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State Policies Can Expand Access to Buprenorphine for Opioid Use Disorder

Many options are available to make this lifesaving medication easier to access

Overview

Medications for treating opioid use disorder (OUD) have been proven to reduce illicit drug use, overdose deaths, and disease transmission via injected drugs, yet access to this lifesaving treatment remains limited.[1] Two highly effective Food and Drug Administration-approved medications, buprenorphine and methadone, have different regulations and restrictions on their modes of distribution. Buprenorphine can be prescribed by physicians, nurse practitioners (NPs), and physician assistants (PAs) in a variety of settings, including primary care offices and clinics, while the federal government requires that methadone can be dispensed only in a small number of highly regulated specialty clinics known as opioid treatment programs (OTPs).[2]

The rate of fatal opioid overdoses in the United States increased more than eightfold between 1999 and 2020, claiming more than 560,000 lives, and approximately an additional 80,000 lives were lost in 2021.[3] Yet in 2021, only 22% of people with OUD received any medications for their condition.[4]

When it comes to accessing lifesaving medications for OUD, states have considerably more leverage in amending rules or laws that can result in greater access to buprenorphine than in addressing methadone access, which the federal government tightly controls. To that end, in recent years there has been a flurry of state activity designed to increase the availability of buprenorphine. These efforts include creating incentives for more providers to prescribe the medication (as of 2020, only 5% of physicians in the U.S. had obtained the federal waiver needed to be able to do so) and making it easier for more patients to start and continue on it.[5]

In late 2022, Congress made it easier for providers to prescribe buprenorphine when it passed the Mainstreaming Addiction Treatment (MAT) Act, which removed a special prescriber registration requirement.[6] But this special registration was not the only barrier to provider prescribing, and arguably not the most important one (it also doesn't supersede state laws that impose their own registration requirements on buprenorphine prescribers).[7] Other reported provider disincentives that states are seeking to change include low reimbursement rates, lack

of experience in treating OUD, and lack of support in meeting a range of the health and social service needs of patients on buprenorphine. From patients' perspective, even when they are able to find a buprenorphine prescriber, some state rules make it difficult to fill prescriptions and stay on the medication. For instance, public and private insurers in some states require approval before buprenorphine can be prescribed, delaying access to this lifesaving medication. And some states require counseling as a condition for patients to receive buprenorphine, despite research showing that medication alone—even without counseling—lowers OUD overdose death rates and improves retention in treatment.[8]

States are also being called on to redress significant access disparities to buprenorphine by race. Across the country, OUD rates are fairly comparable between Whites, Blacks, and Hispanics.[9] However, research finds that buprenorphine providers are less likely to be located in communities of color, and that Black and Hispanic people are significantly less likely to receive buprenorphine than Whites. In addition, data shows that Black and Hispanic people who fatally overdosed were significantly less likely than Whites to have received any treatment for substance use disorder (SUD).[10]

With no signs of the opioid crisis abating, states have been testing strategies to increase access to buprenorphine in more health and behavioral health care settings and to a more diverse patient population. States are doing this through a combination of removing rules that are diminishing access to care, creating a variety of financial incentives to prescribing, and reorganizing health care delivery to better support the needs of buprenorphine prescribers. Such reforms are being led by governors' offices, state legislators, and executive agency officials across state governments, with each using the various policy mechanisms at their disposal (executive orders, legislation, Medicaid waivers, regulatory reform) to create change.

Policies for change

This brief explores the most promising policy options that states can use to make buprenorphine more readily available.[11] It also outlines the mechanisms to enact each option, such as:

Governors' directives: A governor-issued executive order, these are frequently used during a public health crisis or disaster. Directives often create task forces that oversee the development and execution of action plans and elevate important issues within agencies and the public.

Legislative action: Bills passed by state legislatures can mandate or encourage state agency action, remove barriers that exist in state laws or agency rules, and appropriate money to fund state agencies, providers, or community-based groups. Legislatures can also hold oversight hearings on executive branch activities.

