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Opportunities to Improve Polysubstance Use Treatment in Federally Qualified Health Centers (FQHCs)

Prepared by the **Collaborative Family Healthcare Association** for **The Pew Charitable Trusts**

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Table of Contents

Table of Contents 1
Acknowledgements 2
Acronyms and Definitions 4
Executive Summary 5
Overview 9
Historical Context 11
Community Health Center-Level Opportunities 12
A. Build Robust Team-Based Care Infrastructure 12
B. Establish Clinical Champions with Protected Administrative Time 14
C. Develop and Implement Evidence-Based Clinical Pathways 15
D. Use a Low-Barrier Model of Care 15
E. Transform Culture Through Sustained Engagement 16
F. Practice Prevention and Early Intervention 18
State Level Opportunities 20
A. Mitigate Adverse Impact of Medicaid Work Requirements on SUD Treatment Continuity 20
B. Address Fundamental Structural Barriers in FQHC Medicaid Payment for SUD Services 21
C. Eliminate Same-Day Billing Restrictions for Integrated Physical Health and SUD Services 23
D. Expand Medicaid Coverage for Comprehensive SUD Services Beyond Traditional Treatment Models 25
E. Invest in FQHC SUD Workforce Development and Infrastructure Capacity 27
Federal-Level Opportunities 29
A. Adequately Fund Community Health Centers 30
B. Protect and Strengthen the 340B Drug Pricing Program 30
C. Expand and Sustain Investment in Teaching Health Center Graduate Medical Education 31
D. Strengthen Workforce Development Through Loan Repayment and Allied Health Training Programs 31
E. Establish Federal Research Infrastructure for Polysubstance Use Treatment Effectiveness 32
F. Preserve and Expand Medicare Coverage for Integrated Behavioral Health and SUD Services in FQHCs 33
Conclusion 35
Appendix 36
Endnotes 38

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Acronyms and Definitions

AHRQ	Agency for Healthcare Research and Quality
CM	Contingency Management
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model (also referred to as Psychiatric Collaborative Care Model)
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
MAT	Medication-Assisted Treatment
MAUD	Medications for Alcohol Use Disorder
MOUD	Medications for Opioid Use Disorder
NACHC	National Association of Community Health Centers
NHSC	National Health Service Corps
NIH	National Institutes of Health
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCSS	Providers Clinical Support System
PPS	Prospective Payment System
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SUD	Substance Use Disorder
THCGME	Teaching Health Center Graduate Medical Education

Executive Summary

THE PROBLEM

Polysubstance Use Is Now the Norm, With Persistent Treatment Gaps

Although opioid overdose ***deaths*** began declining in 2023, ***polysubstance use*** — defined as "the concurrent or sequential use of multiple substances"[1] — is increasingly common for those with opioid use disorder[2,3]. Polysubstance use can include alcohol, methamphetamine, cannabis, cocaine, benzodiazepines, nicotine, or other substances[4] and requires more comprehensive and flexible treatment approaches than traditional opioid-focused medication-based treatment programs. Meanwhile, federal and state policy, payment, and clinical infrastructure have not kept pace to support polysubstance use treatment.

THE OPPORTUNITY

Primary Care Can Effectively Treat Polysubstance Use — With the Right Infrastructure

Federally Qualified Health Centers (FQHCs) — a subset of health centers that meet federal certification requirements and qualify for Medicare and Medicaid prospective payment or an approved alternative payment methodology[5] — serve more than 32 million patients annually[6]. They disproportionately reach low-income individuals, the uninsured, those experiencing homelessness, and those in rural communities. Based on their integrated model of care, FQHCs are ideally positioned to address polysubstance use in primary care. The five FQHCs profiled in this report — Delaware Valley Community Health (Philadelphia, PA), Waco Family Medicine (Waco, TX), Piedmont Health Services (Chapel Hill, NC), HealthPoint (King County, WA), and Access Community Health Centers (Madison, WI) — demonstrate that generalist primary care providers and their integrated care teams can initiate and manage polysubstance use treatment, challenging the assumption that substance use disorder (SUD) care always requires specialty settings.

Their success rests on four foundational elements:

- **Robust integrated team-based care from health care professionals with training in SUD treatment** including behavioral health clinicians, peer recovery specialists, care coordinators, and nurses working in concert with primary care providers
- **Clinical champions with protected administrative time** to build programs, train staff, and sustain clinical culture change
- **Evidence-based clinical pathways** that support generalist providers in delivering best-practice polysubstance care
- **Low-barrier models of care** embedded throughout the clinic, including naloxone distribution, same-day behavioral health services, and patient-centered engagement strategies

THE BARRIERS

Three Policy Gaps Constrain Community Health Center Capacity

Despite these promising models, FQHCs face structural barriers that limit their ability to deliver polysubstance use treatment at scale. Three critical gaps emerge across every level of the system:

- **Workforce and Team-Based Care Infrastructure:** Although effective polysubstance use treatment requires a trained primary care team, current payment methodologies, loan repayment programs, and training pipelines do not adequately support the multidisciplinary staffing models that FQHCs need to treat polysubstance use at scale.
- **Coverage Stability**: New Medicaid work requirements enacted in Public Law 119-21 (referred to herein as H.R. 1[7]) threaten to disrupt coverage for individuals with SUDs[8]. Although H.R. 1 attempts to exempt people with SUD from work requirements, the behavioral health symptoms associated with SUD may place this population at heightened risk of coverage loss. Medicaid coverage is critical for sustained SUD treatment, as coverage gaps disrupt care continuity, interrupt medications, and undermine recovery.
- **Payment Adequacy**: According to the National Association of Community Health Centers, FQHC Prospective Payment System rates cover only 82% of actual costs of caring for Medicaid patients[9]. This gap is particularly problematic for SUD services, which require time-intensive assessments, care coordination, and crisis intervention. Same-day billing restrictions in many states further undermine integrated care delivery, creating financial penalties for providing the very services that evidence shows are most effective[10].

THE SOLUTION

A Three-Level Policy Agenda

Addressing these barriers requires coordinated action at the health center, state, and federal levels. This report identifies specific, actionable recommendations across all three levels.

Health Center-Level Solutions

FQHCs can adopt policies and practices to expand successful treatment for treatment of polysubstance use. As the five clinics described in our case studies demonstrate, FQHC leaders can build robust team-based care infrastructure and training to support SUD treatment; establish clinician SUD treatment champions with protected administrative time; develop and implement evidence-based SUD clinical pathways for polysubstance use; embed low-barrier models of care throughout clinic operations; and sustain

engagement approaches that make SUD treatment routine and culturally integrated, rather than siloed or stigmatized. Health centers can also invest in prevention and early intervention, using primary care's unique position of established patient-provider relationships to identify substance use early and intervene before disorders become entrenched.

State-Level Solutions

State policymakers can significantly expand FQHC polysubstance use treatment capacity by addressing five priority areas. First, states can help mitigate the losses and administrative burdens from the 2025 reconciliation law's Medicaid work requirement (H.R. 1[11]) by: leveraging existing data; working with health care providers to identify and document patients who may qualify for exemptions; and applying lessons learned from Arkansas's implementation of Medicaid work requirements in 2018-2019[12]. Second, states can address core structural barriers in FQHC Medicaid payment that inhibits SUD treatment by: supporting increased Prospective Payment System rates[13] to reflect the time-intensive nature of SUD care; streamlining change-in-scope processes to make it easier for FQHCs to provide SUD treatment; providing retroactive rate authority for FQHCs offering a broader scope of services; and supporting reductions in administrative burden to provide SUD treatment. Third, states can eliminate same-day billing restrictions that penalize FQHCs for providing integrated physical health and SUD services simultaneously[14], which is the most clinically effective and cost-efficient model of care. Fourth, states can expand Medicaid coverage for comprehensive SUD services beyond an emphasis on opioid use disorder by: including medication where appropriate and evidence-based behavioral interventions where medication is unavailable, consistent with federal encouragement of evidence-based SUD treatment[15]; reducing prior authorization barriers[16]; and expanding reimbursement for peer recovery specialists, community health workers, naloxone distribution, drug testing supplies, and telehealth[17]. Fifth, states can invest in FQHC SUD workforce development and infrastructure capacity through: addiction medicine-specific loan repayment; training and support; competitive compensation support; and capital grants for essential SUD treatment infrastructure.

Federal-Level Solutions

Federal action is foundational to enabling FQHCs to provide treatment for patients with polysubstance use. Congress and federal agencies can focus on six priority areas. First, Congress can provide long-term mandatory funding for the Community Health Center Fund to end the cycle of short-term funding reauthorizations that prevent multi-year program investments needed for SUD treatment[18]. Second, the Health Resources and Services Administration (HRSA) can protect and strengthen the 340B Drug Pricing Program for FQHCs, which generates revenue that allows them to provide comprehensive medications, as well as other services for their low-income and uninsured patients[19]. Third, Congress can expand and sustain the Teaching Health Center Graduate Medical Education (THCGME) Program, which trains physician residents in community settings and creates sustainable primary care workforce pipelines in underserved and rural

communities[20]. Fourth, HRSA can strengthen workforce development by prioritizing addiction medicine placements through the National Health Service Corps (NHSC), expanding technical assistance on SUD program development and billing, strengthening Uniform Data System reporting on SUD workforce capacity, and creating THCGME-to-NHSC pathways. Fifth, the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality (AHRQ) can establish a federal research infrastructure aimed at improving polysubstance use treatment effectiveness, including dedicated funding, enhanced surveillance data, clinical practice guidelines for use in primary care, and FQHC-based research partnerships. Sixth, the Centers for Medicare & Medicaid Services (CMS) can preserve and expand Medicare coverage for integrated behavioral health and SUD services in FQHCs, including revision of payment rates to reflect team-based polysubstance care costs and issuance of clear guidance permitting same-day multi-provider billing.

