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

Volume 35 Number 30
July 31, 2023
Online ISSN 1556-7591

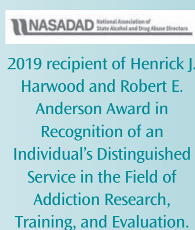
In This Issue...

Our lead stories this week look at the continued support by Congress for the SUPPORT Act in a bill reauthorizing the 5-year-old law, and at the expansion of in-home treatment for SUD.
. . . See stories, this page

Ghrelin blockade study in mice supports new AUD medication
. . . See page 4

Commentary on belief that addiction is the fault of the user
. . . See page 6

After 15 years, parity enforcement bolstered with new rules
. . . See page 6



2019 recipient of Henrick J. Harwood and Robert E. Anderson Award in Recognition of an Individual's Distinguished Service in the Field of Addiction Research, Training, and Evaluation.

Honorable Mention Spot News 2016

2016 Michael Q. Ford Journalism Award

FIND US ON

adawnewsletter

FOLLOW US ON

ADAWnews

© 2023 Wiley Periodicals LLC
View this newsletter online at wileyonlinelibrary.com

Block grant on the hot seat again as House subcommittee marks up SUPPORT Act

During a daylong meeting on July 19, the House Energy and Commerce Committee "marked up" (considered) the SUPPORT for Patients and Communities Act. The initial markup took place on Thursday, July 13. The bill is the Support for Patients and Communities Reauthorization Act, H.R. 4531. Known as the SUPPORT Act, the law, passed by the full Congress in 2018, has never been fully funded.

The SUPTRS (Substance Use Prevention, Treatment, and Recovery Services) block grant (formerly known as the Substance Abuse Prevention and Treatment block grant) is now under scrutiny. In addition, the State Opioid Response (SOR) funds may be constrained by more reporting on the use of funds.

Bottom Line...

The SUPPORT Act with a history of being supported in every way except for financially has now passed the House Energy and Commerce Committee, subcommittee on health. Stay tuned.

The Single State Authorities (SSAs) with authority over the SUPTRS block grant — a formula grant that goes to states — are also responsible for dispensing SOR funds. The 51 SSAs are members of the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Alcohol

Opening up SOR to treatment for more than opioids began in 2020

See **SUPPORT** page 2

Pandemic fueled a major expansion of home-based treatment provider

Leaders of a home-based substance use treatment company that experienced substantial growth during the COVID-19 pandemic said they are establishing important models in both service delivery and payment structure. Most of the media attention to Aware Recovery Care's work has focused on counteracting the notion that addiction care must take place in a facility, but the company's CEO also pointed out that its pioneering managed care contract brings the field closer to value-based payment for services.

Bottom Line...

Aware Recovery Care now operates in 11 states, with a substance use treatment model combining peer services delivered in the home with clinical care via telehealth.

Aware's arrangement with Anthem Blue Cross Blue Shield remains a bundled payment contract, meaning that the provider does not have to bill individually for discrete units of care, such as therapy sessions delivered via telehealth, Aware CEO Brian Holzer, M.D., told *ADAW*. The single payment for all services "can empower us to deliver what works best for each client," Holzer said.

Aware had been operating in four states prior to the pandemic, but that number quickly grew to nine when

See **Home-based** page 7

SUPPORT from page 1

(see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32573), with expanding the use of these funds for the treatment of stimulants. Now there is a call for expanding the SOR funds to alcohol. The House committee took this up in its consideration of the SUPPORT Act.

Flexibility needed

Many in the field, including NASADAD, have stated that it would be better to transition resources away from the SOR grants to the SUPTRS block grant, to allow SSAs the flexibility to use the funds as their own states need them.

The bill would not allow SOR funds to be used for primary alcohol use disorders, but rather, it would allow the use of funds for primary opioid use disorders or for primary stimulant use disorders with concurrent alcohol use disorders. There is no allowable use of SOR funds for the treatment of opioid use disorders concurrent with alcohol use disorders, and no allowable use for those with primary alcohol use disorders.

In addition, more information would be required to clarify the use of funds for treating people with concurrent alcohol use disorders, and how SOR funds are being spent in general, would be added to statute.