State agency actions: State agencies oversee the regulation, licensure, authorization, and funding of a wide range of services and supports to address addiction and have several tools they can use to expand access to buprenorphine, including:

- **Funding:** Grants—including federal block grants—and state appropriations can support a range of reforms, including benefit expansion and expanding and diversifying the provider workforce.
- **Community engagement:** Invite community members to help brainstorm and develop strategies to address problems and expand care based on their own experiences in accessing care.
- **Technical assistance (TA):** Direct technical support to providers can ease administrative challenges.
- **Advancing private insurance reform:** State agency officials can take the lead on incentives and disincentives that help commercial health insurers discard barriers to accessing treatment and medications for opioid use disorder.
- **Enforcing federal parity rules:** State Medicaid directors and insurance commissioners can

promote compliance with federal parity requirements and impose penalties on Medicaid and commercial health plans (except employer-sponsored health plans) that violate the Mental Health Parity and Addiction Equity Act.[12] (This law mandates that mental health and substance use benefit treatment limits cannot be more restrictive than medical or surgical benefits.[13])

Medicaid: Medicaid is a joint federal/state health care entitlement program that serves primarily low-income and disabled Americans and is the largest source of funding for OUD-related services, covering nearly 40% of people with this condition.[14] States have the option of doing more with Medicaid, and many are. For instance, they can expand eligibility for OUD services, increase the range of reimbursable benefits to treat OUD, and increase the relatively low number of Medicaid providers who prescribe buprenorphine through rate increases to providers.[15] The box below describes the different actions Medicaid agencies can take to better serve people with OUD.

Options to Strengthen Medicaid Coverage for OUD Treatment

State plan amendments: States have options to enhance Medicaid services and reimbursement schemes by submitting state plan amendments (SPAs) to the federal Centers for Medicare and Medicaid Services (CMS). SPAs could offer coverage for:

- **Rehabilitation services:** Covers a variety of recovery services for mental health and SUD, including independent living skills, relapse prevention, and job preparedness.[16]
- **Targeted case management:** Reimburses for case management services that connect patients to multiple service systems.[17]
- **Health homes:** Assists Medicaid members with chronic conditions (which can include SUD) and/or serious mental illness.[18] These programs pay for care coordination, patient and family support, and referral to social support services. States receive a 90% federal match for the first two years. A number of states have used the health home option to develop opioid health homes for people with OUD who have or are at risk for another chronic condition.[19]

Medicaid waivers: Time-limited arrangements that provide flexibility to state plans.[20] Waivers let states offer specialized benefits to a particular group of enrollees, restrict enrollees to a specific provider network, or extend coverage to groups beyond those typically allowed by Medicaid.

- 1915 (b)—Medicaid managed care waiver: Lets states deliver care through managed care organizations (MCOs) and limit provider network(s) based on patient needs.
- 1115 Research and Demonstration waiver: Lets states pilot and test policy changes such as expanded eligibility, types of services, and innovative delivery systems for people with OUD.

Medicaid managed care contract language and Medicaid Accountable Care Organization (ACO) standards: Requirements for services, provider types, provider network capacity, and any benchmarks and bonuses related to patient access and outcomes can all be specified through Medicaid managed care contract language or Medicaid ACO standards. Medicaid ACOs are groups of physicians, hospitals, and other health care providers that come together to deliver coordinated care under a payment structure that distributes shared savings as bonuses to providers who meet certain benchmarks for service quality and health outcomes instead of service volume.[21] In 2023, Medicaid ACOs were operating in 11 states.[22]

Medicaid rule changes: State Medicaid agencies can modify rules that hinder access to buprenorphine, such as reducing or eliminating prior authorization requirements and eliminating or clarifying vague medical necessity clauses.

States that enact new policies to increase access to buprenorphine should also perform two key actions: collect data on OUD prevalence and treatment rates, and review and consider mitigating any long-standing structural barriers that will dilute efforts to reduce opioid addiction. States need to look at their OUD prevalence rates, use of medications, and treatment retention by age, race/ethnicity, sex, geography, and other important markers. This is the only way to determine which interventions are most needed and which populations (in which geographic areas) to target. States can collect data for services covered by Medicaid, federal block grants, opioid settlement funds (acquired through lawsuits with drug manufacturers and distributors), state discretionary grants, and commercial health insurers.