Together, these recommendations outline a comprehensive agenda for positioning FQHCs as essential treatment settings for the nation's polysubstance use crisis, leveraging their core strengths of integrated care delivery, commitment to underserved populations, and experience with clinically complex patients.

Overview

Although opioid overdose deaths began declining in 2023, often overlooked is that many individuals with opioid use disorder (OUD) commonly use more than one drug together or within a short period of time, referred to as polysubstance use[21]. Nearly 60% of people with OUD experience current co-occurring substance use disorders (other than opioids), and 72% have experienced one in their lifetime, although this figure varies considerably across studies[22]. The so-called "fourth wave" of the overdose crisis is driven by the use of multiple substances in addition to opioids[23]. With polysubstance overdose trends beginning to accelerate around 2014[24], the contemporary polysubstance overdose crisis is characterized by the co-involvement of fentanyl with stimulants, such as cocaine and methamphetamine, as well as with depressants, such as alcohol or benzodiazepines[25].

Polysubstance use is highly prevalent beyond opioids[26]. Alcohol and cannabis use together is increasingly common[27], and tobacco use frequently co-occurs with other substances[28]. In 2024, alcohol-related deaths, for instance, exceeded opioid deaths[29]. Polysubstance use is clinically complex, with individuals engaging in polysubstance use often presenting with psychiatric comorbidity and associated psychosocial stressors[30]. As evidenced by the 2024 National Institute on Drug Abuse strategic plan, polysubstance use requires more comprehensive and flexible treatment approaches than traditional opioid-focused medication-based treatment programs[31]. While opioid overdoses draw significant attention due to their acute and often fatal nature, the broader impact of polysubstance use and other substance use disorders is substantial.

Substance use disorder (SUD) is generally under-treated: in 2024, an estimated 16.8% of Americans age twelve and older experienced a SUD in the past year, yet only one in eight people receive treatment[32]. Among people with SUD who feel they need treatment but do not receive it, the most common reasons are believing they should be able to handle their alcohol or drug issue on their own and not being ready to start treatment or cut back[33]. These beliefs often shift over time, creating windows of opportunity for intervention. Primary care, with its emphasis on ongoing relationships, accessible care, and treating the whole person, is ideally positioned to reach people during these moments. However, many people with alcohol and opioid use disorders go undiagnosed and untreated in primary care[34]. Workforce shortages and behavioral health staffing gaps pose significant challenges for community health centers in identifying and addressing behavioral health needs and obtaining timely specialty care for patients[35]. With adequate investment, infrastructure, and clinical support, primary care teams could respond in these critical moments and close this treatment gap.

Nearly 60%

of people with OUD experience current co-occurring substance use disorders other than opioids

16.8%

of Americans age 12+ experienced a SUD in the past year (2024)

Federally qualified health centers (FQHCs), with their focus on integrated teams and workflows, offer valuable lessons for treating polysubstance use in primary care. People experiencing homelessness[36] and people with Medicaid coverage[37] — populations disproportionately represented among FQHC patients — have elevated rates of SUD. Behavioral health conditions are among the most common conditions associated with health center visits[38]. Many community health centers have built integrated teams and workflows to provide behavioral health and SUD treatment directly in primary care[39,40].

In January 2024, the Center for Health Care Strategies published, with funding and partnership support from The Pew Charitable Trusts, ***Opportunities to Promote Medications for Opioid Use Disorder in Federally Qualified Health Centers***[41], which highlighted the significant barriers to medications for opioid use disorder (MOUD) treatment for people with OUD. The publication outlined strategies for FQHCs to expand access to MOUD including: staff training on OUD and low-barrier models of care; access to methadone through Opioid Treatment Program (OTP) partnerships; collaboration with Certified Community Behavioral Health Clinics; state payment reform; workforce development; and federal support for MOUD programs.

This report builds on that work by examining polysubstance use treatment in primary care. It draws upon the experiences of FQHC primary care teams to identify lessons and recommendations for improving and expanding treatment. Although focused on FQHCs, the findings have implications for treating SUDs in primary care more broadly. The report is informed by a review of the scientific literature, site visits to five geographically and demographically diverse FQHCs, interviews with subject matter experts, and input from a focus group of content experts.

The report is organized by the same three key areas of opportunity outlined in the Center for Health Care Strategies report[42]:

Community Health Center-Level Opportunities **State-Level Opportunities** **Federal-Level Opportunities**

This report challenges the common assumption that SUD treatment requires specialty settings. The five FQHCs profiled here — Delaware Valley Community Health (Philadelphia, PA), Waco Family Medicine (Waco, TX), Piedmont Health Services (Chapel Hill, NC), HealthPoint (King County, WA), and Access Community Health Centers (Madison, WI) — demonstrate that primary care can efficiently and effectively treat polysubstance use when equipped with integrated behavioral health teams, evidence-based clinical pathways, and approaches rooted in patient-centered, low-barrier models of care. State and federal policymakers can support the treatment of polysubstance use in primary care settings by training and reimbursing multi-disciplinary staffing models, ensuring Medicaid coverage stability through careful implementation of work requirement exemptions, and reforming payment methodologies to adequately reimburse time-intensive services.

Historical Context

Why Do Opioids Receive More Policy Attention Than Polysubstance Use?

What factors drove the recent opioid public policy response in the United States?



A highly visible overdose crisis.

A widely publicized wave of opioid overdose deaths accelerated during the mid-2010s and was initially perceived as an issue affecting White rural communities[43]. This drew attention from policymakers who had formerly viewed drug use as a criminal justice problem, but came to see it as a public health issue[44].



A understanable narative.

A strong narrative of "overprescribed pain medications" due to aggressive pharmaceutical marketing[45] and the promotion of "Pain as the Fifth Vital Sign"[46] were easy for the public to understand.



Significant media attention.

The role the media played in assigning blame to pharmaceutical companies[47].



Availability of FDA-approved meds.

The fact that Food and Drug Administration (FDA)-approved medications existed for treatment of OUD[48].

Why has polysubstance use received less public policy attention?



No single cause of clear policy narrative.

Unlike OUD, in which blame focused on pharmaceutical companies, there is no single cause for polysubstance use. Social stigma instead places blame on individuals with addictions, labeling them inaccurately as dangerous, immoral, or weak[50].



More complex treatment needs.

Most SUDs require individualized, team-based approaches to care. However, unlike OUD, which has multiple FDA-approved medications, some substances like cocaine and methamphetamine have no FDA-approved medication for treatment[51].



No dedicated advocay constituency.

Unlike OUD, there is no national advocacy organization or policy constituency specifically dedicated to polysubstance use.



Policy remains sustance-specific.

Federal policy remains largely substance-specific (opioids, methamphetamine, etc.) rather than polysubstance-focused. Although policymakers may recognize that polysubstance use is the norm[52], this has not translated into:

- Dedicated funding streams for polysubstance treatment models
- Research initiatives specifically studying polysubstance treatment effectiveness
- Clinical practice guidelines for treating polysubstance use
- Separate diagnostic or surveillance systems focused on polysubstance use



No comprehensive federal framework.

Although federal policy has increasingly addressed risks involving multiple substances, Congress has not established a comprehensive federal framework specifically focused on polysubstance use. Congress has, however, enacted the SUPPORT for Patients and Communities Reauthorization Act of 2025 (H.R. 2483; Public Law 119-44), reauthorizing certain opioid- and substance-use-related programs through fiscal year 2030[53].

Key Takeaways

These factors created strong bipartisan consensus on both the causes of and solutions to address opioid overdose deaths, leading to significant, regularly renewed legislation focused on treatment, prevention, and law enforcement at both the state and federal levels[49].

Given this policy gap, FQHCs that have developed polysubstance treatment models offer critical lessons for scaling evidence-based care. Meanwhile, polls show that lowering health care costs remains a top concern of the public[54], creating fiscal pressure on all health initiatives, including treatment for SUD.

Sources for this graphic [43],[44],[45],[46],[47],[48],[49],[50],[51],[52],[53],[54]

Community Health Center-Level Opportunities

Provider-level and organizational factors are associated with successful implementation of SUD treatment[55]. Many of the recommendations here add to the ***Opportunities to Promote Medications for Opioid Use Disorder in Federally Qualified Health Centers*** report[56], but are specifically targeted to improve and expand treatment in primary care settings for those who use multiple substances that result in SUD.

