Research Report

ALLISON J. OBER, SARAH B. HUNTER, ALEX R. DOPP, BRADLEY D. STEIN

A Design Lab Pilot to Inform Strategies for Expanding Access to Medications for Opioid Use Disorder in Community Mental Health Centers

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About This Research Report

Access to medications for opioid use disorder (MOUD), particularly buprenorphine, remains limited in community mental health centers (CMHCs) serving people with co-occurring mental health and opioid use disorders. This report presents findings from a pilot Design Lab, part of a broader, three-phase study on MOUD availability in CMHCs. The Design Lab engaged a small group of CMHC clients receiving MOUD, clinic leaders, and behavioral health policy and payment experts to identify perceived barriers to MOUD implementation and generate strategies to expand access. Participants prioritized strategies based on perceived impact and feasibility. As the Design Lab was exploratory and involved a small, non-representative group, findings should be interpreted as preliminary rather than definitive. The report is aimed at behavioral health system leaders, CMHC administrators, policymakers, payers, funders, and other interest holders interested in improving access to evidence-based treatment for people with co-occurring substance use and mental health needs. It highlights practical opportunities for cross-sector collaboration, with a focus on payment and reimbursement approaches that merit further development and testing.

Health

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Summary

Issue

Medications for opioid use disorder (MOUD), particularly buprenorphine, are an evidence-based standard of care for opioid use disorder, but they remain unavailable in many community mental health centers (CMHCs). This gap is important because CMHCs serve many people with co-occurring mental health conditions and opioid use disorder, a population that may be more likely to receive care in mental health settings than in specialty substance use treatment settings. Despite the potential reach of CMHCs, relatively little research has examined practical strategies for expanding MOUD availability in these settings.

Approach

This report presents findings from a Design Lab pilot conducted as part of a broader three-phase study on MOUD availability in CMHCs. Earlier phases included a survey of CMHCs in 20 states with high-overdose rates and qualitative interviews with CMHC leaders from those states.[1,2] The Design Lab phase convened four workshops with three interest holder groups: CMHC clients receiving MOUD, CMHC leaders, and behavioral health policy and payment experts. Participants identified barriers to MOUD implementation in CMHCs, generated potential strategies to improve implementation, and prioritized those strategies according to perceived impact and feasibility.

Key Findings

- Participants identified four broad categories of barriers to MOUD implementation in CMHCs: stigma, workforce challenges, regulatory complexity, and payment limitations.
- Expanding the mix of insurers that reimburse for MOUD and related services by convening an ongoing learning exchange between CMHC leaders and insurers was the only implementation strategy rated as both high in impact and feasibility.
- Participants viewed the learning exchange as a potential precursor to broader payment reform because it could help insurers better understand the needs of CMHCs and clients with co-occurring opioid use and mental health disorders.
- Other strategies were viewed as potentially high impact but less feasible in the near term. These included provider training, prescriber incentives, bundled payment, value-based payment, pharmacy training, and merging state mental health and substance use agencies.
- Because this was a pilot Design Lab with a small, non-representative participant group, findings should be interpreted as preliminary and hypothesis-generating rather than as a definitive implementation roadmap.

Recommendations

- Behavioral health policymakers, payers, and CMHC leaders should consider piloting a structured learning exchange focused on MOUD reimbursement, ancillary services, and payment models that support care for people with co-occurring opioid use and mental health disorders.
- Future efforts should include a broader and more diverse set of interest holders, including additional clients, caregivers, payers, pharmacy representatives, and CMHCs from varied geographic and policy contexts.
- Researchers and funders should further develop and test the learning exchange model as a potential strategy for supporting payment reform and expanding MOUD availability in CMHCs.
- Future work should examine other high-impact strategies identified by participants, including provider training, prescriber incentives, pharmacy-focused stigma reduction, bundled payments, value-based payments, and regulatory streamlining.
- Any next-stage implementation effort should preserve the pilot framing of these findings by treating the strategies as candidate approaches for refinement, testing, and adaptation rather than as final recommendations.

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A Design Lab Pilot to Inform Strategies for Expanding Access to Medications for Opioid Use Disorder in Community Mental Health Centers

Introduction

Despite a recent decline in overdose deaths in the United States, the opioid crisis continues to have significant health, social, and economic consequences, particularly for individuals with co-occurring mental health (MH) and opioid use disorders (OUD). Psychiatric comorbidities are highly prevalent among individuals with OUD with depression, anxiety, post-traumatic stress disorder, and bipolar disorder frequently observed.[3] Co-occurring substance use and MH disorders are associated with increased morbidity and mortality, homelessness and incarceration, and poor treatment outcomes,[4-8] underscoring the urgent need for effective interventions in this population.

