SAMHSA moves toward allowing Block Grant funds for co-pays

The federal government is looking at the Substance Abuse Prevention and Treatment (SAPT) block grant as a way to change provider practices, mainly by merging mental health and substance use disorder (SUD) funding and in general by repurposing the SUD treatment and prevention requirements as dictated by statute for other work such as data collection, integration and technology. This year, the idea that the SAPT block grant could be used to cover co-payments for people in SUD treatment is introduced.

The SAPT block grant is the safety net for people without the means to pay for needed treatment; these federal dollars constitute the majority of publicly funded SUD treatment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) published its proposed revisions to the application for the SAPT block grant as well as the Community Mental Health Services (CMHS) block grant in the January 8, 2015, issue of Alcoholism: Clinical and Experimental Research (ACER). The new proposal is out for public comment now, in the proposal. . . See top story, this page

Bottom Line…
The SAPT block grant application for 2016–2017 includes many “requests” that are not in the statute, but these may guide or encourage states toward using the money for co-pays and other novel uses.

The Business of Treatment

Analysts in SUD treatment field say mega-deals bring legitimacy

A financial expert who recently moved from a private equity fund targeting industrial energy directly into the substance use disorder treatment industry believes each high-profile business transaction in the field is legitimizing addiction treatment for everyone from Wall Street analysts to talent now working in other sectors of health care.

One of the next likely high-impact transactions could be the sale of fast-growing Elements Behavioral Health; rumors that the company is on the market have been swirling since a New York Post report last fall. It will be interesting to see if possibly a health care buyer with a similar mission to Acadia Healthcare will envision Elements as an opportunity to establish a platform in behavioral health, as Acadia did last year with its acquisition of for-profit giant CRC Health Group (see ADAW, Nov. 3, 2014).

Bottom Line…
Financiers and analysts see talk of impending sales of large addiction treatment operations, as well as new overtures from private equity, as signaling a robust long-term view of the addiction treatment market’s potential.
SAMHSA is requesting approval from the Office of Management and Budget to revise the 2016 and 2017 CMHS and SAPT block grants.

ACA effect

SAMHSA’s desire to repurpose the SAPT block grant was first exposed in 2010, when a contract solicitation sought ways to “identify SAMHSA’s degrees of freedom in terms of authorization and regulations” (see ADAW, Sept. 27, 2010).

Since then, SAMHSA has publicly been operating on the premise that with more patients insured under the Affordable Care Act, the SAPT block grant will be freed up for services that are not covered under health insurance. The SAPT block grant is much larger than the CMHS block grant. Under statute, the each block grant must be used for certain treatment services. Still, with new people coming into state government, looking at the application alone may encourage them to move in one direction, which is what SAMHSA is hoping.

SAMHSA has already accomplished some of its goals: states have the option of using a merged application for the CMHS and SAPT block grants; and the seeds of confusion have been sown by all of the “requests” and “shoulds” in the verbiage.

Integration

For example, while there’s nothing in the federal statute authorizing SAMHSA or the block grants that says this money has to be used for integration, this is one of the overarching goals of the Affordable Care Act and one of the key areas of repurposing. Indeed, in the Federal Register notice, SAMHSA states that it “must establish standards and expectations that will lead to an improved system of care for individuals with or at risk of mental and substance use disorders” going on to say that the packing includes “fully exercising SAMHSA’s existing authority” regarding the use of block grant funds, as well as “a shift in SAMHSA staff functions to support and provide technical assistance for states receiving block grant funds as they fully integrate behavioral health services into health care.”

The application doesn’t clearly distinguish between what is “required” and what is “requested.” What is required: “a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, an executive summary, and funding agreements and certifications.” What is requested: “information on key areas that are critical to the state’s success in addressing health care integration.”

People new to various single state authority (SSA) offices applying for the block grant may not know that they must do what is required, but not necessarily what is requested. The block grants are formula grants: states get a certain amount based on population and many other factors regardless of whether they comply with “requests.”

Co-payments

Specifically, one surprising suggestion in the application itself is that the block grant be used for co-payments when patients have private insurance or Medicaid. “Several states have indicated an interest in using block grant funds to cover client co-pays and insurance premiums, which is allowed as long as states that choose to do so develop specific policies and procedures for assuring compliance with the funding requirements,” the application states. “States should leverage their block grant funding and strive to diversify funding sources. When developing strategies for purchasing services, SMHAs and SSSAs should identify other state and federal sources that can be used to purchase services. States should also consider promoting and supporting the revenue diversification efforts of funded providers to develop a pro-

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Federal Register.