To understand the intractability of the opioid crisis, it's critical to account for long-standing structural barriers that work against treatment and recovery efforts, such as laws related to housing, employment, and incarceration for drug use. For example, drug possession can often lead to incarceration. Of the nearly 2 million people in the nation's prisons and jails, more than half have an SUD.[23] And the availability of medications for OUD in prisons and jails does not come close to meeting the need. Once released, many formerly incarcerated people face housing and employment policies that exclude those with criminal records. In addition, various jurisdictions of the country have rental housing policies that evict people for using substances or for having guests who use substances. Separately and combined, these policies create an instability that corrodes a person's ability to seek treatment and maintain recovery. Although this brief does not address these issues, Pew has and will continue to develop materials to describe policy options that focus on legal system, housing, and employment policies that do not complicate OUD treatment and recovery efforts.[24]

Policy Menu

States can select from many different policy approaches to improve service delivery, remove barriers to treatment access and retention, fund services, reduce racial inequities in care access and outcomes, and expand the treatment workforce. The following tables illustrate (1) policies targeting these specific issues, (2) mechanisms that can be used to enact them, and (3) examples of policies adopted in various states.

A. Reform treatment delivery systems

People with OUD often have a range of needs beyond care for their addiction, including treatment for co-occurring mental illness, general medical care, and access to social supports such as housing and employment. Some states are building delivery models that formalize the connections between these service systems and strengthen individual systems, all with the intent of improving patients' prospects for recovery. Medicaid, as the largest payer of OUD care, has been a leader in implementing many of these system reforms.

1. **The nurse care manager model** helps primary care practices offer care management services to people with OUD.[25] Physicians prescribe buprenorphine to patients, but nurse care managers are their main point of contact, offering other medical care and connecting them to mental health and social service supports.

Option 1	Policy Lever(s)	State Example
Nurse care manager (NCM) model	**Medicaid:** State plan amendment to launch a Medicaid health home or targeted case management option to fund nurse care managers as part of an interdisciplinary team. **State agency action:** Funding for technical assistance (TA). **Legislative action:** Appropriations for TA and program startup funds; require coverage of nurse care manager model under commercial insurance and Medicaid.	The NCM model is used in most of **Massachusetts'** federally qualified health centers (FQHCs), with TA and training paid for by the Dept. of Public Health.[26] MA Medicaid allows FQHC nurse care managers to bill their patients' medical care visits at the same rate as physicians, greatly helping to cover nurse staffing costs.

2. **The hub and spoke model** features specialty addiction clinics (often OTPs) as central "hubs" to treat patients with severe or complex opioid addictions.[27] Hubs are connected to "spokes"—primary care providers, OB/GYN offices, community health centers, and other settings that can prescribe buprenorphine for people with mild to moderate OUD. This model encourages providers to take on patients they may have previously felt had conditions that were too complex and refer them to the hub for more specialized care. As of 2021, the hub and spoke model has been implemented in 27 states throughout the country.[28]

Option 2	Policy Lever(s)	State Example
Hub and spoke model	**Medicaid:** 1115 waiver, state plan amendment (SPA). **State agency action:** Use state opioid response grants (SOR), other Substance Abuse and Mental Health Services Administration (SAMHSA) block grants; state opioid litigation funds to fund model. **Legislative action:** Appropriate funds for this model; state agencies implement funds by directive.	This model originally launched in **Vermont** in 2013 using a Medicaid health home SPA.[29] The SPA added nursing, psychiatry, and care management services to hubs and nursing and addiction counseling staff to spokes. In 2014, the program expanded statewide.[30]

3. **Medicaid opioid health homes (health home option)** allow Medicaid to pay for comprehensive care management that includes care coordination, patient and family support, and social support services referrals.[31] States receive an increased federal Medicaid matching rate of 90% during the first two years of the program.[32] Normally, federal matching rates for fiscal 2024 range from 50% to 77%.[33] Maine, Maryland, Michigan, Rhode Island, Vermont, and Wisconsin have adopted Medicaid opioid health homes.[34]