Medications for opioid use (MOUD), including buprenorphine, naltrexone, methadone, are FDA-approved and considered the standard of care for people with OUD; buprenorphine and naltrexone are approved for delivery in clinic settings. MOUDs are effective for people with co-occurring MH disorders[9] yet access remains limited, especially in community MH centers (CMHCs) in the U.S., where many people with mental health and substance use comorbidity receive care. Only about a third of CMHCs in 20 states with the highest overdose deaths offer MOUD on site,[10] and nationwide, fewer than half of certified community behavioral health clinics (CCBHCs) provide these medications.[11] Increasing MOUD delivery in CMHCs could substantially expand access for this high-need population, but implementation efforts in these settings have lagged behind those in primary care and inpatient hospitals.[12-18]

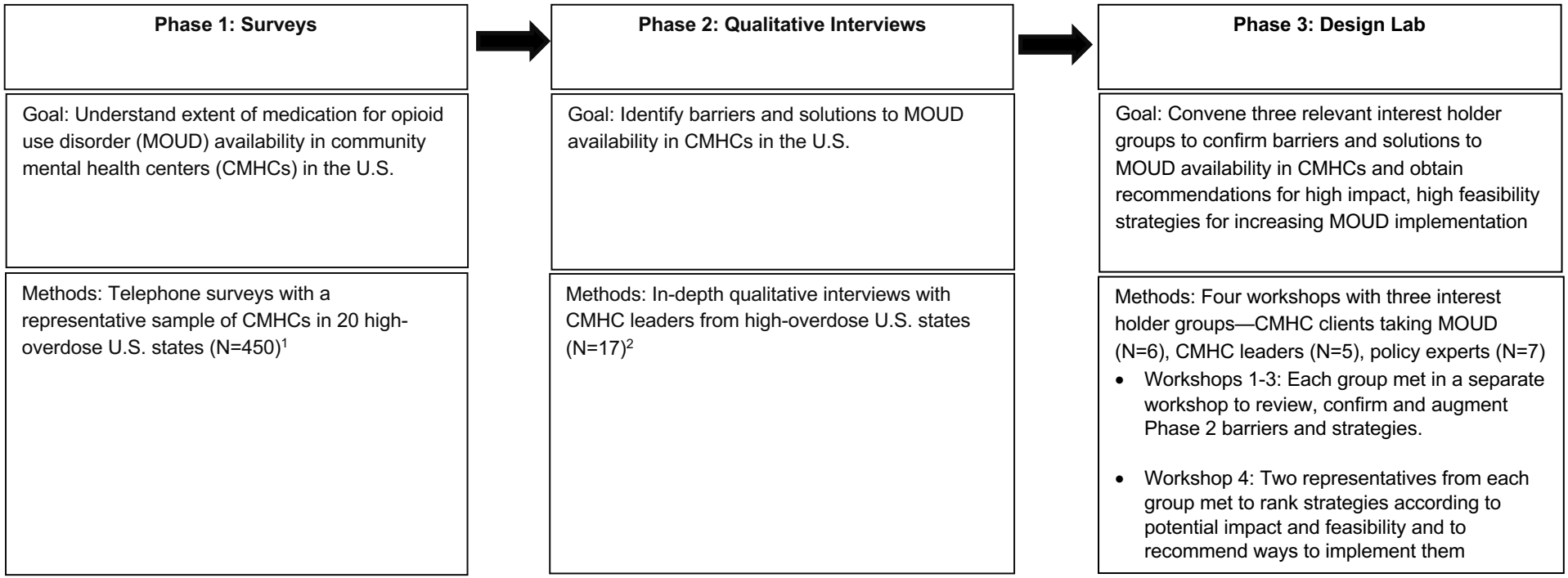
Despite the potential impact, there is limited evidence on effective strategies for implementation MOUD in CMHCs. To address this gap, we piloted a interest holder Design Lab, a structured, facilitated process to engage diverse interest holders into improving health care research.[19] It involves a series of workshops designed to engage interest holders, including patients, early in the research development process in a team-based iterative process of interest holder engagement.[19,20] The aim of this Design Lab was to identify implementation challenges and generate preliminary, interest holder-informed candidate strategies for increasing MOUD implementation in CMHCs. This report describes the strategies prioritized by participants and discusses their implications for future research and policy development.

Methods

Study Overview

This report presents findings from the final phase of a three-phase, mixed-methods study examining MOUD availability in CMHCs (See Figure 1). Phase 1 involved a survey of CMHCS in 20 U.S. states with high overdose rates to document MOUD availability.[1] Phase 2 consisted of qualitative interviews with CMHC leaders to identify barriers and potential strategies for MOUD implementation.[2] Phase 3, described here, piloted a Design Lab to engage interest holders in confirming, refining, and prioritizing candidate strategies for expanding MOUD access in CMHCs.

Figure 1. Overview of the Three-Phase Study and Pilot Design Lab Process



Design Lab Approach

The Design Lab methodology is distinct in several ways:

- **Iterative interest holder engagement**. The process began with separate working groups for three interest holder types: CMHC clients receiving MOUD, CMHC leaders, and behavioral health policy/payment experts. Participation was by invitation-only. This approach allowed for candid, in-depth discussions among participants with similar expertise and experiences, minimizing power differentials and encouraging open dialogue.
- **Neutral facilitation**. Each session was led by a neutral facilitator, unaffiliated with any particular strategy or solution, to ensure balanced participation and prevent bias in the discussion.
- **Collaborative, Non-Attributive Process**. Design Labs operate under a collaborative model, with no attribution to specific individuals or organizations.[19] Only first names were used during the sessions, and participants were asked not to share their organizational affiliation or title, fostering a safe environment for sharing perspectives and ideas.
- **Consensus-Building Across Expertise**. After gathering feedback from the three interest-holder-specific groups, a fourth working group was convened, bringing together members from each interest holder type. This cross-expertise session facilitated collaborative discussion of potential solutions and enabled consensus-building across diverse perspectives.