SAMHSA is requesting approval from the Office of Management and Budget to revise the 2016 and 2017 CMHS and SAPT block grants.
provider pool that is more adept at navigating the new environment.” The word “should” is key in this passage. Later on in the application (p. 51), it says this: “While some states have indicated an interest in using block grant funds for individual co-pays and premium payments, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. If a state chooses to allow the use of block grant funds for these purposes, specific policies and procedures for assuring compliance with the funding requirements must be in place. Under 42 USC § 300x-55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management.” (SAMHSA uses “MHBG” for the CMHS block grant and “SABG” for the SAPT block grant; nowhere in statute are those acronyms used, however.)

Still, people filling out the SAPT block grant application will wonder about what SAMHSA says they “should” do. And if the SAPT block grant goes to co-payments, that much less will go toward funding treatment for people who have no insurance at all, or whose insurance does not cover SUD treatment adequately.

MAT

In addition, there is a focus on medication-assisted treatment (MAT).

The Federal Register notice is urging that providers use it or have the ability to use it — and whether this is methadone, buprenorphine, or Vivitrol in an opioid treatment program, or treatment with buprenorphine or Vivitrol in an office, is not made clear. “SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to utilize MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need,” the Federal Register notice states. “Individuals with substance use disorders who have failed abstinence based treatment in the past and who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments.”

There are also proposed revisions to encourage the use of information sharing via electronic health records to promote integrated care, and a proposal to allow the use of vouchers so patients can purchase their own “participant-directed care.”

The CMHS block grant application is due September 1; for the SAPT block grant, the application is due October 1. For the merged MH/SAPT application, the due date is September 1.

Comments on the proposed revision are due March 9.

For the Federal Register notice, go to https://www.federalregister.gov/articles/2015/01/08/2015-00063/agency-information-collection-activities-proposed-collection-comment-request.

For the revised block grant application, go to www.samhsa.gov/sites/default/files/bg_application_fy16-17_12112014_final_draft_clean_rev_r122914d.pdf.

DEA revokes registration for buprenorphine physician

The Drug Enforcement Administration (DEA) has revoked the registration of a physician who prescribed buprenorphine, based on misconduct, including prescribing without following the rules. It’s clear that the infractions included going above the patient limit or “cap,” but this was only a small part of the numerous violations. In fact, the DEA doesn’t track when physicians violate the 30- or 100-patient limits, Ad4W has learned. The Substance Abuse and Mental Health Services Administration (SAMHSA) says they do, but according to Barbara Carreno, DEA press officer, “we do not track such violators.” She added that the revocation order “was in response to the state of Ohio revoking his state controlled substance registration” and that the Controlled Substances Act states that a federal registration can’t be granted unless the prescriber is registered in the state in which he or she practices.
Continued from previous page
she practices. “Thus when a state revokes a CS [controlled substances] registration, we have to also,” she said. She added that “SAMHSA would be a better source” in reference to “doctor compliance with DATA 2000/2003.” The DEA “just registers narcotic treatment program doctors for 30 or 100 patients per SAMHSA’s request to us,” she said.

So the DEA’s answer to the question of who is tracking how many physicians go above their patient caps is SAMHSA, and SAMHSA’s answer is the DEA.

Boasted about 150 patients

Nevertheless, the revocation decision, published in the January 23 Federal Register, does make note of the fact that the physician, Jose Raul S. Villavicencio, M.D., of Parkersburg, West Virginia, did go above the 100-patient limit. In fact, at one of his hearings, in which the DEA said his testimony was “self-serving,” he boasted about having 150 patients on Suboxone, the only buprenorphine brand at the time.

Villavicencio lost his license in Ohio in 2012, after which he requested that his DEA registration be transferred to West Virginia. The DEA investigated, as did West Virginia. The end result was the legal decision published last month in Virginia. The end result was the legal decision published last month in which he can no longer prescribe buprenorphine. The investigation included data from the state’s prescription drug monitoring program (PDMP).

