Dr. Goldstone to expand our clinical services and to further enhance the quality of services delivered throughout Acadia's comprehensive treatment centers." When Acadia acquired CRC, it got not only the company's many residential and outpatient programs, but also the huge OTP network, including that of Habit Opco in the Northeast, which CRC had recently acquired (see *ADAW*, Dec. 23, 2013). The acquisition of QAM also adds

geographically strategic OTPs to Acadia's growing portfolio.

STATE NEWS

COMPA removes 'methadone' from name

The Committee of Methadone Program Administrators of New York (COMPA) last month announced that it was changing its name to the Coalition of Medication-Assisted Treatment Providers and Advocates. In the announcement, it said the new name better reflects the stated purpose "to promote growth, coordination, and communication within the pharmacotherapeutic opioid dependence treatment field, including patient, staff, community and government; to enhance patient care and the provision of pharmacotherapeutic treatment services to substance abusers and their families; to advise its members as to changes in applicable laws and regulations and advances in opioid dependence treatment." On the COMPA website, listed corporate members include Alkermes (Vivitrol), Orexo (Zubsolv, a brand of buprenorphine), Mallinckrodt (methadone and buprenorphine) and Roxane (buprenorphine). COMPA represents opioid treatment programs, which traditionally used methadone, but now use all three medications. Former COMPA director Henry Bartlett last year joined Alkermes to represent Vivitrol in New York (see *ADAW*, Dec. 22, 2014).

Visit our website:

www.alcoholismdrugabuseweekly.com

For more addiction information, visit

www.wiley.com

In case you haven't heard...

"The faces of the budget" — that's how one New Jersey state senator referred to the 30 patients from Newark-based Integrity House who went with senior director Earl Lipphardt to the New Jersey Senate Budget and Appropriations Committee hearing March 10. It's a great phrase, and it shows why it helps for patients to advocate. The topic was Gov. Chris Christie's proposed \$33.8 billion spending plan for the coming fiscal year, *The Record* reported. Lipphardt said the state needs to fund transitional housing for people who have just completed treatment; Integrity's post-Hurricane Sandy grant, which funded 48 housing slots, is about to run out. "The clients who are with me today are not going to have those opportunities and they're going to go back to being couch homeless," he said. "Their cycle of addiction is going to be infinitely harder to break." One of several senators who said they would try to help was Sen. Paul Sarlo, a Democrat. "The faces that we're looking at really are the faces of the budget," said Sen. Sarlo. "Government has an obligation to look after some of our most vulnerable folks in society."