Working Group Activities

Each interest holder-specific working group began by reviewing challenges and strategies identified in earlier phases of the study. Participants were invited to confirm, modify and augment these findings based on their own experiences. Discussions were structured to elicit new ideas and refine existing strategies, with facilitators prompting participants to consider both barriers and potential solutions. In the final cross-interest holder session, participants reviewed the synthesized list of strategies, discussed their potential impact and feasibility, and collaboratively ranked them using a consensus-based process. The group prioritized strategies and discussed implementation considerations, with the aim of identifying actionable, interest-holder-informed approaches for expanding MOUD access in CMHCs. Further details on participant recruitment and the workshop procedures are provided in Appendix A.

Analysis

All workshops were recorded and transcribed. Analytic work occurred in stages that corresponded to the workshop flow. After each of the first three interest holder-specific workshops, members of the research team entered notes into a rapid analysis spreadsheet template. The template included domains aligned with the workshop goals, including implementation challenges, potential strategies, and participant comments or clarifications. Three

members of the research team rotated facilitator roles across workshops, with one serving as lead facilitator and another as co-facilitator. Following each workshop, the facilitator and co-facilitator reviewed the transcript and/or recording, updated the rapid analysis spreadsheet, and identified emerging themes and candidate strategies.

One researcher then reviewed the recordings and spreadsheet entries across workshops, and two researchers met weekly to discuss and reach consensus on the themes and strategies to present during the final prioritization workshop. Categories of challenges and strategies were developed inductively during rapid analysis rather than imposed in advance. The research team grouped related challenges into four domains — stigma, workforce, payment, and regulatory challenges — and grouped related strategies into four categories: training, workforce support, payment alternatives, and leadership/regulatory solutions.

Results

Across the three workshops, participants were six clients, 5 clinic leaders, and 6 policy experts (see Appendix B for more details).

Identified Challenges and Strategies

Table 1 summarizes challenges and potential strategies identified across at least one interest holder workshop. Although findings generally overlapped across groups, differences reflected participants' roles and experiences. Stigma emerged as a cross-cutting challenge and was discussed as a challenge at the provider, pharmacy, and community levels. It included stigma toward people with OUD, stigma toward the use of MOUD, and stigma toward harm reduction approaches. Clients receiving MOUD emphasized stigma particularly strongly.

Operational and structural barriers were emphasized more often by CMHC leaders and behavioral health policy and payment experts. Workforce challenges included limited training on OUD and MOUD for prescribers and staff, as well as staffing shortages. Payment challenges included prior authorization requirements, low or insufficient reimbursement, and limited funding for ancillary services related to OUD treatment beyond MOUD, such as individual and group counseling, laboratory services, care coordination, and client transportation. Regulatory challenges involved dual requirements from state mental health and substance use agencies for CMHCs offering MOUD and other integrated care for people with co-occurring substance use and mental health disorders.

Participants also discussed potential strategies for addressing these challenges that could be studied in future research. These were captured in four categories: training, workforce support, payment alternatives, and leadership/regulatory solutions.

Table 1. Challenges to and Potential Strategies for Implementing MOUD in CMHC

Category, Challenge	Description	Potential Strategies for Addressing Challenges
OUD/MOUD Stigma		
Provider stigma	• Negative attitudes toward people with OUD among providers • Lack of desire to treat people with OUD • Lack of philosophical belief in treating OUD with MOUD	• Leadership/regulatory: State agencies for substance use disorder and mental health convene, lead changes, merge • Training: Provider, pharmacy, community, medical school • Workforce Support: Peer consultation, mentorship • Payment: Payer education, increase payer mix
Pharmacy stigma	• Negative attitudes towards people with OUD among pharmacists and staff • Low prioritization of MOUD prescriptions despite withdrawal urgency	
Community stigma	• Negative attitudes towards MOUD among community service providers such as sober living facilities and halfway houses for pregnant women • MOUD not allowed in facilities	
Workforce Issues		
Prescriber shortage	• Dearth of prescribers in CMHC • Dearth of prescribers in CMHC willing to prescribe MOUD	• Payment: Payer education, increase payer mix • Payment: Bundled and value-based payments • Training: Provider, medical school • Workforce Support: Peer consultation, mentorship • Workforce Support: Prescriber incentives
Lack of training	• CMHC prescribers and staff not well-trained on MOUD or on providing care to people with OUD	• Training: Provider • Workforce Support: Peer consultation, mentorship
Complex, bifurcated regulatory requirements	• Separate mental health and substance use regulations that complicate billing, training, and licensing	• Leadership/regulatory: Single state agencies (SSAs) for substance use disorder and mental health convene, lead changes, merge
Liability fears	• Concern about MOUD diversion and liability	• Workforce Support: Institute checks and balances to prevent diversion
Payment		
Low reimbursement/lack of incentives	• Low provider reimbursement • Lack of incentives	• Payment: Bundled and value-based payments • Workforce support: Prescriber incentives
Insufficient payment	• Fee-for-service (FFS) model limits ancillary services that can optimize MOUD treatment	• Payment: Bundled and value-based payments • Leadership/regulatory: Single state agencies for substance use disorder and mental health convene, lead changes, merge
High costs for clients	• MOUD co-pays too high for non-Medicaid clients	• Payment: Payer education, increase payer mix