Specifically, the physician:
• “inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document his treatment of these patients”;
• “repeatedly and/or continually treated patients by excessively and/or inappropriately prescribing medications” and “continued to prescribe controlled substances without appropriately pursuing or documenting the pursuit of alternative non-narcotic therapies”;
• “failed to record in the patients’ medical records the reason(s) he prescribed medication and/or the need … for prescribing multiple medications”;
• “repeatedly and/or continually treated patients without performing and/or documenting appropriate physical examinations or evaluations, and/or without utilizing and/or documenting appropriate diagnostic testing or other methods of evaluating the patients’ health conditions, and/or without devising and/or documenting treatment plans, and/or without periodically reassessing or documenting the reassessment of the effectiveness of treatment for illnesses”;
• “failed to adequately and/or appropriately diagnose and/or document an adequate or appropriate diagnosis of the patients’ medical conditions”;
• “failed to document in the patient record adequate findings to support his diagnoses”;
• “repeatedly and/or continually treated patients without making appropriate and/or timely referrals to specialists”;
• “failed to keep and maintain adequate records reflecting his care and treatment of the patients[,]” because “[t]he entries in the medical records frequently appeared verbatim from one office visit to the next and from one patient to another, with few or no changes.”

Not specific to buprenorphine

The violations aren’t particularly specific to buprenorphine rules. “This type of violation could occur anywhere and with any physician,” said H. Westley Clark, M.D., former director of SAMHSA’s Center for Substance Abuse Treatment (CSAT), told ADW in an email last week. “The issue of the buprenorphine cap is clouded by the other allegations of misconduct.”

According to Clark, who strongly questioned raising the cap when he was at CSAT, “this case is more about recording keeping and truth telling than about buprenorphine.” It is, he said, “a cautionary tale for clinicians to keep their business and patient records intact — and it is a reminder that PDMPs are ‘watching you.’”

The 100-patient limit is mentioned, so it did figure into the decision to revoke Villavicencio’s license said Clark; nevertheless, it’s difficult to tell how much weight was given to this particular violation — probably, given the lack of concern from both the DEA and SAMHSA about patient limits, not much.

“Opioid treatment programs and other buprenorphine-prescribing physicians need to keep basic care issues in mind,” said Clark. “Good records, good diagnostic algorithms and appropriate monitoring should come before testing the 100-patient limit.”

The interesting question, said Clark, would be “What if the registrant had prescribed buprenorphine to 150 patients, had kept meticulous records, had documented when and why he had engaged in the violation of the 150-patient limit, and had no other infractions?” In his argument before the Ohio Medical Board, the registrant argued that he was able to return to function “a fair number of nurses, businessmen, teachers, computer programmers and homemakers,” according to the Federal Register. If everything else had been done properly, the DEA adjudicator “would have been confronted by a conflict in imperatives, i.e., strict adherence to the 100-patient limit versus compassionate care for opioid-dependent patients,” said Clark. “Unfortunately, continues on page 6
Why recovery matters even more in 2015

By Michael T. Flaherty, Ph.D.

As the 21st century started, so did a new science for understanding and addressing America’s problem with illicit substance use and addiction. In the previous century, addiction was seen as one’s fault or the inevitable outcome of bad decisions for which society also suffered. In response, society, via very limited insurance, offered one or two supported treatment experiences before it threw up its hands to public health, criminal justice or death to address the failures and societal consequences. Whole industries were born around the illness that more often retreated rather than address its root cause or its need for coordinated continuing care while providing relieving medical care, temporary stabilization and, in exasperation, more and more jails, intensive care units and — for the fortunate — long-term rehabilitation. Early in the 20th century, addiction treatment, albeit seen mostly through the eyes of alcoholism, designed a full array of well-intentioned but largely ineffective treatment approaches ranging from brain surgery to shock therapy to early alcohol-laden replacement elixirs to individual re-learning and/or mandated religious conversion with moral pledges as the then best attempt to de-spirit the spirited. Miraculously, amidst these constant attempts of science some — although far too few — still found recovery.

Later in the century, a focus on the brain and what treatments seemed to scientifically work in the short term for the pathology led to initial successes, but long-term care remained generally absent. With still limited success, it came as no surprise that as the new century dawned, scientists and practitioners began to ask again, “Are we understanding and addressing this illness properly?”