The bill would not allow SOR funds to be used for primary alcohol use disorders, but rather, it would allow the use of funds for primary opioid use disorders or for primary stimulant use disorders with concurrent alcohol use disorders.

More oversight

Under the bill that cleared the Energy and Commerce Committee on July 19, the Substance Abuse and Mental Health Services Administration (SAMHSA), which administers the SUPTRS block grant and SOR, would be required to include the following additional information in a report to Congress (which is already required annually on the SOR program):

- The amount of SOR money each state received for the year being described by the report;
- The amount of SOR grant funds spent by each state for the year being described by the report, "disaggregated by the uses for which such funds were spent;"
- The number of states that did not spend-down the money for the year being described by the report; and
- The number of states requesting a no-cost extension for the year being described in the report.

Challenges that states have encountered in spending down the funds and the reasons for such challenges persist, "including to what extent reporting requirements and other requirements [have] placed an increased burden on the ability to spend all of the funds."

PPW programs

Under the package approved by the Energy and Commerce Committee, both the residential Pregnant and Postpartum Women's (PPW) program and the state pilot would be reauthorized from 2024 to 2028. The language was originally introduced as a stand-alone bill by Reps. Marie Gluesenkamp Perez (D-WA) and Young Kim (R-CA).

NASADAD has long supported SAMHSA's Center for Substance Abuse Treatment's (CSAT) PPW's

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

Editor Alison Knopf
Contributing Editor Gary Enos
Copy Editor Donna Petrozzello
Production Editor Nicole Estep
Publishing Editor Valerie Canady
Publishing Director Lisa Dionne Lento

Alcoholism & Drug Abuse Weekly (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 third Monday in April, the first Monday in September and the last Mondays in November and December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Online only: $646 (personal, U.S./Can./Mex.), £334 (personal, U.K.), €421 (personal, Europe), $646 (personal, rest of world), $8381 (institutional, U.S./Can./Mex.), £4279 (institutional, U.K.), €5410 (institutional, Europe), $8381 (institutional, rest of world). **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; email: cs-journals@wiley.com. © 2022 Wiley Periodicals LLC. 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: Wiley Periodicals LLC, 111 River Street, Hoboken, NJ 07030-5774; Alison Knopf, email: adawnewsletter@gmail.com; (914) 715-1724.

To renew your subscription, contact Customer Service at (800) 835-6770; email: cs-journals@wiley.com.

WILEY

Residential Services Program, which provides resources to providers to support comprehensive, family-centered services to pregnant women/women with young children and their families in a residential setting. NASADAD worked with Congress through the Comprehensive Addiction and Recovery Act (CARA) to develop a PPW state pilot program that provides money to this same population using a family-centered approach in non-residential settings. Unlike the PPW Residential Services Program, the state pilot program specifically directs resources to state alcohol and drug agencies. The program was funded at $36 million in FY 2023.

Support from field

Field groups, including the National Association for Behavioral Healthcare (NABH), praised some provisions of the SUPPORT Act. "NABH has long supported removing the outdated Institutions for Mental Diseases (IMD) exclusion, and NABH is pleased to see Congress acknowledge this through provisions in the SUPPORT Reauthorization Act," said Shawn Coughlin, NABH president and CEO.

And NASADAD supported the reauthorization of many programs incorporated in the bill. However, as always, the question is not onlky one of authorization, but of appropriations, which are still to come. "We appreciate the work done by the Committee to reauthorize the PPW programs — both the residential and pilot programs — and hope Congress provides adequate funding for the program as well," NASADAD executive director and director of legislative affairs Rob Morrison told *ADAW* last week.

Andrew Kessler, principal of Slingshot Solutions, as always pointed out that putting SOR money into the block grant would make the most sense, allowing states to use SUD funding where they need it. ""The SOR grant and the block grant have different guidelines, and slightly different funding formulas," he told *ADAW* last week. "Several states have used SOR funds for workforce initiatives which are going extremely well. If at some point in the future the two grant programs could combine the best of both worlds, resulting in simpler administration with maximum flexibility, I think there would be a fair amount of support for such an effort."