NOTE: This table summarizes themes identified across interest holder workshops and does not indicate that each theme was raised by every interest holder group. Some themes were emphasized more strongly by particular groups, as described in the text.

Prioritization of Impactful, Feasible Strategies

Figure 2 presents the matrix of strategy rankings from the final workshop, recreated from the original Zoom whiteboard used during the workshop. Below, we describe each high-impact strategy in detail. Medium-impact strategies were not discussed due to time constraints, and there were no low-impact strategies.

Figure 2. Proposed Strategies for MOUD Implementation in CMHCs - Impact x Feasibility Matrix

		Feasibility					
		High		***Medium***		***Low***	
Impact	***High***	**Payment:** Insurer education/mix		**Training:** Provider	**Workforce Support:** Provider Incentives	**Payment:** Bundled payment	**Training:** Pharmacy
				Training: Medical school		**Payment:** Value-based payment	**Leadership/Regulatory:** Merge state agencies
	Medium	**Training:** Community	**Workforce Support:** Peer consultation			**Leadership/Regulatory:** Single State Agency (SSA) convene, lead	
		Workforce Support: Provider mentorship	**Leadership/Regulatory:** Checks & balances				

Definitions:

Payment
Insurer education/mix: Increase number of insurers; educate insurers on OUD/MOUD
Bundled payment: Change payment models from fixed fee-for-service to a model that includes necessary ancillary services such as counseling, groups, transportation. Bundled payment refers to a payment model that provides a single payment for a defined set of services, such as MOUD visits, counseling, care coordination, laboratory services, or peer support.
Value-based payment: Change payment models from fixed-fee for services to a model that rewards quality care, Value-based payment refers to reimbursement models that link payment to quality, outcomes, or performance metrics rather than paying only for individual services delivered.

Training
Pharmacy: Train pharmacists and staff on OUD, MOUD, stigma
Medical school: Training medical school students on OUD, MOUD, stigma
Community: Conduct widespread and targeted trainings and outreach on OUD, MOUD, stigma
Provider: Train prescribers and mental health staff on OUD, MOUD, stigma

Workforce Support
Peer consultation: 1:1 consultation to prescribers for prescribing questions
Provider mentorship: 1:1 or group mentorship to prescribers (e.g., monthly video meetings)
Provider incentives: Offer bonus to prescribers for developing expertise in OUD, MOUD

Leadership/Regulatory
Single state agency (SSA) Convene, Lead: State mental health and substance use SSAs take leadership role on advancing MOUD prescribing through meetings, policies, funding
Merge state agencies: Merge substance use disorder and mental health state agencies and licensing and training regulations
Checks and Balances: Institute checks and balances at the clinic level (e.g., pill counting) to reduce provider concerns about liability

Increasing the mix of payers who reimburse for MOUD and ancillary services, such as case management and counseling was the only strategy perceived as having both high impact and high feasibility. Here, *payers* refers broadly to organizations or programs that finance or reimburse care, including Medicaid, Medicare, commercial insurers, managed care organizations, and public or grant-funded behavioral health programs. To implement this strategy, the group recommended convening a learning exchange with CMHC leaders and insurers to discuss specific needs of CMHCs and their clients regarding medications, workforce reimbursement and ancillary services, and types of payment models offered by insurers. In this context, a "learning exchange" refers to an ongoing, structured series of meetings between CMHC leaders and insurers, designed to facilitate mutual understanding of needs, share best practices, and collaboratively develop and test new payment models for MOUD delivery. Participants recommended that current insurers that provide reimbursement for MOUD, as well as those providing limited or no reimbursement for MOUD, work closely with CMHC leaders to determine needs and payment models that would benefit CMHC clients with MOUD. Participants felt that bringing together groups that typically are siloed to discuss the needs of CMHC clients and providers and the potential impacts of different payment models is an important precursor to increasing the mix of insurers who reimburse for MOUD and ancillary services, trying alternative payment models (versus more typical "fee-for-service" models), and ultimately improving uptake of MOUD in CMHCs.