Many dedicated researchers, policymakers, clinicians and, most of all, those in recovery said “no” or, more pointedly, “not based on my experience.” Ironically, when the failures of individual episodes of care were seen more longitudinally and the sense of futility passed, the very clue that continuing care seemed more an answer than a failure emerged and the world of addiction understanding and treatment changed. A new scientific paradigm was born. Key studies led to this early redefining of addiction. One, “Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation” by A. Thomas McLellan, David C. Lewis, Charles P. O’Brien, and Herbert D. Kleber, published in the October 4, 2000, issue of the Journal of the American Medical Association, courageously identified drug dependence as a chronic medical illness and, while showing similar or better outcomes to other “chronic illnesses” if so approached, also asked what then would be the full implications of such understanding for treatment, insurance and ultimate outcomes with all individuals seeking help for addiction. When other similar studies appeared, those dedicated to addiction at all levels began to scramble. Our treatment systems were built on an acute illness model and understanding that at best might combine time-limited formal treatment with occasional “aftercare” and a distanced connectivity to fellowships or peer support groups to meet the need for continuing care required by all chronic illnesses. Moreover, within the old acute model, the outcome of treatment was measured by the “completion of a treatment episode.” Within a chronic model, illness recovery or illness reduction and self-management would become the new outcome — similar to other chronic illnesses.

Shifting then to those in recovery for answers, in 2006 William White and Ernest Kurtz described a variety of recovery experiences and how recovery seemed to be obtained therein. White also surveyed the literature at that time on this reframed (chronic) understanding of “addiction recovery” and found that since 1997 more than 150 related articles had emerged in peer-reviewed journals related to addiction as chronic and recovery. In 2007, a Betty Ford Institute Expert Panel, seeking to modernize the purpose of treatment from this perspective published the first consensus definition of recovery. Today that definition is used and elaborated upon by the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment in the United States and — with local and cultural modifications — worldwide in similar evolutionary efforts. In 2014, White returned to update his bibliography and found well over 1,500 related books and articles worldwide (see http://williamwhitepapers.com). A worldwide science was emerging. He also co-authored the first study identifying a common structure to the experience of recovery as evidenced across diverse pathways to it (Flaherty, Kurtz, White, & Larson, 2014).

Treatment lagging

Indeed, our view of addiction and the goals of treatment has changed prolifically since 2000. Still, one may fairly ask if our policies and clinical practice and treatment systems have kept up? What is the purpose

Continues on next page
Continued from previous page of treatment today?

Today our treatment systems remain largely those built while addressing addiction via an acute (episodic) illness approach. Buildings and the systems supporting them are difficult to change. Providers and practice can adapt more easily. To reach the practice transformation needed given this history and the existing realities today within the community, several key next steps seem necessary:

- A recognition that substance use and addiction are scientifically best understood and treated from the chronic disease model or understanding of care (i.e., while it may not be chronic for all, it is best addressed from that potentiality).
- As with all chronic illnesses, strong prevention and early intervention integrated within general health care are the first and best steps to deterrence and sustained health and wellness — for the individual, family and community.
- Treatment must be available along an available clinical continuum of care that recognizes the nature of the illness and the precise needed intervention — or the illness will become worse.
- The individual’s “illness” defines the needed level of intervention and length of care. The return to one’s life, choices, health, citizenship and potential defines individual recovery.
- All treatment should offer the possibility of recovery as defined for each individual.
- Recovery should be defined for each person, family and community — with reportable measures.
- Recovery is not universally alike, nor are the pathways found in any one approach to it.
- There are phases to recovery and specifics to the management of recovery within each phase.
- Recovery may be supported by acute care, co-occurring care and/or medications — all of which are not recovery in themselves but may be critical aids to it.
- Addiction can arise from prescribed or illicit drugs — depending on the person and use.

Given the numbers today needing care and the advancement of pharmaceutical and illicit drug use, to complete this new paradigm a highly trained and expanded workforce is needed. Each worker must think of his/her role along the chronic illness prevention-intervention-treatment and recovery continuum and apply themselves competently and effectively wherever along that illness trajectory they serve. The “illness” and its measurable “recovery” must be the driver of care — not a payment methodology, fee or revenue generation. To achieve this, all professional disciplines will need to know the nature of “addiction” and better collaborate peer to Ph.D. and M.D. across generalist and specialty care settings — including schools and law enforcement — to address the need of each individual for intervention or treatment that can lead to a real possibility to prevent the illness or to attain and sustain recovery from it. To succeed, each local community must be actively involved in this planning, subsequent action and evaluation — as with other chronic illnesses. Emerging models do exist in counties across the nation, large cities such as Philadelphia and states such as Connecticut, Michigan and, most recently, Ohio, to name a few.