Opioid OD reversal drugs

The bill also directs the Secretary of the Department of Health and Human Services (HHS) to issue a regulation or guidance promotion of the term "opioid overdose reversal drug" in HHS grant programs …" for any grant program that addresses opioid misuse and use disorders; any reference to an opioid overdose (OD) reversal drug (such as a reference to naloxone) is inclusive of any opioid overdose reversal drug that has been ..." FDA approved for "... emergency treatment of a known or suspected overdose." The bill recognizes that there are other opioid overdose reversal drugs in the pipeline. The bill requires terminology to be updated in SOR and programs housed within CSAT.

A long-term concern of treatment providers has been the gradual creep of naloxone into the rubric of "treatment" and "prevention." Naloxone treats overdose and prevents death. It does not treat or prevent addiction or use. Whether there are other "opioid overdose reversal drugs" that do either is not known.

Medicaid

The bill would maintain the 1915(l) option for the institution of mental diseases (IMD) exclusion for substance use disorders (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32159), by permanently establishing the State Plan Amendment (SPA) option that was originally included in Section 5052 of the SUPPORT Act that allowed states to apply for Medicaid payment for services provided in IMDs for those people ages 21 to 64 years with substance use disorders. Services may be covered for a total of up to 30 days annually for an eligible enrollee. The Centers for Medicare & Medicaid Services issued a "Dear State Medicaid Director Letter" on this option in 2019 that can be found here https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.32118).

In addition, the bill would extend Medicaid's requirement to cover medication assisted treatment (MAT) by mandating states

Continues on page 4

Followup: NIAAA on hepatitis nomenclature

Last week, we reported on the Liver Meeting's conclusion that "fatty" and "alcoholic" be removed from hepatitis diagnostic nomenclature (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.33841). The National Institute on Alcoholism and Alcohol Abuse (NIAAA) had yet to weigh on the changes, which are supported by the American Association for the Study of Liver Diseases. Early last week, NIAAA director George F. Koob, Ph.D., met with the liver society. NIAAA agrees with the new nomenclature and the reasons for the changes, he told us this week. Here is his quote: "NIAAA agrees with the new nomenclature. The motivation for the change was two-fold. First, the old nomenclature, particularly the terms 'fatty' and 'alcoholic,' could be stigmatizing. Second, the new terminology better reflects our improved understanding of the pathology of "fatty liver" and steatohepatitis."

Continued from page 3

to certify that their Medicaid program maintains coverage of MAT, with that certification to take place at least once every five years.

Programs reauthorized

Below are key programs reauthorized by the House and Energy Committee bill:

- SAMHSA's Youth Prevention and Recovery: The program would be reauthorized from 2024 to 2028. No funding amount was listed.
- SAMHSA's First Responder Training: The program would be reauthorized from 2024 to 2028 at $56 million (the FY 2023 level).
- SAMHSA's Building Communities of Recovery (BCOR): The program would be reauthorized from 2024 to 2028 at $16 million (the FY 2023 level).
- SAMHSA's National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support: The program would be reauthorized from 2024 to 2028 at $2 million (the FY 2023 level).
- SAMHSA's Comprehensive Opioid Recovery Centers (CORCs): The program would be reauthorized from 2024 to 2028. No funding level was listed. The program was funded at $6 million in FY 2023.
- SAMHSA's Treatment, Recovery, and Workforce Support Grants: The program would be reauthorized from 2024 to 2028 at $12 million (the FY 2023 level).
- Health Resources and Services Administration's (HRSA's) Mental and Behavioral Health Education and Training Grants: The program would be reauthorized from 2024 to 2028. No funding level was listed.
- HRSA's Loan Repayment Program for the Substance Use Treatment Workforce (STAR): The program would be reauthorized from 2024 to 2028 at $40 million (the FY 2023 level).
- Reauthorization of CORCs, the Comprehensive Opioid Recovery Centers program.

What happens next: the House Committee on Rules will consider the bill, which will then be voted on by the full House of Representatives. •

Follow us on Facebook: @adawnewsletter

Ghrelin blockade study in mice supports new AUD medication

Almost 10 years ago, *ADAW* interviewed Lorenzo Leggio, M.D., Ph.D. about his research with ghrelin, a hormone produced by the stomach which may link alcoholism and eating behavior. At the time, a small animal study showed that ghrelin was linked to reward in mice. Even before then, however, Leggio, working as a clinician in Italy, had heard about the link between ghrelin and alcoholism, so he conducted a study with patients in treatment for alcoholism which showed that those with lower ghrelin levels had lower cravings and were more likely to maintain abstinence, while patients with higher levels were more likely to relapse (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.20396).