Option 3	Policy Lever(s)	State Example
Medicaid opioid health homes	**Medicaid:** SPA to implement health homes. **Legislative action:** Appropriate money and direct Medicaid agency to implement an opioid health home.	In 2017, **Maine's** Medicaid program received $3M in state funding to create an opioid health home.[35] Medicaid enrollees with OUD who have—or are at risk for—an additional chronic condition qualify. The model features a clinical team lead, buprenorphine prescriber, clinical counselor, nurse care manager, patient navigator, and a peer recovery coach.[36] As of June 2022, opioid health homes were operating in over 90 locations in 14 of Maine's 16 counties.[37]

4. **Certified community behavioral health clinics (CCBHCs),** a relatively new model developed by SAMHSA, offer coordinated comprehensive mental health and substance use care regardless of one's ability to pay.[38] These clinics must get people into care quickly and offer core services including 24/7 crisis services; screening for mental health, addiction, and primary care needs; access to outpatient and family support services; and care coordination with medical and social services. The CMS has approved waivers for 10 states to implement a prospective payment system for CCBHCs at an enhanced rate that sets a uniform bundled payment for each patient encounter regardless of duration or intensity.[39] And in March 2023, SAMHSA released another round of $1 million planning grants to each of 15 states. These grants will let states develop a Medicaid prospective payment system and a CCBHC certification system, as well as help

them apply for a four-year federal Medicaid CCBHC demonstration grant.[40] There are currently more than 500 CCBHCs operating in 46 states; Washington, D.C.; Puerto Rico; and Guam.[41]

Option 4	Policy Lever(s)	State Example
CCBHCs	**Medicaid:** States can use 1115 waivers and SPAs to implement Medicaid's enhanced payment rates for CCBHCs. **State agency action:** In March 2023, SAMHSA announced $1 million in CCBHC planning grants to each of 15 states. Grants were awarded to state Medicaid, mental health, or single state agencies (responsible for managing federal SUD funds).[42] **Legislative action:** Several states passed laws to establish CCBHCs and have directed their state Medicaid agencies to apply to CMS for enhanced funding for the model.	**West Virginia** passed legislation to establish the CCBHC model via a Medicaid SPA and align its CCBHC standards to federal standards set out in 2014's Protecting Access to Medicare Act.[43]

5. **Hospital emergency departments (EDs)** can offer buprenorphine and coordinate to have primary care providers continue care.[44] EDs are often the only source of health care for many people with OUD and thus a critical location for delivering buprenorphine.[45] Yet despite evidence that this model improves health outcomes, few EDs offer these services, which require (among other efforts) intentional changes to ED staffing and strengthening of connections with community providers for follow-up care.[46]

Option 5	Policy Lever(s)	State Example
Hospital EDs	**Medicaid:** Establish rate structures to pay for program staff and services either through fee-for-service programs or managed care contracts. **State agency action:** SOR grants, opioid settlement funds, or other discretionary grants to train providers, fund peer navigators, issue guidance, promulgate regulations, and other activities. Health departments can develop standards for treating OUD in hospital EDs.[47] **Legislative action:** Appropriate funding with directives to state agencies to implement, provide oversight, and report back to legislature.	The **California** Bridge program offers immediate access to buprenorphine in EDs and connects to follow-up care in the community.[48] In 2020, the state appropriated $20 million to pilot the program in 206 hospitals. In 2022, the state appropriated an additional $40 million to launch the CA Bridge Navigator Program with the goal of enabling all 330 hospital emergency departments to provide 24/7 care.[49]