Because of our re-understanding of addiction and the recovery focus, today the world is closer to a unified scientific, experiential and community-validated understanding and solution to addiction and recovery. The year 2015 can provide the next evolutionary step. Keeping a recovery focus and building recovery management and systems are not the easiest solutions, but the challenge to do so now matters more than ever — lest we lose the purpose of why we do what we do.

Michael T. Flaherty, Ph.D., is a clinical/consulting psychologist in addictions and recovery in Pittsburgh, Pa. He currently focuses on building a recovery focus in practice and communities across the nation. He can be reached atmailto:flahertymt@gmail.com.

References


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“My perspective is that all of the market activity is a huge positive for the industry,” Chad Elliott, who now works full-time in business development and investment roles for the fledgling Recovery Centers of America, told ADFW. “Private equity’s involvement typically signals the beginning of long-term trends. It usually gets involved when there is a need for capital, when there is a fragmented industry that needs consolidation, and when it sees something with long-term potential, not just something with a few-year consumer preference.”

The Post originally reported late last year that private equity and venture capital firm Frazier Healthcare was seeking a buyer for Elements, whose family of facilities includes well-known names such as Clarity Way, Lucida Treatment Center, The Ranch, Right Step, and Promises centers in California and Texas. Neither Frazier Healthcare nor Elements officials have commented further on the reports. Elements President and CEO David Sack told ADFW that he “cannot discuss potential sale-related issues … at this time.”

Maintaining stability

A managing partner with a leading health care mergers and acquisitions firm says that given the typical holding cycle in private equity, it is probable that Elements will be sold at some point in the relatively near term. Cory Mertz, managing partner at Mertz Taggart, added that it is likely that Elements’ executive leadership would stay intact and continue to be able to grow the organization.

“The private equity transactions are almost a non-event for management,” Mertz told ADFW. “If it is done correctly, private equity is not the operator. They keep that machine going.”

While it is true that the Affordable Care Act (ACA) and the federal parity law have played a large role in bringing about the kinds of expectations for treatment access that have fueled much business activity, Mertz says not all of the movement in the field can be attributed to these developments. Those interested in entering the addiction treatment space also have been able to draw from the example of earlier entrant Bain Capital, which completed a successful exit from the market last year with the CRC sale, he said.

Much of the current activity in the industry is private equity–driven. Generally, these investors see someone else succeeding in a certain market and make plans to follow suit.

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Medicaid glitch in Pennsylvania hurts SUD patients, providers

Healthy Pennsylvania was former Gov. Tom Corbett of Pennsylvania’s way of expanding Medicaid without actually expanding Medicaid. The program, which uses Medicaid expansion dollars to subsidize private health insurance, has created a huge problem for substance use disorder (SUD) patients, as Michael Harle, president and CEO of Gaudenzia, told The Philadelphia Inquirer. In the January 25 article, Gaudenzia said that he was told in December 2013, a year before the rollout of Healthy Pennsylvania, that his patients would be able to keep Medicaid. They weren’t. Last December, Medicaid beneficiaries were moved to Healthy Pennsylvania, and immediately a glitch, which still has not been fixed, surfaced showing that SUD patients were not being moved to private insurance completely instead of Healthy Plus, the Healthy Pennsylvania plan for pregnant women, seniors, and people with disabilities. In fact, they had no coverage for SUD treatment at all. According to Harle and Deb Beck, president of the Drug and Alcohol Service Providers Organization of Pennsylvania, the result is that patients are locked out of treatment. “The problem with addiction is you can’t wait,” Beck told the Inquirer. “Alcohol and other addictions are progressive and are always fatal illnesses if they go untreated. You can’t wait.”

Residential treatment programs like Gaudenzia have been the hardest hit; at Gaudenzia, which has 900 beds, admissions fell by 247. “They really botched this up,” said Harle.

Former Gov. Corbett was opposed to Medicaid expansion, but after he lost his reelection campaign to Gov. Tom Wolf in November, he approved a limited version, called Healthy Pennsylvania; under this version, all Medicaid beneficiaries saw cuts, but patients in SUD programs were supposed to be covered. “I’m guessing that whoever did the data entry didn’t understand the addiction-treatment system and how it related to Medicaid,” Beck said. “And the misunderstanding became practice.”