A. Build Robust Team-Based Care Infrastructure

Because specialty referrals are often difficult for those who are uninsured or on Medicaid, community health centers' comprehensive care model, which increasingly includes behavioral health and SUD treatment, fills a critical gap in health services[57].

Why teams matter in treating polysubstance use: A team-based approach is particularly important for polysubstance use. While OUD treatment is individualized and may include behavioral therapy and psychosocial supports, it often centers on medication treatment, including methadone dispensed through OTPs and buprenorphine prescribed in primary care settings[58]. Many other SUDs, however, lack FDA-approved medications[59]. Whether or not medications exist for treatment, robust care teams with behavioral health expertise are essential. Effective teams ensure care is cohesive and seamless and, in addition to primary care providers, may include some combination of the following team members[60]:

- **Behavioral Health Clinicians**
  - Practice as generalist counselors addressing behavioral factors that impact aspects of health, including all SUDs
  - Provide same-day counseling interventions
  - Engage in patient panel management and care coordination activities that free up primary care provider time

BUILDING FROM THE MOUD REPORT

A 2024 report authored by the Center for Health Care Strategies staff and funded by The Pew Charitable Trusts recommended practices for FQHCs to improve medication treatment for patients with OUD:

- **Promote** low-barrier models of care including naloxone distribution, fentanyl test strips, sterile syringes, overdose safety planning
- **Provide access to methadone** through OTP partnerships establishing medication units or pursuing OTP certification
- **Consider partnerships with Certified Community Behavioral Health Clinics** to offer enhanced behavioral health services and specialty SUD expertise
- **Address housing instability** among patients, including pursuing Health Care for the Homeless designation and strengthening partnerships with housing and homeless services organizations

- **Peer Recovery Specialists**
  - Bring lived experience with substance use to build trust and engagement with patients
  - Navigate barriers to care and provide practical support (e.g., for accessing transportation, navigating food and housing resources)
  - Model recovery in ways that resonate with patients' experiences
- **Addiction Medicine Specialists**
  - Serve as champions for expanded SUD care within the organization
  - Support non-specialists through consultation on complex cases
  - Train clinicians in treatment and interventions like naloxone and drug checking equipment
  - Design low-barrier care workflows
- **Psychiatry Consultants**
  - Review care for patients receiving SUD treatment services
  - Recommend treatment changes to primary care providers as needed
  - Provide consultation on managing SUDs and co-occurring mental health conditions
- **Care Managers**
  - Maintain a registry of patients receiving SUD treatment
  - Provide regular virtual or in-person patient contacts for care continuity
  - Monitor patient outcomes
  - Review patient care with psychiatry consultants and communicate treatment recommendations to primary care providers
  - Deliver brief standardized behavioral interventions
- **Patient Care Navigators**
  - Connect patients with community services
  - Assist with accessing insurance, transportation, and housing
  - Coordinate communication between the clinic and community resources

FQHC Examples:
HealthPoint's Whole Care program in King County, WA, exemplifies a team-based approach, bringing together a primary care provider, behavioral health clinician, SUD counselor, nurse, patient care navigator, peer support specialist, medical assistant, and consulting psychiatrist to create a "one-stop shop" for patients with complex needs. Other HealthPoint clinics serving broader patient populations have adopted similar team structures to strengthen their SUD care.

Delaware Valley Community Health in Philadelphia, PA, uses a comparable model at their Fairmount clinic, with the addition of pharmacists and attorneys. Pharmacists manage medication procurement and delivery (including protocols for long-acting injectables), provide staff education and training, and address medication questions from patients and clinicians. Attorneys help resolve legal and social issues that affect patient health — such as housing disputes, child custody matters, or disability benefits — recognizing that these social determinants directly impact recovery.

B. Establish Clinical Champions with Protected Administrative Time

Clinical champions are essential for developing sustainable care models for polysubstance use[61]. All five FQHCs interviewed identified champions as foundational to their success.

Selecting and supporting champions: Effective champions typically have experience in addiction medicine and view SUDs as chronic health conditions requiring ongoing management, much like diabetes or hypertension. Clinicians with expertise managing OUD are often well-positioned to expand into polysubstance use treatment. Champions can be medical providers, nurses, behavioral health clinicians, or counselors with dedicated administrative time to take on the role of champion[62]. Ideally, clinic champions represent more than one professional discipline since system change requires buy-in across multiple roles. The FQHC leaders interviewed for this report emphasized that champions cannot build new care models while maintaining full clinical schedules.

Champions typically contribute by:

- Developing and delivering training on polysubstance use treatment
- Creating clinical pathways for multiple substances beyond opioids (e.g., stimulants, alcohol, benzodiazepines, nicotine)
- Mentoring colleagues who feel overwhelmed by complex cases or treating multiple substances simultaneously
- Leading by example, demonstrating that patients with polysubstance use can be successfully integrated into primary care workflows

FQHC Examples:

At Waco Family Medicine in Waco, TX, Dr. Zach Sartor and his leadership team received protected time to develop the Primary Care Addiction Medicine program, which trains family medicine residents in SUD treatment, and the Waco Guide to Psychopharmacology in Primary Care, a practical toolkit for treating polysubstance use in primary care.

At Access Community Health Centers in Madison, WI, Dr. Walker Shapiro was designated as physician champion with protected administrative time to pilot new treatment approaches, educate staff on assessing and treating multiple SUDs, and develop workflows that accommodate polysubstance use complexity.

At Piedmont Health Services in Chapel Hill, NC, champions emerged from the behavioral health team. Two licensed clinical addiction specialist counselors had protected time to develop clinical workflows, manage opioid settlement funds, coordinate community partnerships and referrals, and train other behavioral health providers.

C. Develop and Implement Evidence-Based Clinical Pathways

Clinical pathways outline evidence-based steps for treating specific conditions, helping generalists manage unfamiliar problems. They provide a standard structure for care that ensures consistency across clinicians and sites[63].

Why pathways matter for polysubstance use: Treating one SUD is typically less complex than treating multiple disorders simultaneously. Clinical pathways become especially valuable when managing polysubstance use, as they can address[64]:

- Steps involved in treating each SUD
- Screening tools and laboratory tests, with guidance for interpreting and acting on results
- Sequencing decisions when patients use multiple substances (e.g., which to address first, how to manage competing priorities)
- Team-based care coordination, including specific roles for medical providers, behavioral health clinicians, nurses, and peers, with clear guidance on when and how to engage each team member
- Metrics to track for each condition to monitor the pathway's effectiveness

FQHC Examples:

Piedmont Health Services in Chapel Hill, NC, developed pathways for alcohol, nicotine, and stimulant use disorders after seeing success with their OUD pathway. Each pathway spans one to two pages with steps outlined in a flowchart, describing screening tools and labs, treatment options, key assessment questions, and team member roles. Piedmont credits these pathways with facilitating more team-based care and increasing overall SUD treatment.

Waco Family Medicine in Waco, TX, created The Waco Guide to Psychopharmacology in Primary Care, an online resource and mobile phone app that provides more comprehensive decision support than typical clinical pathways. The Guide makes SUD treatment feasible within routine primary care visits by offering detailed evidence-based decision tools, including first-, second-, and third-line pharmacotherapy options, augmentation strategies, titration schedules, and behavioral interventions for both mental health disorders and SUDs.

D. Use a Low-Barrier Model of Care

Low-barrier care seeks to remove obstacles that prevent people from initiating and remaining engaged in treatment, rather than imposing requirements that may discourage

or delay access[65]. It is person-centered, meets patients where they are, and emphasizes flexibility, cultural responsiveness, and trauma-informed approaches.

Why low-barrier care matters for polysubstance use: Research demonstrates that low-barrier approaches improve treatment engagement and retention, reduce costs, and decrease emergency department visits and hospitalizations[66]. This model is especially important for patients with polysubstance use who may not be ready to address all substances simultaneously. Thus, one example of a low barrier might be the team's willingness to accept ongoing use of some substances as a necessity to initiate treatment for others[67].

Key elements of low-barrier care include[68]:

- **Accessibility and availability:** Multidisciplinary teams provide services largely on-demand; virtual care expands access
- **Flexibility:** Patients receive the type of help they want, avoiding rigid rules for seeking or staying in care; low-barrier principles guide clinical decisions, including thoughtful use of urine drug testing
- **Responsiveness:** Treatment plans meet each patient's unique needs and are adjusted as needed in a non-punitive manner
- **Collaboration:** Complex needs require diverse team members in primary care plus community partners offering essential services
- **Continuous learning and quality improvement:** Regular training on low-barrier practices and SUD treatment, with program evaluation and feedback loops to adjust care delivery

FQHC Example:

All five profiled FQHCs used low-barrier care models. HealthPoint's Whole Care program in King County, WA, exemplifies this approach with a multidisciplinary team trained in low-barrier care, walk-in scheduling, physical spaces designed to invite open discussion among the team, and strong connections to community organizations. The clinic "reserves" urine drug testing for when there is a medical necessity, viewing it as having limited clinical value and potential to undermine patient-provider trust. Other HealthPoint clinics have adopted similar practices, all offering walk-in hours specifically for SUD care. During these hours, a behavioral health provider sees walk-ins first to gather history and begin treatment planning, enabling the primary care provider to also accommodate same-day visits.