B. Remove barriers to buprenorphine access

In 2021, only 22% of people with OUD received any medications for their condition.[50] Societal stigma toward people who use drugs and reports of racial discrimination in medical settings are factors that contribute to this statistic.[51] But state rules also play a role in slowing access to buprenorphine when patients seek it, despite research that shows that delays in starting medication increase the likelihood of death.[52] Regulations in many states—such as required prior authorization from health insurers before a provider can prescribe, mandates for initial intake assessments before prescribing, and prohibitions on in-office initiation of medication—have been criticized as unnecessary and blocking patients from immediately receiving buprenorphine.[53] Additionally, Congress' intent in passing the MAT Act was to allow states to eliminate obstacles to prescribing, such as those

put in place by the "X waiver"—established by a 2000 law requiring providers to obtain separate registration and buprenorphine-specific training, and that capped the number of patients a provider can treat. But it's noteworthy that the MAT Act does not mandate that states adopt these changes, thus the new law does not supersede any state rules that remain pertaining to these three domains.[54] These state rules can be removed without imperiling patient safety.[55]

In addition to removing unnecessary regulations, states can actively promote models of care to offer immediate access to buprenorphine when a patient wants treatment (known as low-threshold treatment), without additional conditions.[56] States can launch these models in a variety of settings, including typical health care locations such as primary care offices, clinics, and hospitals, as well as alternative locations such as syringe services programs—which provide clean needles for people who inject drugs—homeless shelters, and fire departments.

Policy options to expedite buprenorphine treatment include:

1. Remove regulations that prevent immediate access

<table>
<tr><th>Policy Options</th><th>Policy Lever(s)</th><th>State Example</th></tr>
<tr><td>Remove prior authorization: Require Medicaid/commercial health insurance to cover at least one FDA-approved medication for OUD without prior authorization and remove such requirements for initial buprenorphine prescriptions.</td><td rowspan="4">Medicaid: Medicaid can remove prior authorization and initial intake assessment requirements for Medicaid enrollees and allow (and offer an enhanced reimbursement rate) at-home induction through contracting language with MCOs, Medicaid regulatory changes, an SPA, or 1115 waiver.

State agencies: Use federal block grants, opioid settlement dollars, or state discretionary grants to increase funding for programs that offer same-day medication initiation as well as help develop a network of low-threshold programs in a variety of settings. Adopt guidelines released by the American Society of Addiction Medicine (ASAM) on proper at-home induction of buprenorphine.[57]

Legislative action: Legislatures can restrict use of prior authorization, remove intake assessment requirements, allow at-home inductions, and remove state rules/laws that require additional steps to prescribe buprenorphine beyond federal requirements.

Executive order: The governor can: (1) direct the health insurance commissioner to identify and address any Mental Health Parity Act violations related to coverage of addiction treatment, such as prior authorization requirements that apply only to medications for opioid use disorder; (2) direct state health agency to draft clinical guidelines to increase access to treatment, including at-home induction of buprenorphine.

Also, state medical boards can issue clinical guidelines for at-home induction.</td><td>The New York Legislature passed a law requiring every health insurance plan that provides medical and other similar coverage to immediately cover buprenorphine, methadone, or long-acting injectable naltrexone without prior authorization for the treatment of a SUD.[58] Twenty-one states and D.C. have enacted similar laws.[59]</td></tr>
<tr><td>Allow buprenorphine to be prescribed prior to a comprehensive physical/mental health/environmental assessment.[60]</td><td>Missouri's Department of Mental Health amended its billing requirements to allow providers up to 30 days to complete a comprehensive substance use intake assessment after prescribing buprenorphine.[61]</td></tr>
<tr><td>Remove state-level restrictions similar to federal X waiver: Remove any language in rules or laws that requires a separate registration/license to prescribe buprenorphine, places patient caps on prescribing, or mandates additional training requirements specific to prescribing buprenorphine, to align with the MAT Act.[62]</td><td>The MAT Act passed Congress in December 2022. There are currently no state examples to share due to this recent change.</td></tr>
<tr><td>Allow for at-home induction of buprenorphine.</td><td>The Rhode Island Health Department and Department of Behavioral Healthcare funds a 24/7 buprenorphine hotline where people with OUD can receive a telehealth assessment and a prescription for buprenorphine for at-home induction (if appropriate) and can coordinate ongoing care with an outpatient provider.[63]</td></tr>
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2. Help community-based organizations, harm reduction providers, and other low-barrier treatment providers initiate buprenorphine.