The learning exchange described by participants could involve case study presentations by CMHC leaders on the needs of people with co-occurring OUD and MH disorders and an ongoing collaboration to develop, implement, and evaluate payment models to meet these needs. Participants unanimously agreed that because this strategy could potentially impact other challenges, such as workforce shortage and stigma, it would be highly impactful, and that changes to payment models were less likely to be successful without a precursor like this to obtain insurers' deep understanding of the issues. The strategy was also perceived as highly feasible to implement because clinic leaders indicated their willingness to participate, they perceived that insurers would be willing to participate, and because it would require fewer resources than most other strategies.

Several other strategies were also seen as potentially high impact but only moderately feasible, including 1) training for prescribers and other clinicians on patient-centered care for people with OUD; 2) prescriber training on the standard of MOUD care for people with co-occurring disorders; 3) workforce support for prescribers and other clinicians through incentives; and 4) training medical school students on OUD and MOUD. Participants noted that the impact of prior efforts like these has been limited because of a lack of time, resources, and engagement.

System-level payment reforms were also viewed as high impact but low feasibility (without a precursor like the learning exchange). These included the use of bundled payments, which are payments that cover ancillary services as well as MOUD, and the use of value-based payment mechanisms, where reimbursement is contingent on achieving specific performance metrics.

Training for pharmacists and other pharmacy staff to reduce stigma toward people with OUD was also viewed as a high-impact, low feasibility strategy, with the primary difficulty perceived as the infeasibility of implementing stigma training on OUD and MOUD in large retail pharmacies.

Leadership and regulatory changes that would result in state MH and substance use disorder agencies merging to streamline regulations, requirements, and payment was also perceived as high impact but low feasibility. In many states, these agencies are separate and have separate training and reimbursement requirements. Agencies wishing to provide integrated substance use and MH care in these states often must comply with both sets of regulatory requirements. This was discussed as potentially having a high impact, but participants noted that this strategy has been under discussion for many years with little progress, with some state agencies already merging but without improvement in streamlined, integrated care.

Discussion

Expanding the mix of insurers who reimburse for MOUD and needed ancillary services for people with co-occurring OUD and MH disorders, such as case management, counseling, and peer navigation, by convening an ongoing, cross-sector learning exchange between CMHC leaders and insurers was perceived by a diverse group of interest holders as the highest impact and most feasible strategy to improve uptake of MOUD in CMHCs. Workgroup participants discussed that prior insurer efforts to better understand consumer needs has not meaningfully influenced the historic lack of collaboration between CMHCs and insurers due to mismatched incentives and fragmented systems of care, or the substantial discrepancies in coverage for MOUD across different plans and states that influence patient treatment access.[21] Design lab participants saw the need for a new approach: an ongoing setting in which interest holders could learn from each other and work together to address the challenges that naturally occur in efforts to implement innovative models of care.

Currently, some states and plans provide more comprehensive coverage for MOUD (e.g., Arizona, California, and Massachusetts), while others have restrictive policies that limit access to necessary medications and services (e.g., Arkansas, Idaho, and Mississippi).[21,22] Further, some health insurance plans include features that discourage coverage for MOUD, such as high deductibles and co-pays, which are prohibitive for many potential patients,[23] and some insurance plans still require prior authorization for medications used in treating OUD, which involves additional paperwork and leads to delays in treatment initiation.[24] While these barriers have been widely recognized, efforts to address them are often implemented without the participation of multiple affected interest holders, often resulting in partial or ineffective implementation with only modest impact in enhancing care.

Although the literature on cross-sector collaborations tends to focus more on community organizations partnering together or with government entities than on insurer partnerships with

community-based organizations, existing literature suggests a clear need for partnered solutions to evolving and complex health and behavioral health problems between groups that typically act within their own siloes.[25-28] Albeit sparse, there is some literature suggesting that working groups between CMHCs and insurance leaders can lead to meaningful improvements in transparency and program implementation.[29] While potentially an effective way to bridge gaps between siloed groups, spending resources to develop relationships in new cross-sector collaborations is thought to be essential for establishing norms and trust needed to lead to effective solutions given different organizational cultures and priorities.[30] This likely is especially true for bridging gaps between insurance providers and CMHCs.

Working group participants suggested that a cross-sector learning exchange between CMHC leaders and insurers would facilitate bidirectional discussion of the needs of people with co-occurring OUD and mental health disorders, critical components of MOUD care, payment gaps, and the benefits and drawbacks of current payment models. The prevailing view among participants was that collaboration between CMHC leaders and insurers could ultimately result in more insurers reimbursing CMHCs for MOUD and ancillary services in ways that would improve MOUD availability and overall service delivery.

Because insurers were not included in the pilot Design Lab, the learning exchange should be interpreted as a candidate strategy requiring further development and testing with insurer participation, rather than as a fully specified or validated implementation approach. Future work should include insurers directly to assess the feasibility, acceptability, structure, and potential sustainability of a CMHC-insurer learning exchange. Although the proposed learning exchange centered on CMHC leaders and insurers, future efforts also should consider how to incorporate client perspectives directly so that payment and service delivery models reflect the needs and experiences of people receiving MOUD in CMHCs.