E. Transform Culture Through Sustained Engagement

Creating a culture where polysubstance use treatment is routine in primary care requires sustained transformation efforts that go beyond one-time education. Many factors may

foster resistance to expanding SUD care, including provider stigma, time constraints, insufficient training, and inadequate team support[69].

Why sustained engagement matters for polysubstance use: Preparing a system to treat a single SUD, as many FQHCs have done for OUD, is already challenging. Preparing a system to address polysubstance use adds layers of complexity. Building this culture requires time and intentionality, using strategies such as[70]:

- Starting with motivated early adopters rather than mandating universal participation, allowing champions to demonstrate success
- Providing graduated exposure where providers begin with less complex cases (e.g., patients on stable medication treatment) before progressing to polysubstance use
- Offering real-time consultation support through informal discussions with physician champions or consulting psychiatrists
- Using clinical pathways to reduce cognitive burden and provide decision support for complex cases
- Tracking and sharing outcomes showing patient improvement, which in turn builds provider confidence and buy-in
- Providing ongoing training rather than one-time webinars, recognizing that many providers lack adequate training in polysubstance use treatment
- Making training universal across all staff levels — front desk, call center, medical assistants, clinical providers — to ensure consistent, non-stigmatizing patient experiences
- Providing regular messaging from leadership that SUD treatment is routine primary care, not a specialty service
- Regularly reinforcing low-barrier, person-centered models of care

FQHC Examples:

Each FQHC visited emphasized different aspects of cultural transformation. Access Community Health Centers in Madison, WI, provides comprehensive, continuous training, including bias- and trauma-informed care training every six months and addiction-specific training for all new staff, including call center personnel. Piedmont Health Services in Chapel Hill, NC, focuses cultural transformation on hiring decisions, recruiting strong generalist primary care providers and building teams to support them rather than hiring addiction medicine specialists. Waco Family Medicine in Waco, TX, makes SUD treatment routine by providing The Waco Guide to Psychopharmacology in Primary Care, helping providers feel confident addressing multiple SUDs and co-occurring mental health conditions. HealthPoint in Seattle, WA, sustains its culture through a robust training pipeline, educating over 200 learners annually from various disciplines, many of whom join HealthPoint after training — ensuring cultural alignment from the start.

F. Practice Prevention and Early Intervention

Routine screening for unhealthy substance use, followed by a brief intervention (often called Screening, Brief Intervention, Referral to Treatment, or SBIRT), is an evidence-based approach to prevent significant health issues[71]. Research supports using SBIRT to prevent unhealthy alcohol use in youth and adults[72]. To prevent unhealthy drug use, the evidence is mixed due to a lack of evidence weighing the benefits and harm for adolescents[73]. Despite this, SBIRT remains widely recommended[74]. However, screening and brief interventions are under-utilized in youth[75]; adults are more likely to be screened, but only a minority receive any intervention[76].

Why prevention and early intervention matters for polysubstance use: Most people with SUD do not recognize it as an issue, creating a significant barrier to engage in treatment. Screening in primary care settings offers an opportunity for a trusted clinician to intervene early to improve substance use outcomes and prevent future health issues that may require more intensive treatment later.

Research and expert interviews identify several keys to implementing SBIRT successfully[77]:

- **Use validated screening tools** for both youth[78] and adults. Brief validated tools exist for both alcohol[79] and drugs[80]. Non-validated tools can produce false-positive results leading to unnecessary intervention or false-negatives leading to missed opportunities.
- **Consult comprehensive online resources** for implementation support, such as those from the state of Oregon (https://www.sbirtoregon.org) or from the Substance Abuse and Mental Health Services Administration (SAMHSA; https://www.samhsa.gov/substance-use/treatment/sbirt).
- **Train clinicians in brief interventions.** Lack of training is commonly cited as one reason why SBIRT interventions are often not provided, and poor-quality interventions are a known implementation concern[81]. Trainings can be provided internally if available, or through asynchronous learning or continuing education (e.g., https://sbirt.care/training.aspx).
- **Utilize a behavioral health team member** to deliver the brief intervention in tandem with the primary care visit. In this way, the team member with the strongest expertise in behavioral change can work collaboratively with the primary care provider for the most impact, saving the time of the medical clinician.
- **Emphasize intervention over referral.** Evidence for the value of screening and brief intervention is stronger than evidence for treatment referral, and most patients referred to treatment will not complete the referral[82].

FQHC Example:

The clinical pathways developed at Piedmont Health Services (Chapel Hill, NC) use an SBIRT framework. Universal screening is conducted by medical assistants who use brief initial screeners, followed by longer screeners for positive initial screens. Patients who screen positive on the longer screener are routinely offered a same-day visit with behavioral health, helping ensure a brief intervention is delivered.

State Level Opportunities

BUILDING ON 2024 MOUD REPORT RECOMMENDATIONS

A 2024 report authored by staff from the Center for Health Care Strategies and funded by The Pew Charitable Trusts recommended these state policies to help FQHCs improve medication treatment for patients with OUD:

Funding and Reimbursement:

- Engage health centers to discuss prospective payment system rates and/or alternative payment models
- Incorporate OUD-specific performance measures into payment models for FQHCs
- Leverage opioid settlement funds to support MOUD adoption
- Consider payment parity for OUD-related telehealth and in-person visits

Workforce and Partnerships:

- Integrate training on OUD/SUD into clinical training and licensing
- Leverage grants to support clinician training and capacity building
- Leverage grants to facilitate partnerships between FQHCs and other entities

Regulation and Policy:

- Review state policies that may impede access to OUD treatment, including:
  - Prior authorization requirements
  - Counseling requirements as a condition of treatment
  - Assessment requirements before prescribing
  - Licensing requirements for SUD specialty designation
  - Scope of practice rules for behavioral health counselors
  - Same-day billing restrictions for physical and behavioral health services

Based on the current policy landscape and the evidence regarding effective SUD treatment in FQHCs, the following policy interventions represent critical priorities for ensuring substance use treatment access and sustainability at the state level.

A. Mitigate Adverse Impact of Medicaid Work Requirements on SUD Treatment Continuity

Medicaid is the single largest payer of behavioral health services in the United States, accounting for a quarter of all spending for both mental health and substance use treatment[83]. Medicaid coverage gaps disrupt SUD care continuity, interrupt medications, and undermine recovery. In July 2025, H.R. 1, a major budget reconciliation package, was signed into law[84] with new federal work requirements for Medicaid recipients. While H.R. 1 exempts people with SUD from work requirements through two pathways (those determined to have a chronic substance use disorder under the medically frail category, those actively participating in a drug addiction or alcoholic treatment and rehabilitation program[85,86]), a Centers for Medicare & Medicaid Services (CMS) interim final rule published June 1, 2026, narrows the 'medically frail' exemption to require that qualifying conditions must 'significantly impair' an individual's ability to comply with the work requirement[87]. The behavioral health symptoms (such as impaired concentration and difficulties managing stress[88]) and related social challenges (including housing instability[89]) associated with those who have SUD place this population at increased risk of

coverage loss[90]. The Congressional Budget Office estimates that 10 million people will become uninsured over the next 10 years because of Medicaid changes, Affordable Care Act Marketplace changes, and other policies[91,92].

As the work requirements are implemented beginning January 1, 2027[93], state Medicaid agencies should consider the following protective measures[94]:

- **Data Verification**: States should prioritize verification for SUD diagnosis and treatment using existing data sources without requiring beneficiaries to submit additional documentation[95,96]. This includes leveraging Medicaid claims data, diagnostic codes, encounter data from managed care organizations, state behavioral health agency records, and FQHC encounter data to automatically identify individuals with SUD diagnoses or treatment participation. The CMS interim final rule specifically names the Federal Data Services Hub as a required data source[97].

- **Partner with Providers to Identify Exempt Individuals**: States should collaborate with managed care plans, FQHCs, and treatment providers to proactively identify exempt individuals and reduce administrative burdens[98,99]. FQHCs should be recognized as qualified entities for SUD diagnosis verification and as "qualifying SUD treatment programs" under the treatment participation exemption pathway.

- **Define Exemption Criteria Broadly**: The June 1, 2026, CMS interim final rule interprets the medically frail exemption to require that qualifying conditions, including chronic substance use disorder, must "significantly impair" the individual's ability to comply with the work requirement[100]. States should operationalize this exemption as broadly as the rule permits, using standard diagnostic codes (International Statistical Classification of Diseases and Related Health Problems, 10th Revision; ICD-10) from Medicaid claims and encounter data to identify individuals with active or chronic SUD diagnoses that impair daily functioning[101,102]. States should ensure that the separate treatment participation exclusion, which does not require establishing impairment, is applied to all individuals actively participating in qualifying SUD treatment programs[103].

- **Build System Flexibility and Apply Lessons from Arkansas**: States should build flexibility into eligibility systems to accommodate potential modifications[104]. Arkansas's brief work requirement implementation (2018-2019) resulted in nearly 17,000 people losing Medicaid coverage in three months, 95% of whom were already working or should have been exempted, with no increase in employment[105]. To avoid this negative outcome, states should conduct extensive member outreach using multiple communication modes, simplify reporting processes, and ensure adequate information technology infrastructure and staffing capacity[106,107].