Treatment programs had to choose between not treating patients who didn’t have Medicaid or continuing to treat them and deal with the problems. Gaudenzia is still treating them.

Gov. Wolf, who was inaugurated last week, has said that he will expand Medicaid. According to Estelle Richman, who is on Gov. Wolf’s transition team, it is a priority for Secretary of Human Services Theodore Dallas to “fix the drug and alcohol problem.” She expected a plan to be released soon. “Forcing providers to eat large sums of money only weakens them and their ability to provide comprehensive services to their clients,” she said.

Harle recommends going back to HealthChoices, which has been in place since the 1990s. “It has rules and a system and a common language that people understand,” he said.
Continued from previous page

“There is little attachment to the space itself,” Mertz said. “Every few years they buy a platform, do some add-ons and sell it in three to five years.”

The private equity trend is extending into other aspects of behavioral health care services as well, such as intellectual and developmental disabilities, Mertz said.

Widespread interest

Elliott says just about every private equity firm with a health care team is looking at addiction and behavioral health treatment. He specifically cited Kohlberg Kravis Roberts as one firm aggressively seeking a platform in addiction treatment.

“All of the long-term trends are pointing toward decreased stigma and increased coverage opportunities for people to get help,” Elliott said.

These entities also see opportunities to revamp the business model, moving toward more of an extended, continuum-of-care approach to treating a chronic illness. “It’s not going to be solved in 30 days — I don’t even care if it’s 90 days,” Elliott said.

He also believes recent activity shows that different business models can thrive in the treatment field. The initial public offering for American Addiction Centers (AAC), and its debt refinancing plans, will continue to enhance the addiction field’s standing with Wall Street, according to Elliott (see ADAW, Oct. 6, 2014, for the story on the AAC initial public offering). “AAC went public at 15 and is now trading at 30,” said Elliott, whose work with Recovery Centers of America is based on venture capital.

Elliott believes the space of activity in the field will affect its talent pool in a positive way. “There will be a migration from other health care opportunities, as some people look for a fast-paced career,” he said.

While some concern has been expressed that the flurry of business activity could result in oversupply of beds and services in some markets, Elliott says he does not foresee that scenario. The emergence of new and expanded entities will be offset by an attrition of underperforming providers, he believes.

“I see us being very far away from a ‘bubble,’” Elliott said. “We are just in the nascent stages. There is a real opportunity for people to change the business model and make a difference.”

Coming next week: How are smaller stand-alone addiction treatment providers positioning themselves as larger players continue to emerge?

In case you haven’t heard…

Did you know that Tennessee lost two-thirds of its methadone patients between 2012 and 2013? Neither did the advocate Zachary Talbott, who picked up on this as soon as he saw the new big data project from the Substance Abuse and Mental Health Services Administration (SAMHSA). Last month, SAMHSA released its second annual “Behavioral Health Barometer.” The report gives data on mental and substance use information for 2013 and compares it to the previous report, which came out a year ago, with data for 2012. There is one national report, and an additional report for each state. According to the report for Tennessee, there were about 4,000 fewer methadone patients in the state in 2013 compared to 2012, a two-thirds drop. We asked Peter Delany, Ph.D., through the SAMHSA press office, to explain this. (Delany heads SAMHSA’s Center for Behavioral Health Statistics and Quality, which produced the report.) “It is true that the count in Tennessee went from 6,079 in 2012 to 2,422 in 2013,” said Delany. “I do not know the reason for this change or even if the change is anomalous. The fact that these are counts on one particular day could cause some variability from year to year.” Delany recommended that we use national data instead. But some, including Talbott, who is director of Tennessee’s advocacy chapter, have questioned the reliability of the entire report. Nationally, there were 306,512 methadone patients on March 30, 2012, and 330,308 on March 29, 2013, noted Delany. The data comes from the National Survey of Substance Abuse Treatment Services (N-SSATS), said Delany. And still nobody knows whether that factoid is true or not — but it’s hard to believe, according to Talbott, who is administrator of the Peer Recovery Network of the Medication Assisted Recovery Services project and is very familiar with the opioid treatment providers in Tennessee.