When Leggio came to the U.S. and joined the faculty at Brown University, he started getting funding from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) for another ghrelin study, this time looking at cue activity. A very small study, with various challenging issues, including the concern that the researchers were inducing a symptom of the disease by giving them ghrelin and exposing them to alcohol cues, this research hypothesized that ghrelin would increase alcohol craving. The study was completed just before our 2013 interview and did indeed find that ghrelin increased the urge to drink alcohol, but not the urge to drink fruit juice.

Last month Leggio, founder of the Clinical Psychoneuroendocrinology and Neuropsychopharmacology Section, a joint NIDA and NIAAA laboratory, and colleagues published a study showing that blocking ghrelin reduces binge drinking in mice. "Pharmacological GHSR (ghrelin receptor) blockade reduces alcohol binge-like drinking in male and female mice," published online June 25 in *Neuropharmacology*, the study was funded by NIDA and NIAAA.

The study results "provide further and novel evidence that the ghrelin system is a potential treatment target for AUD [alcohol use disorder]," the researchers write. "Although we focused on binge-like drinking in the current study, targeting GHSR may be effective in rodent models of alcohol dependence," they added.

Six different GHSR antagonists were tested in the study: JMV2959, PF-5190457, PF-6870961, HM-04, YIL-781, and LEAP2. All except for YIL-781 and LEAP 2 reduced alcohol intake in mice of either sex. In male mice, but not female mice, YIL-781 decreased alcohol intake. LEAP2 did not reduce alcohol intake in either sex.

Binge drinking

Binge drinking is a step on the pathway to AUD, but the role of ghrelin in binge drinking is unclear. Typically, binge drinking in humans corresponds to at least five drinks in row for men or four for females. Drinking-in-the-dark (DID) is the way scientists measure binge alcohol consumption in the special breed of mouse developed for these experiments. The blood-alcohol level associated with binge drinking is 0.08 g/dl.

It is illegal under federal copyright law to reproduce this publication or any portion of it without the publisher's permission.

The 0.08 g/dl blood alcohol level for humans was associated with the more than 5g/kg in four hours in mice, a level of intoxication that meets NIAAA's definition of binge drinking.

Giving the mice a sweetened alcohol solution resembles types of alcohol beverages frequently consumed by humans.

Sweet solution?

The researchers also tested the specificity of the GHSR blockade effects to the intake of alcohol, not to the sweetened solution, and found differences.

For the unsweetened alcohol solution, JMV2959 decreased intake in male, but not female mice, while PF-5190457 and HM-04 decreased intake in both sexes. PF-6870961 and LEAP2 had no effect on the intake of an unsweetened solution. There was an increase in intake of an unsweetened solution at 10 mg/kg of YIL-781, but no effect at other doses.

The data suggest that the GHSR blockade reduces alcohol intake in the DID-based mouse model, "with a few minor sex differences," the authors wrote.

The calorie content of the alcohol did not appear to affect the effects of the GHSR blockade. Saccharin (a non-caloric sweetener) was used to compare the effects as well.

There may be a greater motivation to consume rewarding stimuli, i.e., sweet flavors and alcohol, than to access calories, the researchers speculated.

Sedation

The researchers noted that side effects, particular sedative effects, should be taken into consideration in drug development. The mice that were tested for motor coordination and for most of the GHSR blockades had ataxia and a decrease in spontaneous locomotion. However, the blockade did not impede the ability of the mice to access the bottle and drink, just to perform such tests as running around in a circular corridor.

> **"There are data suggesting that ghrelin blockade leads to less eating, less appetite, weight loss....[but] "the translational to humans is still in progress."**
>
> Lorenzo Leggio, M.D., Ph.D.

Several drugs that are already used off-label to treat AUD, such as gabapentin and topiramate (both endorsed by the American Psychiatric Association as potential second-line treatments), also produce sedation, the authors noted. "Thus, having sedation as a side effect does not necessarily exclude a drug from having clinical utility or improving quality of life, particularly when the benefits and on-target efficacy outweigh side effects and risks," the authors concluded.