Continuous Medicaid coverage is critical for sustained SUD treatment. Coverage gaps disrupt care continuity, interrupt medications, and undermine recovery — even when FQHCs continue treating uninsured patients.

B. Address Fundamental Structural Barriers in FQHC Medicaid Payment for SUD Services

FQHCs disproportionately serve populations most affected by polysubstance use disorders[108] and often serve as primary medical homes for individuals with serious mental illness[109]. Research documents that a disproportionate share of FQHC patients has behavioral health conditions[110] and that individuals experiencing homelessness and criminal legal system involvement face substantially elevated rates of polysubstance use and significant barriers to evidence-based treatment[111]. These health centers require flexibility to provide evidence-based treatments that extend beyond traditional office-based care models to address the complex reality of polysubstance use disorders.

Multiple structural deficiencies in state Medicaid payment methodologies directly impede FQHCs' capacity to establish and sustain comprehensive SUD treatment programs. For example, FQHC Prospective Payment System (PPS) rates cover only 82% of FQHCs' actual costs of caring for Medicaid patients, according to the National Association of Community Health Centers (NACHC)[112]. This cost-coverage gap is particularly problematic for SUD services, which require time-intensive assessments, care coordination, and crisis intervention that extend well beyond standard primary care visit parameters.

States should consider addressing five core payment challenges that would better support SUD treatment:

- **Prospective Payment System (PPS) Methodology Reform**: FQHCs receive Medicaid reimbursement through a PPS based on a cost formula adjusted annually for inflation[113]. However, these PPS rates have not kept pace with either inflation or changes in the scope of services FQHCs provide[114]. States should transition to cost-plus reimbursement methodologies that account for uncompensated care associated with uninsured SUD patients and provide financial sustainability for program expansion. While federal law allows states to implement Alternative Payment Methodologies that pay FQHCs at least the PPS amount[115], states can also use the Alternative Payment Methodologies flexibility to develop payment models that better support comprehensive SUD treatment programs.

***FQHC Examples:** Waco Family Medicine in Waco, TX, initially relied on a Health Resources and Services Administration (HRSA) medication-assisted treatment (MAT; now MOUD) grant, but now depends primarily on encounter-based Medicaid reimbursement, which inadequately compensates for time-intensive polysubstance use treatment. In contrast, HealthPoint in Seattle benefited from Washington State's Alternative Payment Model 4, which demonstrated how value-based payments can expand team capacity and better align with SUD treatment requirements[116].*

- **Change-in-Scope Process Standardization**: When FQHCs add new services such as MOUD, referred to in Medicaid statute as MAT, or expand SUD counseling programs, they must request a change-in-scope adjustment to their PPS rates[117,118]. However, processes for these adjustments vary widely across states in terms of timelines, documentation requirements, and approval criteria[119,120]. States should establish

streamlined, predictable change-in-scope processes with clear timelines (ideally 90-120 days), specific documentation requirements, and guaranteed rate adjustments for evidence-based SUD services.

- **Retroactive Rate Adjustment Authority**: Current rate review and approval processes typically require 12-24 months, during which FQHCs operate new or expanded SUD programs at financial loss. States should permit retroactive rate modifications effective from the date services were initiated, particularly for evidence-based SUD treatment programs, to prevent financial penalties during the extended review period.

- **Payment Parity Requirements**: Significant payment disparities exist across care settings for comparable SUD services. For instance, tribal FQHCs receive $718 per visit (calendar year 2025), reflecting the Medicare outpatient per visit payment rate[121], while non-tribal FQHCs receive $202.65 (calendar year 2025) plus geographic adjustments[122]. Some states differentiate PPS rates by service type, paying different rates for medical, behavioral health, and dental services[123]. H.R. 1 specifically exempts mental health and substance use disorder treatment from new cost-sharing requirements, recognizing the importance of maintaining access to these services[124]. Building on this federal recognition, states should establish payment parity between FQHC and hospital outpatient department rates for comparable SUD services, including MOUD initiation and management, intensive outpatient programs, and specialized counseling services.

- **Administrative Burden Reduction**: Medicaid productivity screening methodologies are designed for standard primary care visits to evaluate, measure, and ensure the efficiency, accuracy, and quality of Medicaid-funded services, but they fail to account for the time-intensive nature of evidence-based SUD treatment. States should modify productivity screening methodologies to reflect the clinical reality of SUD treatment delivery, whether by establishing separate productivity standards for behavioral health integration or adopting alternative payment models better aligned with SUD treatment requirements[125].

These payment reforms are essential prerequisites for FQHC investment in comprehensive SUD treatment capacity. Without addressing these fundamental financial barriers, clinical workforce development and care delivery innovations remain economically unsustainable. Financial pressures across the health center sector are substantial. A 2024 publication out of the Geiger Gibson Program found that in 2022 a majority of community health centers — more than 750 nationwide — were operating on thin margins below 5%, with financially stressed centers present in every state, raising concerns about the long-term sustainability of the safety net primary care infrastructure[126].

C. Eliminate Same-Day Billing Restrictions for Integrated Physical Health and SUD Services

Current Medicaid policies in multiple states prohibit reimbursement for both medical and behavioral health services provided on the same day, directly contradicting the integrated

care model that represents core FQHC mission and clinical best practice[127]. While some states like Hawaii allow FQHCs to bill for one medical or optometry visit and one behavioral health visit per day[128] (see Appendix), and others like Rhode Island specify that FQHCs may bill for multiple encounters on the same day[129], many states maintain restrictive same-day billing limitations. This restriction is particularly problematic for polysubstance use populations, who typically present with multiple co-occurring chronic conditions requiring simultaneous management.

The prohibition on same-day billing creates a false choice: FQHCs must either absorb unreimbursed costs for integrated care or require patients to return for separate appointments — an approach that increases missed appointments, treatment dropout, and fragmented care. For patients managing active SUDs alongside diabetes, hypertension, hepatitis C, or other conditions, requiring multiple visits represents a significant barrier to treatment engagement. Well-supported by the research, integrated behavioral health improves quality of care, strengthens patient outcomes, and reduces costs[130]; moreover, research finds that FQHC patients have 24% lower total health care costs than similar patients who do not receive care at FQHCs[131].

The clinical rationale for integrated, same-day services is particularly compelling for SUD treatment, and federal policy developments reflect this growing recognition that integrated care delivery represents a best practice for SUD treatment. For example, federal guidance recognizes that FQHCs may provide "services such as behavioral health and treatment for substance use disorders" as part of their Medicaid-covered scope of services[132]. Medicare now covers Behavioral Health Integration services and Psychiatric Collaborative Care Model (CoCM) services for patients with behavioral health conditions including SUDs, billable through the treating medical provider[133]. Since 2018, designated FQHCs may bill Medicare for these integrated behavioral health services[134], and since 2024, Medicare covers Intensive Outpatient Program services in FQHCs for SUD treatment[135].

However, many barriers at the state level can be addressed through:

- **Authorizing Billing for Same-Day Medical and SUD Services**: States should explicitly permit FQHCs to receive full reimbursement for both medical and behavioral health/SUD services provided on the same day without financial penalty. This aligns with clinical evidence that integrated care improves outcomes and reduces overall costs[136].

> ***FQHC Example**: HealthPoint's Whole Care clinic in Seattle, WA, demonstrates the clinical effectiveness of integrated same-day services, using a primary care provider, behavioral health clinician, and SUD counselor to provide comprehensive care in a single visit. Access Community Health Centers in Madison, WI, similarly structures care around routine same-day integration of mental health and SUD services.*

- **Including Same-Day Integrated Visits in PPS Rate Calculations**: States should either incorporate the full cost of integrated same-day services into PPS rate calculations or, alternatively, permit separate billing for distinct service categories (medical, behavioral health, dental) as some states currently do[137]. Rhode Island's model, which allows separate encounters for primary care, behavioral health, and dental services, provides a useful framework[138].

- **Removing "One Encounter Per Day" Restrictions**: States should eliminate blanket restrictions that limit FQHCs to one billable encounter per patient per day, which conflict with evidence-based integrated care models. Federal regulations define an FQHC encounter as a face-to-face contact with one or more qualified health professionals[139]. While Medicare permits FQHCs to bill a medical visit and a mental health visit separately on the same day, it does not permit multiple behavioral health visits, which includes SUD-related service types as distinct billable encounters — a limitation that inadequately reflects the complexity of polysubstance use care[140]. Federal policy should be expanded to recognize same-day encounters for the full range of SUD services as distinct billable visits.

- **Recognizing Integrated Care as Clinically Superior and Cost-Effective:** State payment policies should affirmatively support integrated care delivery rather than creating financial disincentives. Evidence from FQHCs indicates that embedding mental health and prevention services within primary care settings can yield meaningful long-term savings by reducing avoidable hospitalizations and psychiatric crises before they escalate[141]. Additionally, treating people with medications for SUDs leads to significant savings, decreasing use of hospitals, emergency departments, and outpatient care centers[142].