Participants believed that CMHC leaders engaging with insurers to address gaps in knowledge about MOUD and the needs of clients with co-occurring disorders is a necessary precursor to expanding the payer mix and making system-level changes needed for MOUD payment reform. Recent Medicaid demonstration projects in the United States suggest that payment can be an effective policy lever for improving the delivery of substance use treatment.[31] Although a learning exchange would not immediately address all barriers to MOUD treatment in CMHCs — including limited availability of social services in some areas, provider knowledge gaps, and low client readiness for treatment[32,33] — participants expressed that collaboration between insurers and CMHC leaders could help increase access to MOUD in CMHCs. Over time, this could also help mitigate related challenges, such as stigma toward OUD and MOUD, workforce deficits due to low reimbursement, and provider willingness to prescribe MOUD.

Because CMHC financing and regulation vary substantially across states, a cross-sector learning exchange would likely need to be adapted to local policy and payment contexts rather than implemented as a single uniform model. In states where Medicaid managed care organizations play a central role in behavioral health reimbursement, the exchange could focus

on plan-level coverage policies, prior authorization requirements, reimbursement for ancillary services, and contracting mechanisms that support MOUD delivery in CMHCs. In states with county-based or state-administered behavioral health systems, the exchange might instead emphasize alignment among state mental health and substance use agencies, public behavioral health authorities, and CMHCs. In CCBHCs, for which substance use disorder treatment is a required service, the learning exchange could focus on how existing payment structures can be used or modified to support MOUD prescribing, care coordination, counseling, peer support, and other services needed by people with co-occurring OUD and mental health disorders. Across these contexts, the core function of the learning exchange would be to create a structured forum in which CMHC leaders and insurers can identify payment barriers, clarify service needs, and develop context-specific approaches to improving reimbursement for MOUD and related care. Future research should examine how this model functions across different state policy environments and whether participation in such exchanges leads to changes in insurer policies, CMHC reimbursement, MOUD availability, or service delivery for clients with co-occurring disorders.

The learning exchange proposed by Design Lab participants would not need to be developed in isolation. Existing national and state initiatives suggest growing interest in cross-sector approaches to OUD financing and opioid response infrastructure. For example, opioid settlement funds have led many states to establish advisory committees or other governance structures to guide opioid remediation spending.[34] Additionally, organizations such as the National Governors Association and the National Council of Wellbeing have launched collaborative efforts to improve access to evidence-based OUD treatment and support payment reform for behavioral health services.[35,36] Other initiatives, including Medicaid demonstration projects and state-level integrated care pilots, are testing new payment models and care coordination strategies.[37] Although these initiatives are broader than the CMHC-focused learning exchange envisioned by Design Lab participants, they suggest that future efforts to expand MOUD availability in CMHCs could build on existing payment-model, state policy, and settlement-fund infrastructure rather than creating entirely new structures. A CMHC-focused learning exchange could complement these broader efforts by centering the specific reimbursement, workforce, and ancillary-service needs of CMHCs serving clients with co-occurring OUD and mental health disorders.

While broad policy changes are still needed for payment reform,[23] some limited initiatives testing alternative payment strategies for OUD treatment are already underway, albeit not specifically for people with co-occurring disorders.[31,38-40] According to a recent review of the MOUD payment landscape,[40] traditional Medicare, Medicare Advantage, and Medicaid all, at the time the study was conducted, provided coverage for buprenorphine, naltrexone, and methadone, although methadone (which typically is not available outside designated opioid treatment programs) is less likely to be covered by private insurers. Further, some form of bundled and value-based payment models are already provided by many insurers, but to a limited

extent, with substantial gaps that still need to be addressed.[21,40] The extent to which this applies to the range of services needed for people receiving MOUD in CMHCs is not well studied.

Other high-impact strategies discussed by participants were determined to be less feasible, generally due to perceptions that the strategies require too much time and money, that they rely on motivated providers, or that changes such as merging of state agencies are slow-moving and require deep institutional change. Regarding the strategy that suggested training on stigma for large pharmacy retailers, although this was considered to be low-feasibility, clinical pharmacists were actually early adopters of buprenorphine, and efforts to train pharmacists on MOUD already exist.[41,42] Nevertheless, further study is needed to assess whether the other high-impact strategies would be feasible.

Limitations

The study had several limitations. Because the goal was for participants to identify challenges and strategies and discuss the prioritization of potentially impactful and feasible strategies, the researchers relied on group members' perspectives and consensus during the workshops. As a result, certain topics less familiar to participants may have been missed. In addition, the pilot included a small, non-representative group of interest holders. Participants who received MOUD from a CMHC represented one rural CMHC and were racially and ethnically homogenous (all were White). Further, none were newly initiated on MOUD, which also may have shaped their perspectives on barriers and facilitators.