Details

Leggio's group previously tested PF-5190457 and found it was safe and tolerable in heavy drinking individuals and may reduce cue-induced craving.

Ghrelin levels are higher in females — whether alcohol dependent or not — than in males.

Treatment with the ghrelin antagonist was administered via cannulae in the brain; all mice were alcohol-naïve at the time the surgery was performed.

The 'hunger hormone'

One of the guidelines of Alcoholics Anonymous is "HALT" – don't get hungry, angry, lonely, or tired. Hunger is possibly a key issue in the ghrelin story, and in fact, many people in recovery know to eat something when they have a craving for a drink. Ghrelin increases appetite and food intake. Where the ghrelin blockade falls in the current rage over "obesity" drugs — originally meant to treat diabetes — that take away appetite is unclear.

"There is growing preclinical evidence that GLP-1 analogs reduce alcohol and drug intake/seeking in rodent models," Leggio told *ADAW* last week. "Among other publications, please see our mouse-rat alcohol work published with semaglutide in JCI Insight: https://pubmed.ncbi.nlm.nih.gov/37192005/"

Furthermore, a recent randomized controlled trial done in Denmark suggests that exenatide reduces drinking but only in people with AUD and obesity comorbidity, he added (https://pubmed.ncbi.nlm.nih.gov/36066977/).

"New studies with semaglutide are under way and those studies are important before conclusions can be made," Leggio told us.

"There are data suggesting that ghrelin blockade leads to less eating, less appetite, weight loss," said Leggio, cautioning that "the translational to humans is still in progress."

Incidentially, ghrelin was originally called (as a nickname) "the hunger hormone," noted Leggio. "However, it's not as easy as 'less ghrelin, less obesity.' There are many compensatory effects in the body, plus ghrelin's functions are more complex than just "appetite control" (e.g., stress, survival, and much more) and not completely understood." •

Online?
Visit our website at
www.wileyonlinelibrary.com/journal/adaw

Commentary on belief that addiction is the fault of the user

Rob Kent has been general counsel for the New York state Office of Addiction Services and Supports and the federal Office of National Drug Control Policy. He has worked to support the rights of drug users to treatment, and to dignity.

A highly skilled lawyer with top word-smithing skills, and a deep and often cynical, as is the way of lawyers, understanding of human nature, he is unable to understand why addiction is not given more of a place in today's parlance. For example, look at the publicity surrounding President Biden's announcement last week about new rules for parity for substance use and mental disorders (see story below). All of the descriptions revolved around "mental health" or "behavioral health." Kent, now a consultant who is free to speak his mind, sent *ADAW* the following last week.

Why do people seem to accept/tolerate more than 100,000 people a year dying from drug overdoses without an outcry, without taking bold and urgent action!

Why do they use the term "behavioral health" to talk about mental illness and addiction when they are more interested in addressing mental illness and not addiction?

I believe that they tolerate all the overdose deaths, but not mental illness, because of a belief that mental illness happens to you and addiction happens because of you; a belief that drug use is a choice.

I think about this often and a good friend reminds me regularly that I am not going to change that belief. She is likely correct!

While I support harm reduction services and principles, I do not believe that you should stop trying to get folks not to use drugs. The drugs will ultimately kill them, and I do not want to see that happen to anyone! However, let's be clear: Criminalizing drug use has not, and will NEVER, stop folks from using drugs.

So, moving forward, I will not spend my time trying to win folks' heart and minds as to why people use drugs.

I will focus on the fact that drug use causes medical conditions that can kill. That these medical conditions require intervention. That there are medicines that can help. That naloxone can save them and give them a chance to save themselves. That folks who use drugs are human beings — somebody loves and cares for them and will miss them terribly if they die! That it is unnatural for kids to die before their parents!

We need to treat the damn medical issues and stop wasting a moment judging the drug user.