The integration of SUD treatment within primary care settings represents one of FQHCs' core comparative advantages in addressing polysubstance use. State payment policies should support, rather than penalize, this evidence-based approach.

D. Expand Medicaid Coverage for Comprehensive SUD Services Beyond Traditional Treatment Models

The current polysubstance use crisis[143] — characterized by concurrent use of fentanyl with other drugs such as cocaine, methamphetamine, alcohol, and benzodiazepines[144,145] — requires more comprehensive and flexible treatment approaches than traditional opioid-focused, medication-based treatment programs[146]. Current Medicaid coverage limitations constrain FQHC capacity to implement evidence-based interventions appropriate for complex polysubstance use. Research demonstrates that polysubstance use is common among individuals seeking treatment for SUD, with patients consuming an average of 3.5 different substances[147,148]; it is also associated with significant clinical complexity, including higher rates of psychiatric comorbidity and psychosocial stressors[149].

States should consider expanding covered services to include:

- **Medication Coverage Expansion**: States should cover medications for all SUDs, not limiting coverage to MOUD. All FDA-approved OUD treatment medications must be covered by state Medicaid programs[150]; coverage for medications treating alcohol use disorder varies by state[151,152]. Research shows that treating people with medications for alcohol or opioid use disorders leads to significant cost savings, with health care costs averaging 30% lower for those with alcohol use disorder who received treatment medications compared to those who did not[153]. Further, while there are no FDA-approved medications for stimulant use disorder, the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry endorse the use of medications approved for other purposes for treating this SUD in certain circumstances[154]. Comprehensive medication coverage should extend to all FDA-approved SUD medications, and states should examine coverage for medications that are not FDA-approved for substance use treatment but are shown to be effective.

- **Stimulant-Specific Interventions: Contingency Management**: Contingency management (CM) — an evidence-based intervention that uses tangible incentives, such as vouchers or gift cards, to reinforce negative drug tests and treatment engagement — is among the most effective interventions available for stimulant use disorders, including methamphetamine and cocaine, for which no FDA-approved medications exist[155]. As of January 2025, five states (California, Delaware, Hawaii, Montana, and Washington) received federal approval through Medicaid 1115 demonstration waivers to provide CM[156]. No additional waivers have been approved since January 2025. States with existing CM waiver authority should explicitly ensure FQHCs are eligible providers. For states without waiver authority, existing State Opioid Response grant funding — which explicitly supports stimulant use disorder services — provides an alternative financing pathway, though the long-term availability of State Opioid Response funding as a standalone program is uncertain given proposed federal budget consolidations[157]. Regardless of financing mechanism, states should prioritize CM as a reimbursable service in FQHCs and ensure FQHC eligibility across all available funding streams.

***FQHC Examples**: Washington State's CM policy positions HealthPoint and other FQHCs to offer this evidence-based intervention. In contrast, Waco Family Medicine in Texas remains unable to offer CM despite significant stimulant use challenges among patients.*

- **Prior Authorization Barriers**: While states are now permanently required to cover all FDA-approved MOUD under Medicaid[158], prior authorization remains a significant and ongoing barrier for SUD treatment[159,160]. The Mental Health Parity and Addiction Equity Act prohibits more restrictive prior authorization requirements for SUD benefits than for comparable medical and surgical benefits[161]. However, widespread non-compliance and the current federal non-enforcement of the 2024 rules mean this protection remains largely unrealized in practice[162]; even in states

where Medicaid prohibits it, many Medicaid managed care plans require prior authorization for SUD medication treatments[163]. To address this, a growing number of states have enacted legislation eliminating prior authorization for MOUD in state-regulated insurance markets[164].

- **Workforce Expansion: Peer Recovery Specialists and Community Health Workers**: States should include peer recovery specialists and community health workers in FQHC PPS rates, recognizing the evidence base for peer support in SUD treatment retention and recovery outcomes[165]. Beginning in 2024, Medicare expanded coverage to allow community health workers and peer support specialists to address social determinants of health for Medicare beneficiaries, with some limitations[166]. At FQHCs, 1 in 5 patients served are uninsured individuals, 1 in 3 are living in poverty, and 1 in 5 are rural residents[167] — all populations that benefit from peer support[168] and community health worker interventions[169]. Medicaid should follow Medicare's lead in recognizing these evidence-based workforce roles.

- **Lifesaving Services**: All states cover the opioid reversal medication naloxone, with 38 states plus the District of Columbia having the nasal spray formulation on their preferred drug lists[170]. However, states should also reimburse additional interventions including naloxone distribution, drug testing equipment such as fentanyl test strips, and syringe services programs that reduce overdose mortality and infectious disease transmission. Many states have already legalized these low-barrier care model services in light of the opioid overdose crisis[171]; however, comprehensive reimbursement for these services for FQHCs remains inconsistent across states.

- **Telehealth Flexibility**: States should ensure comprehensive telehealth reimbursement for SUD treatment services. This is particularly critical for rural FQHCs where access to addiction medicine specialists is limited. According to 2024 HRSA data, 92.5% of health centers used telemedicine for mental health services and 60.5% used telemedicine for SUD services[172]. For Medicare, FQHCs can report non-behavioral health visits furnished via telecommunication technology, including audio only, using Healthcare Common Procedure Coding System code G2025, through December 31, 2027[173]. State Medicaid programs should provide comparable telehealth flexibility and reimbursement for SUD services.

Community health centers require payment flexibility to provide evidence-based treatments that extend beyond traditional office-based care models to address the complex reality of polysubstance use disorders.

E. Invest in FQHC SUD Workforce Development and Infrastructure Capacity

Workforce capacity represents the fundamental long-term constraint on FQHC SUD treatment expansion. Regardless of payment adequacy or coverage expansion, treatment access depends on availability of trained addiction medicine providers, counselors, and support staff. FQHCs face severe workforce shortages across all SUD treatment

disciplines, exacerbated by rural location, compensation limitations, and competition with higher-paying health systems. CMS recognized that workforce shortages limit access to mental health and substance use disorder services and has prioritized closing the gap between Medicaid and Medicare payment rates to improve provider participation[174,175,176]. While the 2026 National Drug Control Strategy emphasizes community-based recovery support, peer services, and supply reduction[177], federal leadership on SUD workforce development and payment reform will be essential to sustaining the primary care treatment infrastructure that FQHCs have built.

States should consider implementing the following comprehensive workforce development strategies:

- **Targeted Loan Repayment Programs**: States should establish addiction medicine-specific loan repayment programs for physicians, nurse practitioners, physician assistants, licensed clinical social workers, and certified substance use disorder counselors committed to FQHC practice. The HRSA currently operates the National Health Service Corps (NHSC) Loan Repayment Program[178], which provides loan repayment for clinicians serving in Health Professional Shortage Areas[179], including FQHCs[180]. However, additional state-level programs specifically targeting addiction medicine specialists would address the acute shortage of providers with SUD treatment expertise. Research demonstrates that provider views on substance use and treating patients with SUD can influence whether they provide SUD treatment[181,182], suggesting that workforce development must address both supply and training gaps.

- **Training and Technical Assistance**: States should provide funding for existing primary care clinicians to obtain medication treatment training and ongoing clinical consultation support for complex polysubstance cases. Following the elimination of the Drug Addiction Treatment Act of 2000 (DATA-2000) waiver requirement in 2023[183], all Drug Enforcement Administration-registered practitioners who can prescribe controlled substances are now permitted to prescribe buprenorphine for OUD. However, many primary care providers still require training in addiction medicine, motivations for treating polysubstance use, and management of complex cases. SAMHSA funds the Providers' Clinical Support System (PCSS) programs, including PCSS–MOUD and PCSS–Medication for Alcohol Use Disorder (MAUD), which provide training and consultation support[184]. States should supplement federal PCSS training resources with state-specific technical assistance for FQHCs that addresses state Medicaid billing requirements, scope of practice laws, prior authorization policies, and managed care contractual obligations, all of which vary significantly across states and directly affect how FQHCs can deliver polysubstance use services in practice.

- **Competitive Compensation Infrastructure**: States should ensure Medicaid payment rates are sufficient to support competitive wages that enable FQHC recruitment and retention in competition with hospital systems and private practices. According to the NACHC, FQHCs account “for less than 2% of total

Medicaid spending yet provide care to 16% of Medicaid enrollees"[185], demonstrating their efficiency. However, this efficiency should not come at the expense of appropriate workforce compensation for qualified addiction medicine specialists and other care team members.

- **Capital Investment for Infrastructure**: FQHCs serving patients with SUD often lack the physical infrastructure, technology, and storage systems required to safely and effectively deliver integrated treatment, creating practical barriers that persist even when payment and workforce challenges are addressed. States should provide targeted grants for essential SUD treatment infrastructure including:
    - **Secure medication storage systems** for buprenorphine and other controlled substances required for medication treatment programs
    - **Point-of-care and laboratory toxicology testing equipment** for drug screening, medication monitoring, and identification of polysubstance use patterns
    - **Electronic health record modules** for SUD-specific documentation, prescription drug monitoring program integration, and treatment outcome monitoring
    - **Physical space modifications** for behavioral health integration, group counseling, and confidential SUD treatment services

- **Program Development Support**: States should fund FQHCs in program design, regulatory compliance, clinical protocol development, and quality improvement for SUD services. The National Governors Association's Policy Academy on stimulant and polysubstance use identified eight focus areas including effective governance, treatment, and data and quality information[186], all of which require support for successful implementation. SAMHSA offers support through programs like the Treatment, Recovery, and Workforce Support grant, which offered career services for people in recovery and provided workforce training[187].