The study did not systematically sample CMHCs by characteristics such as ownership type, CCBHC status, payer mix, or state policy context. Further, while we included three interest holder groups affected by or knowledgeable about MOUD implementation in CMHCs, we did not include other relevant groups, such as caregivers, pharmacy representatives, or insurers. Because insurers were not included, the feasibility of the CMHC-insurer learning exchange reflects the perceptions of participating clients, CMHC leaders, and policy/payment experts, but not the perspectives of insurers themselves. Payment and policy experts contributed important perspectives but did not represent perspectives of the full range of payer types, such as Medicaid agencies, managed care organizations, Medicare, commercial insurers, or grant-funded programs. Further, because some CMHC leaders had participated in earlier study phases, their prior contact with the research team may have shaped their familiarity with the project, although the Design Lab was structured to focus on reviewing, refining, and prioritizing strategies generated from the broader study.

Although the Design Lab was interest-holder-informed and included participant discussion, strategy generation, and real-time prioritization, participants were not involved in co-analyzing the workshop data or co-interpreting the final findings after the workshops. The research team conducted the rapid analysis and synthesized the final themes and strategies.

We do not know to what extent a larger or more diverse group of participants, additional interest holder feedback cycles, or a more participatory analytic approach would have changed

the findings. Future research with a larger and more diverse group of interest holders should include insurers directly; assess the feasibility, acceptability, structure, and potential sustainability of a CMHC-insurer learning exchange; examine its relevance across varied policy and payer contexts; and explore other high-impact strategies identified in this pilot.

Conclusions

Design Lab participants consisting of CMHC clients and leaders, as well as behavioral health policy experts, perceived that expanding the insurer mix through an ongoing, cross-sector learning exchange between CMHC leaders and insurers could be a critical first step toward improving MOUD payment models and routinizing delivery of MOUD in CMHCs. Additional payers offering adequate reimbursement for services provided to people with co-occurring MH and OUD in CMHCs ultimately could help reduce stigma, improve CMHC support for MOUD, and normalize treatment. Because OUD prevalence is high among individuals who receive services in CMHCs, increasing MOUD availability in CMHCs could accelerate access to MOUD for people with co-occurring MH and OUDs, ultimately helping to improve health outcomes and reduce deaths from opioid overdose.

Appendix A. Participant Recruitment and Workshop Procedures

Participant Recruitment

CMHC Leaders. We sent invitation emails to CMHC leaders that had participated in our Phase 2 study who had indicated interest in participating in the Design Lab. Because these CMHC leaders had participated in Phase 2 interviews, they had prior contact with the research team; this was consistent with the sequential study design, in which Phase 3 built on findings from earlier phases. Eligible participants were 18 or older and worked at a CMHC in a leadership role.

Clients. CMHC leaders that participated in Phase 2 distributed fliers to clients who had received MOUD. Fliers included a toll-free number that clients could call to answer screening questions. Eligible individuals were 18 or older and had taken MOUD prescribed to them by a CMHC provider to treat their OUD. There was no minimum required length of time that individuals had received MOUD to participate.

Behavioral Health Payment and Policy Experts. We contacted behavioral health policy and payment experts identified through the study team's prior work, professional networks, and knowledge of national experts in substance use disorder treatment policy, behavioral health financing, and payment reform. Experts could be affiliated with nonprofit, federal, state, or private organizations. Because the Design Lab focused on expanding MOUD availability in CMHCs, recruitment focused on experts with substance use disorder treatment policy or payment expertise rather than experts whose experience was limited to specialty mental health policy. Experts had to be 18 or older.

In summary, the study incorporated varied interest holder perspectives, but the pilot Design Lab was not designed to produce a representative sample of CMHCs, payers, or policy environments. Client participants were drawn from one rural CMHC, while CMHC leaders represented a small number of rural and urban settings across several U.S. regions. Payment and policy experts brought national behavioral health, health care advising, payment policy, and strategic planning perspectives.

Workshop Procedures

All workshops were conducted virtually using a secure Zoom.gov account. The four workshops took place between October 2024 and February 2025. Each participant received an individual meeting invitation, and participants' last names and organizational affiliations were removed from display names before they were admitted to the virtual workshop room. These procedures were intended to reduce the disclosure of identifying information in the group setting.

The research team developed discussion guides and slide decks for each workshop. Before each workshop, participants received an email describing the purpose of the session and outlining the topics that would be discussed. Facilitation differed by workshop type. In the individual interest holder workshops, facilitators used the guide and slides to review challenges and potential strategies identified in earlier study phases and to prompt discussion about whether these findings resonated with participants' experiences, what should be modified, and what additional challenges or strategies should be considered. In the combined workshop, facilitators used a structured prioritization process to review the strategies generated across interest holder groups, add any additional strategies suggested by participants, and to guide participants through consensus ranking of each strategy by perceived impact and feasibility.

After all workshops, all participants were emailed a link to a brief electronic survey asking about demographics and for any final comments. Brief demographic surveys included some items tailored to each interest holder group's role in the Design Lab (e.g., clients were asked about how long they had received MOUD, clinic leaders were asked about their licensing status and policy experts were asked about their policy experience). These surveys were intended to describe participants' primary interest holder roles rather than systematically capture overlapping lived, clinical, leadership, or policy experiences.

Participants provided verbal consent to participate in the study and to be recorded. Participants received a $150 gift card upon survey completion for each workshop. All procedures were approved by the RAND Human Subjects Protection Committee (HSPC).