If we cannot do this, eventually ALL of us will lose someone we love and care about! •

After 15 years, parity enforcement bolstered with new rules

The Mental Health Parity and Addiction Equity Act (MHPAEA), a victory for substance use disorder (SUD) patients and providers, was enacted as part of the bank bailout law in 2008 (see https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20157). Going full steam ahead, the MHPAEA quickly righted some of the wrongs, by making certain limitations the same for behavioral (SUD and mental health) conditions as they were for medical/surgical conditions. However, a major disappointment took place when the Obama administration decided that enforcement would be left up to the states, not the federal government (see https://onlinelibrary.wiley.com/doi/epdf/10.1002/adaw.20301).

Now, more than 15 years after the law was enacted and 12 years after the decision was made that states would enforce parity, the Biden administration has taken steps to make sure that insurance companies don't make it any more difficult to access benefits for SUD treatment than they do for medical/surgical care.

Last week, in issuing new rules, President Biden said that "too many Americans still struggle to find and afford the care they need."

The proposed rule, announced on July 25, would:

Require health plans to make changes when they are providing inadequate access to mental health [and substance use disorder] care. In 2020, Congress made changes to MHPAEA that require health plans to conduct meaningful comparative analyses that will help ensure that access to mental health and substance use benefits is no more restrictive than to medical benefits. "Today's proposed rule would make clear that health plans need to evaluate the outcomes of their coverage rules to make sure people have equivalent access between their mental health and medical benefits," the White House stated. "This includes evaluating the health plan's actual provider network, how much it pays out-of-network providers and how often prior authorization is required and the rate at which prior authorization requests are denied. These analyses will show plans where they are failing to meet their requirements under the law and will require plans to improve access to mental health

It is illegal under federal copyright law to reproduce this publication or any portion of it without the publisher's permission.

care — by including more mental health professionals in their networks or reducing red tape to get care — to be in compliance with the law."

Make it clear what health plans can and cannot do. "The proposed rule will provide specific examples to make clear that health plans cannot use more restrictive prior authorization, other medical management techniques, or narrower networks that make it harder for people to access mental health and SUD benefits than their medical benefits," said President Biden. "Under the proposed rule, health plans must use similar factors in setting out-of-network payment rates for mental health and SUD providers as they do for medical providers."

Close existing loopholes

When MHPAEA was first enacted, it did not require non-federal governmental health plans, like those offered to state and local government employees, to comply with its requirements. Today's proposed rule would close that loophole and codify congressional changes made to MHPAEA by requiring more than 200 additional health plans to comply with MHPAEA, providing critical protections to 90,000 consumers.

President Biden also announced the White House intention to issue a request for information on how it can best work with states to ensure compliance with MHPAEA's critical protections for the millions of Medicaid beneficiaries enrolled in private Medicaid health plans. •

For the proposed rule, go to https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/requirements-related-to-mhpaea-proposed-rules.pdf.

Home-based from page 1

in-person treatment dwindled across the country amid COVID-19 restrictions. Aware now operates in 11 states in the Northeast/Mid-Atlantic (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Virginia), Midwest (Indiana, Kentucky, Ohio) and Southeast (Florida, Georgia).

COVID-19 also resulted in a shift in Aware's treatment model, from all in-person services at home to what is now more of a hybrid of in-home peer recovery support and virtual clinical care.

Holzer suggested that the company likely will put the brakes on expansion into additional states for a while. "Our goal is to build density in the states we're in now," he said.

Struck by treatment models

Holzer was trained as a physician but did not end up practicing medicine. He served in numerous roles on the business side of health care, including in pharmaceuticals and developing home health and hospice agencies before becoming Aware's CEO 14 months ago.

His arrival occurred as the result of a planned transition of Aware's founding leadership, including former CEO Steve Randazzo, to the company's board of directors (see "Home-based model makes inroads with insurer's support in two states," *ADAW*, May 1, 2017; https://doi.org/10.1002/adaw.30929). The leadership transition also coincided with Aware's securing of private equity financing back in 2021.

> **"The peer coach is in the home, not on Zoom…. "The coach looks, feels, acts like the client. Almost all of them are in recovery."**
>
> Brian Holzer, M.D.

Unlike Randazzo and former Aware vice president Matt Eacott, whose combined vision for the company was shaped by their personal, and largely disappointing, experiences with traditional treatment modalities, Holzer had no experience either in recovery or working in the field. "I saw it as an innovative new care model," he said of Aware's program and the opportunity to lead it.