Workforce development represents a long-term investment with delayed return, but remains essential for sustainable SUD treatment capacity. Optimal payment policies cannot generate treatment access in the absence of qualified providers with appropriate training, infrastructure, and support systems.

Federal-Level Opportunities

The federal government plays a foundational role in enabling FQHC capacity to address polysubstance use disorder through its authority over the Health Center Program. While state-level Medicaid policy reforms address payment methodologies and coverage expansion, federal action can ensure the underlying sustainability and infrastructure that make FQHC SUD treatment programs possible.

BUILDING ON 2024 MOUD REPORT RECOMMENDATIONS

A 2024 report authored by the Center for Health Care Strategies and funded by The Pew Charitable Trusts recommended state policies to help FQHCs improve medication treatment for OUD:

Funding: Consider FQHC-specific grants to build or strengthen MOUD and SUD programs; Offer supplemental grants to encourage FQHCs to partner with OTPs to launch medication units

Quality Measurement: Include a quality-of-care measure focused on OUD treatment in HRSA's Uniform Data System for FQHCs

Regulations: Consider maintaining telehealth flexibilities for buprenorphine induction; Clarify guidance on data sharing for SUD under 42 CFR Part 2

In 2025 important legislation reauthorized critical behavioral health programs through fiscal year 2030, including more than $500 million annually for overdose prevention and the reauthorization of the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program for the SUD treatment workforce located in underserved areas[188]. The recommendations below identify opportunities for federal policy to enhance FQHC polysubstance use treatment capacity.

A. Adequately Fund Community Health Centers

The primary grant funding for FQHCs, known as the Community Health Center Fund, is not permanent and frequently faces expiration cliffs[189]. Community Health Center funding is typically reauthorized by Congress every two to three years[190], though recently it has been extended via short-term, temporary measures[191]. As this report's site visits demonstrate, developing comprehensive polysubstance use treatment programs requires multi-year commitments: hiring and training specialized staff, establishing clinical pathways, building peer support networks, and investing in infrastructure. For FQHCs working to expand complex care services like polysubstance use disorder treatment, this funding uncertainty remains a structural barrier to long-term program development[192].

B. Protect and Strengthen the 340B Drug Pricing Program

The 340B Drug Pricing Program, enacted by Congress in 1992, requires drug manufacturers that participate in Medicaid to make covered outpatient drugs available at discounted prices to eligible health care organizations, known as covered entities, including certain safety-net hospitals, community health centers, and other providers serving low-income or uninsured patients[193]. For FQHCs serving populations disproportionately affected by polysubstance use, savings from the 340B generates an essential revenue stream that enables comprehensive SUD services. As the site visits for this report demonstrate, community health centers use 340B savings to provide comprehensive medication coverage for SUDs (e.g., buprenorphine, naltrexone, MAUD), support non-billable services including peer recovery specialists and care coordination, and serve uninsured and underinsured patients who may be unable to afford SUD medications out-of-pocket[194]. HRSA should use its technical assistance and program guidance functions to encourage FQHCs to maximize 340B purchasing for all FDA-

approved SUD medications and should ensure that manufacturers are making these medications available at 340B ceiling prices.

***FQHC Example**: Access Community Health Centers and Piedmont Health Services both rely on 340B drug pricing to help uninsured and underinsured patients afford medications for polysubstance use treatment. Without 340B, these FQHCs would face impossible choices between medication access and financial sustainability.*

C. Expand and Sustain Investment in Teaching Health Center Graduate Medical Education

The Teaching Health Center Graduate Medical Education (THCGME) Program provides payments directly to community-based ambulatory patient care centers — primarily FQHCs, rural health clinics, and tribal health centers — to train primary care providers in underserved communities[195]. Since 2011, the program has supported 3,090 new primary care physicians and dentists who completed residencies in community-based settings, with residents treating nearly 610,000 patients during more than 630,000 patient contact hours annually[196]. The THCGME program trains residents in community-based primary care settings alongside behavioral health teams[197], offering a natural infrastructure for building clinical competency in SUD care. The Accreditation Council for Graduate Medical Education added requirements for addiction medicine training in internal medicine residencies in 2022[198], reflecting growing recognition that primary care physicians must be prepared to treat SUDs as part of routine care.

Federal action could increase support for accredited resident positions and prioritize programs with addiction medicine training integrated throughout residency curricula.

***FQHC Example:** Waco Family Medicine's residency program, launched in 1970 as Texas's first family practice residency, has directly addressed regional provider shortages — more than half of McLennan County's practicing family physicians are program graduates[199]. The program now embeds addiction medicine training, creating a sustainable pipeline of providers equipped to treat polysubstance use in primary care settings.*

D. Strengthen Workforce Development Through Loan Repayment and Allied Health Training Programs

The NHSC provides loan repayment for clinicians committing to practice in underserved areas, including many FQHCs located in Health Professional Shortage Areas[200]. As we learned during the FQHC site visits, NHSC loan repayment represents a powerful recruitment tool for FQHCs seeking clinicians with addiction medicine training, as the combination of loan repayment, meaningful clinical work, and mission-driven practice can attract providers who might otherwise choose higher-paying positions.

***FQHC Example:** Despite Waco Family Medicine's success in training behavioral health clinicians through its residency program, the organization struggles to retain staff, as highly skilled clinicians are recruited by external organizations offering higher compensation. Expanded loan repayment programs specifically targeting addiction medicine providers committed to FQHC practice would address retention challenges while building sustainable workforce capacity.*

HRSA should consider:

- Expanding technical assistance to FQHCs on developing and sustaining SUD treatment programs, including polysubstance use treatment, through HRSA's National Technical Assistance Programs program and Bureau of Primary Health Care[201]. Technical assistance should cover clinical protocol development, workforce training, billing and coding for SUD services, and quality improvement, with priority given to health centers in underserved rural and urban areas with high rates of polysubstance use.
- Strengthening Uniform Data System reporting requirements and quality benchmarks related to SUD screening, treatment, and workforce capacity – including addiction medicine staffing ratios, MOUD prescriber availability, and behavioral health integration[202] to generate the data needed to identify workforce gaps, target training investments, and surface best practices across the health center network.
- Prioritizing addiction medicine placements at FQHCs with demonstrated commitment to SUD treatment capacity[203].
- Ensuring that NHSC loan repayment programs, which already cover a broad range of SUD workforce disciplines, are actively promoted and accessible to FQHC-based providers, and that the priority criteria be expanded to specifically incentivize addiction medicine specialists serving polysubstance use populations in underserved communities[204].
- Expanding the THCGME program to increase the number of residency positions at FQHCs with demonstrated SUD treatment capacity, with incentives for graduates to remain in FQHC-based practice serving polysubstance use populations[205].

E. Establish Federal Research Infrastructure for Polysubstance Use Treatment Effectiveness

Despite widespread recognition that polysubstance use is common among individuals with SUDs,[206] federal research and surveillance infrastructure remains oriented toward single-substance models[207,208]. While federal research initiatives such as the HEAL Initiative have begun to address polysubstance use[209], no major national advocacy organization or dedicated federal policy infrastructure exists specifically for polysubstance use as a distinct issue. SAMHSA's National Survey on Drug Use and Health tracks substance use prevalence and treatment receipt, but does not capture treatment outcomes or effectiveness, particularly for polysubstance use, leaving significant gaps in understanding which interventions work for this population in primary care settings[210]. Similarly, the Agency for Healthcare Research and Quality's (AHRQ) ***MOUD Playbook*,**

developed to support the integration of OUD treatment into primary care[211], does not address polysubstance use.

***FQHC Examples:** The innovative approaches developed by the five FQHCs in this report — from Waco's Guide to Psychopharmacology to HealthPoint's Whole Care model — emerged through practice-based trial and error rather than systematic research. Federal investment in FQHC-based research infrastructure would enable rigorous evaluation of polysubstance use treatment models and accelerate dissemination of effective practices.*

Federal agencies should consider:

- Establishing a polysubstance use research program with dedicated funding for effectiveness research, implementation science, and health services research[212]
- Enhancing National Survey on Drug Use and Health and other federal data systems to capture polysubstance use patterns, treatment modalities, and outcomes[213]
- Developing evidence-based clinical practice guidelines specifically for polysubstance use disorder management in primary care settings[214]
- Funding research partnerships between FQHCs and academic institutions to study real-world polysubstance treatment delivery
- Ensuring polysubstance research includes diverse populations and explicitly examines health equity[215]

F. Preserve and Expand Medicare Coverage for Integrated Behavioral Health and SUD Services in FQHCs

Recent Medicare policy developments have expanded coverage for integrated behavioral health services that support polysubstance use treatment. Since 2018, Medicare has covered Behavioral Health Integration and Psychiatric Collaborative Care Model (CoCM) services for SUD patients[216]. Since 2024, Medicare covers Intensive Outpatient Program services in FQHCs for SUD treatment[217] and expanded coverage to allow community health workers and peer support specialists to address social determinants of health[218] — roles essential to comprehensive SUD treatment. Currently Medicare allows FQHCs to use audio-only telehealth for services through December 31, 2027[219].