Workshop Session Structure

At each interest holder-specific workshop, the facilitator started with an overview of the study's focus: expanding access to MOUD, primarily buprenorphine, in CMHCs. The workshop's goal was to confirm and augment the list of key challenges and potential strategies for improving MOUD availability in CMHCs that had been identified in earlier phases. Participants first reviewed slides summarizing findings from Phase 2, followed by a facilitated discussion to assess whether these challenges and strategies reflected their own experiences. For each item, the facilitator offered a brief explanation and invited participants to comment on its clarity, relevance and accuracy, as well as to suggest modifications or additional challenges or strategies.

After the interest-holder-specific sessions, a fourth cross-interest holder workshop was convened, including two participants from each of the three prior groups. Selection was based on expressed interest, with invitations extended sequentially until each group was represented. In this session, participants did not formally represent their original groups; instead, the facilitator presented a synthesized list of strategies identified across all workshops, along with the associated challenges each strategy was aimed to address. Participants were encouraged to supplement or refine the list as needed.

The facilitator then guided the group through a structured prioritization process using a virtual whiteboard. Participants collaboratively ranked each strategy by perceived impact (high, medium or low) on expanded MOUD in CMHCs. Once impact rankings were established, the group assessed the feasibility of each strategy, considering how easily and quickly it could be implemented. Strategies were visually organized into an impact-by-feasibility matrix, and participants discussed and voted on each placement. When disagreements arose, the facilitator encouraged open discussion until consensus was reached.

After finalizing the rankings, participants discussed practical steps for implementing the highest-impact, most feasible strategies. Following the workshop, all participants were invited to review the priority matrix and provide additional feedback via a brief follow-up survey. The research team reviewed these comments for any corrections or substantive disagreements. As feedback was limited and did not warrant changes, the consensus rankings were confirmed as final.

Appendix B. Participant Characteristics

Table B.1 shows participant characteristics, obtained through self-report on the brief, online survey completed after each of the first three workshops.

Table B.1. Participant Characteristics (Workshops 1-3)

Characteristic	Clients n = 6		CMHC Leaders n = 5		Payment Experts n = 6[a]	
	n	%	n	%	n	%
Age						
35-44	3	50%	2	40%	2	33%
45-54	2	33%	2	40%	3	60%
55+	1	17%	1	20%	1	17%
Sex						
Female	3	50%	3	60%	2	33%
Male	3	50%	2	40%	4	67%
Hispanic/Latino ethnicity	0	0%	0	0	0	0
Race						
Black or African American	0	0	0	0	1	17%
White	6	100%	5	100%	5	83%
Highest level of education						
No high school diploma or equivalent	1	17%	0	0	0	0
High school diploma or equivalent	4	67%	0	0	0	0
Associate's degree	1	17%	0	0	0	0
Some College, no Degree	0	0	1	20%	0	0
College Degree	0	0	0	0	0	0
Master's Degree	0	0	2	40%	5	83%
Doctoral Degree or Equivalent	0	0	2	40%	1	17%
Time in mental health treatment						
< 10 years	2	33%	n/a	n/a	n/a	n/a
10 years or longer	4	67%	n/a	n/a	n/a	n/a
Time on MOUD						
< 10 years	2	33%	n/a	n/a	n/a	n/a
10 years or longer	4	67%	n/a	n/a	n/a	n/a
Provider type						
Licensed alcohol and drug counselor	n/a	n/a	1	20%	n/a	n/a
Licensed clinician	n/a	n/a	3	60%	n/a	n/a
Psychiatrist	n/a	n/a	1	20%	n/a	n/a
CMHC leader roles						
Supervisor, department or program leader	n/a	n/a	3	60%	n/a	n/a
Clinic leader, executive, or administrator	n/a	n/a	2	40%	n/a	n/a
U.S. census region, urban/rural designation[b]						
Northeast (New England), urban (small metro)	0	0	1	20%	n/a	n/a
Northeast (Mid-Atlantic), rural (micropolitan)	0	0	1	20%	n/a	n/a
Midwest (East North Central), rural	6	100%	1	20%	n/a	n/a
West (Pacific), urban (1 large, 1 small metro)	0	0	2	40%	n/a	n/a
Policy expert roles	0	0				
National behavioral health/health care advising	n/a	n/a	n/a	n/a	2	33%
Payment policy consulting and strategic planning	n/a	n/a	n/a	n/a	4	67%

NOTES: na = "not applicable" as respondents were not queried on item; [a]One participant did not complete the survey; [b]Hub RHI. Am I Rural - Tool. July 10, 2025, 2025. https://www.ruralhealthinfo.org/am-i-rural#/

Abbreviations

CCBHC	Certified community behavioral health clinic
CMHC	Community mental health center
FDA	U.S. Food and Drug Administration
FFS	Fee-for-service
FORE	Foundation for Opioid Response Efforts
IRB	Institutional review board
MH	Mental health
MOUD	Medications for opioid use disorder
OUD	Opioid use disorder
SSA	Single state agency
SUD	Substance use disorder
U.S.	United States
VA	Veterans Affairs

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