Holzer said he sees the key component of Aware's success as its combination of paraprofessional and licensed professional services. Each client in the yearlong program is assigned two peer recovery advisers who between them are able to conduct two at-home visits per week. The client then has access to a clinical treatment team that includes addiction psychiatrists, nurse practitioners and care coordinators, with sessions delivered mainly via telehealth. Medication treatment for substance use disorders is also a prominent component of the program, as are family support services.

"We aim for 150 visits over the course of a stay," Holzer said. Average stays in treatment are around 250 days, with much of the last couple of months devoted to community re-engagement strategies. Completion of treatment is based more on reaching concrete goals than on a set duration, Holzer said.

"The peer coach is in the home, not on Zoom," Holzer said. "The coach looks, feels, acts like the client. Almost all of them are in recovery."

Aware identifies the ideal candidate for this clinical model as a person whose treatment needs fall somewhere between what outpatient and lower-intensity residential care traditionally provide, Holzer said. Those with higher intensity needs often will have to be served in a facility for a period of time, after which a referral to Aware for

Continues on page 8

Continued from page 7

ongoing care often occurs, he said.

Aware was created in 2011 and secured its first in-network benefit contract with Anthem Blue Cross Blue Shield in 2015. It now has more than a dozen managed care contracts as an in-network provider with entities that include Anthem (recently rebranded as Elevance Health, under the Carelon umbrella), Florida Blue, Beacon Health Options, Tufts Health Plan and Aetna, the latter for a state government contract in Connecticut. It does not serve any Medicaid or Department of Veterans Affairs clients at this time.

Patients have a self-pay option that averages in the low $40,000s range, but Holzer said self-pay represents a very small percentage of Aware's business. Aware is dually Joint Commission-accredited for in-home health and behavioral health, he said.

Future prospects

Publicly released information about outcomes from the Aware program has been limited thus far, as most of the data rests with payers. Holzer said participating health plans have seen per-member-per-month costs decline during patients' year in treatment and are continuing to see savings in the second year. "We're building a platform for sustained sobriety," he said.

The program has served around 7,300 patients in the three regions of the country over the past three years, Holzer said. Around two-thirds are dealing with an alcohol use disorder and around one-third have an opioid use disorder, he said.

In some cases, Aware will encounter an individual who likely could benefit from the in-home services and support but who believes that medication for substance use disorder is all they need. The organization is therefore piloting a separate medication management and medically managed detoxification track virtually that offer bridge services to more comprehensive care for these individuals, Holzer said.

Despite the fact that Aware's model can eliminate some of the hurdles associated with factors such as direct billing for telehealth, Holzer said he is not surprised that competitors haven't surfaced. "New things in health care take time," he said. "Payers are not used to paying for a yearlong utilization model. They are more apt to pay for a 30-day residential stay, even if that is followed by the need for two more residential stays in a year."

He added, "We're not billing for telehealth. We're paid to deliver health care. If telehealth is an appropriate part of the person's care, we deliver that."

Holzer said he doesn't expect providers to embrace a completely at-home model anytime soon, "because it's hard. It's just a lot easier to do what you see other people doing out there." •

Coming up...

The **National Prevention Network conference** will be held **August 15-17** in Birmingham, Alabama. For more information, go to **http://npnconference.org/**

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, Massachusetts. 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...

The National Association of Addiction Treatment Providers (NAATP) last week commended the Biden administration for its willingness to enforce parity (see story, page 6), last week. NAATP has been a leader in calling for this enforcement. The proposed regulations would mandate that insurers analyze their coverage to ensure equivalent access to mental health care based on outcomes. "Insurance companies would have to look at how they respond to requests from doctors to authorize treatments for substance use disorder and mental illness, as compared to physical ones," NAATP said. "They would also be required to analyze their provider networks and how much they reimburse providers out of network for these services compared to physical health. Reimbursement rates are a critical issue and have exacerbated the workforce challenges for substance use treatment providers. The rule would also establish when health plans are prohibited from requiring doctors to obtain the insurers' prior authorization to prescribe a medicine or procedure, or otherwise put-up roadblocks for patients seeking mental health, as well as substance use treatment. Insurers could face fines for failing to offer comparable coverage for mental health. NAATP has advocated for the ability to fine insurers who continually ignore the law with few consequences."