Despite these important advances, significant gaps remain that limit FQHCs' ability to fully deliver integrated, team-based SUD treatment to Medicare beneficiaries. Recent Medicare policy has expanded billing options for integrated behavioral health services, including Behavioral Health Integration and CoCM codes now available to FQHCs that can be billed in the same month as primary care services[220]. However, core restrictions remain on same-day reimbursement under Medicare PPS, as FQHCs cannot separately bill additional SUD service types or multi-provider team visits as distinct encounters, regardless of how many providers a patient sees[221]. This creates particular barriers for team-based SUD care where patients may need primary care, medication management, and behavioral health support on the same day. Medicare's audio-only telehealth flexibilities for non-behavioral medical services in FQHCs — critical for medication management and medical monitoring components of SUD treatment for patients with transportation barriers, unstable housing, or stimulant use disorders — are temporary and set to expire December 31, 2027, when

Congress must act or FQHCs lose the ability to deliver these non-behavioral services via audio-only technology[222]. Finally, despite recent rate increases for behavioral health integration, significant gaps remain in Medicare's coverage of the full continuum of SUD care — including gaps in coverage and reimbursement adequacy for patients with stimulant, alcohol, and polysubstance use disorders — and reimbursement structures were not designed with the complexity and intensity of team-based polysubstance use treatment in mind[223,224].

***FQHC Example:** As Medicare beneficiaries increasingly present with polysubstance use resulting in one or more substance use disorders, FQHCs like Access Community Health Centers that have built integrated primary care and SUD treatment models need Medicare reimbursement policies that support same-day, team-based care rather than requiring separate visits for medical and behavioral health services.*

CMS should consider:

- Revising Medicare payment rates for integrated behavioral health and Intensive Outpatient Program services in FQHCs to reflect the actual costs of team-based polysubstance use treatment — including eliminating the 'lesser of actual charges or hospital outpatient rate' payment limitation for FQHCs — and establishing complexity adjustments for patients with co-occurring stimulant, opioid, alcohol, and benzodiazepine use disorders[225,226].
- Issuing clear billing guidance explicitly permitting same-day reimbursement for multi-provider SUD care teams in FQHCs and revising PPS payment methodology to separately recognize medication management complexity when furnished as part of team-based polysubstance use care — rather than bundling all services into a single undifferentiated per-visit rate regardless of clinical intensity[227,228].

Medicare's recent expansions of integrated behavioral health coverage represent meaningful progress, but the patchwork of remaining restrictions — on same-day multi-provider billing, medication management reimbursement, and temporary telehealth flexibilities — leaves FQHCs structurally constrained in their ability to deliver the coordinated, team-based care that polysubstance use disorders require. Realizing the full promise of integrated SUD treatment for Medicare beneficiaries will require a reimbursement framework explicitly designed for the complexity and intensity of comprehensive polysubstance use care in FQHC settings.

Conclusion

Polysubstance use disorder has become the dominant pattern among individuals seeking SUD treatment, with patients consuming an average of 3.5 different substances[229] and polysubstance use associated with significant clinical complexity including psychiatric comorbidity and psychosocial stressors[230]. Yet the US health care system, including FQHCs, remains oriented toward single-substance treatment models, particularly opioid-focused medication treatment programs[231,232]. The five health centers profiled in this report — Delaware Valley Community Health (Philadelphia, PA), Waco Family Medicine (Waco, TX), Piedmont Health Services (Chapel Hill, NC), HealthPoint (King County, WA), and Access Community Health Centers (Madison, WI) — demonstrate that primary care settings can effectively address the complexity of polysubstance use when equipped with clinician champions, evidence-based clinical pathways, robust team-based care infrastructure, intentional strategies for provider engagement, flexible staffing models, and sustained cultural transformation. However, these health centers also reveal substantial gaps between what is needed and what current policy and financing structures support — particularly in workforce and team-based care infrastructure, payment adequacy for integrated services, and coverage stability for the patients they serve.

Realizing FQHCs' potential to address the polysubstance crisis requires comprehensive policy reforms at health center, state, and federal levels. At the local health center level, organizations must build robust team-based care infrastructure, establish clinical champions with protected time, develop evidence-based clinical pathways, use low-barrier care models, sustain cultural transformation, and practice prevention and early intervention. At the state level, policymakers must mitigate adverse impacts of Medicaid work requirements on SUD treatment continuity, address fundamental structural barriers in FQHC payment methodologies, eliminate same-day billing restrictions, expand Medicaid coverage for comprehensive SUD services, and invest in workforce development and infrastructure capacity. At the federal level, policies should ensure adequate funding levels, strengthen workforce development, establish research infrastructure for polysubstance use treatment effectiveness, and preserve Medicare coverage for integrated behavioral health services. Together, these recommendations outline a comprehensive agenda for positioning FQHCs as essential treatment settings for individuals with polysubstance use disorders, leveraging their core strengths — integrated care delivery, commitment to underserved populations, and experience with complex patients — to address one of the nation's most pressing public health crises.



Appendix

Details on Same Day Billing Restrictions for FQHCs, available via interactive map from The Center for Connected Health Policy, as of March 2026.

Category 1: States Allowing Medical + Behavioral Health + Dental Same-Day Encounters

1. Alabama - One medical, one behavioral health, one dental
2. Arizona - Multiple disciplines allowed if different specialties
3. Connecticut - One medical, one behavioral health, one dental explicitly stated
4. District of Columbia - Four types: primary care, behavioral health, preventive/diagnostic dental, comprehensive dental
5. Florida - Up to three encounters: medical, dental, behavioral health
6. Georgia - Allows core vs. other ambulatory services separately
7. Hawaii - One medical, one behavioral health, one dental
8. Idaho - Three per day for FQHCs (two for rural health centers)
9. Louisiana - One medical, one behavioral health, one dental
10. Maryland - Somatic, mental health, SUD, and dental services
11. Michigan - Maximum three: one medical, one dental, one behavioral health
12. Mississippi - Four types: medical, mental health, dental, vision
13. Nevada - Up to three service-specific visits if separate rates established
14. North Carolina - Maximum three encounters per day with proper documentation
15. North Dakota - One medical, one dental, one mental health
16. Pennsylvania - One medical physical, one medical behavioral, one vision, one dental
17. Rhode Island - Medical, behavioral health, or dental allowed separately
18. Tennessee - Medical, behavioral health, and/or dental
19. West Virginia - One medical, one behavioral health, one dental
20. Wisconsin - One medical, one behavioral health, one dental

Category 2: States Allowing Medical + Behavioral Health (or Medical + Dental)

21. Alaska - Dental or mental health separate from medical
22. California - Medical and dental only (no explicit behavioral health provision)
23. Colorado - Medical + integrated care services (Health Behavior Assessment and Intervention /CoCM) allowed; one behavioral health total
24. Delaware - Medical and mental health explicitly allowed
25. Indiana - Multiple encounters if different primary diagnoses
26. Iowa - Multiple types allowed with specific exemptions
27. Maine - Core service + mental health/behavioral health with different practitioners
28. Minnesota - One medical and one dental
29. New Hampshire - One medical and one behavioral
30. New Jersey - Physical health and behavioral health if different practitioners
31. New Mexico - Medical and mental health/"other health"
32. Oklahoma - Multiple encounters with distinctly different diagnoses; medical and dental/mental health examples given

33. Oregon - Multiple encounters with distinctly different diagnoses across service types
34. South Dakota - Two visits maximum; behavioral health or dental separate from medical
35. Texas - Medical and "other health" visit
36. Vermont - Medical and mental health
37. Washington - Different cost centers allowed (medical, dental, SUD)
38. Wyoming - Different specialties or unrelated diagnoses

Category 3: Restrictive States (One Encounter Per Day with Limited Exceptions)

39. Arkansas - Single encounter unless subsequent illness/injury; family planning exception exists
40. Illinois - Only one medical encounter per day
41. Kansas - Single visit unless different services for different illness/injury
42. Massachusetts - Cannot bill for more than one service on same day/location (tobacco cessation exception)
43. Montana - One encounter unless different specialties or unrelated diagnoses
44. Nebraska - Single visit unless subsequent illness/injury
45. New York - Only one threshold visit per day (except hemophiliac transfusions)
46. Ohio - Single visit unless different services for different illness/injury
47. Puerto Rico - Each provider limited to one type of visit per day
48. Utah - One encounter per day

Category 4: States With Unclear or No Referenced Policy

49. Kentucky - No reference found
50. Missouri - No reference found
51. Virginia - No reference found
52. Virgin Islands - No reference found
53. South Carolina - One medical encounter unless different primary diagnosis

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