Policy Options	Policy Lever(s)	State Example
Help other community providers initiate buprenorphine	**Medicaid:** 1) Examine credentialing or contracting policies that hinder Medicaid participation of community-based organizations, harm reduction providers, and low-barrier treatment providers, 2) provide TA to providers interested in accepting Medicaid, 3) reimburse for consultations with expert health care providers, 4) ensure that managed care contracts include adequate reimbursement and network adequacy standards and establish MOUs with these organizations and providers.[64] **State agency actions:** (1) Offer training and TA to community-based/faith-based groups and harm reduction providers to initiate buprenorphine (with staff either on-site or on contract), (2) examine state policies that may create barriers for contracting, credentialing, and reimbursing these settings to initiate buprenorphine, (3) pay buprenorphine providers to work on-site in these locations, as well as shelters, FQHCs, and rural medical practices. **Legislative action:** Use oversight authority or pass a law to require agencies to review and remove any policies that hinder Medicaid participation by community-based organizations, harm reduction providers, and other low-barrier treatment providers. Fund TA for first-time Medicaid providers.	**New Jersey's** Department of Human Services funded syringe service programs to offer buprenorphine via an at-home induction model.[65]

C. Promote treatment retention

The National Institute on Drug Abuse (NIDA) notes that with buprenorphine, many providers recommend staying on the medication for at least one year, and NIDA states that some patients with OUD may benefit from being on it indefinitely.[66] Yet treatment retention rates are found to be highly variable, with one recent study showing that only 20% of patients who start buprenorphine remain on it more than six months.[67] A number of rules at the state level can stand in the way of patients receiving ongoing access to medication—or to a sufficient dose of medication—while in treatment.[68] For instance, research finds that medication alone lowers OUD overdose death rates and improves treatment retention.[69] Expert bodies such as the National Academy of Sciences and the American Society of Addiction Medicine (ASAM) say that counseling should not be required as a condition of receiving these medications.[70] Yet a federal government report found that as of 2018, 16 states required counseling as a condition of receiving buprenorphine.[71]

Also, experts increasingly recognize that patients using medications for OUD who are also using other drugs can still benefit from these lifesaving medications. For example, ASAM recently updated its practice guidelines to state, "The use of cannabis, stimulants, alcohol, and/or other addictive drugs should not be a reason to withhold or suspend opioid use disorder treatment."[72] Yet programs in some states terminate OUD treatment when patients are using other substances.[73] Finally, some state Medicaid programs limit the time a patient can remain on buprenorphine, running counter to evidence-based guidance that some patients may need long-term treatment.[74] And many state Medicaid agencies impose maximum daily dosage limits on buprenorphine, despite expert guidance that dosages should be flexible to meet a patient's needs.[75]

Policy options to promote treatment retention include:

Policy Options	Policy Lever(s)	State Example
Eliminate counseling requirement	**Medicaid:** (1) Remove counseling from bundled payments for buprenorphine, (2) Remove non-evidence-based rules regarding buprenorphine access, duration, and dosing from fee-for-service and managed care plans.	**Missouri's** Department of Mental Health developed the Medication First treatment approach, which prohibits publicly funded substance use treatment programs from requiring counseling as a condition of receiving buprenorphine.[76]
Prohibit patient discharge for other substance use	**State agency action:** Pertinent agencies (including medical boards) can: (1) review regulations and remove requirements placing unnecessary conditions on continued treatment, (2) issue written guidance or otherwise communicate with prescribers/ program administrators about rule change. **Legislative action:** Establish laws that call on pertinent state agencies to remove non-evidence-based rules on buprenorphine access, dosage, and duration.	The **North Carolina** Department of Health and Human Services in 2019 published guidance specifying that prescribers should not discharge patients or discontinue buprenorphine products solely based on polysubstance use.[77]
Stop time-limiting buprenorphine		**Tennessee's** Department of Health and Department of Mental Health and Substance Abuse Services updated the state's buprenorphine treatment guidelines to state that "similar to other disease states, tapering from the treatment medication shall only occur when clinically appropriate and in agreement with the patient."[78]
Remove maximum daily dosage levels of 24 milligrams to allow clinicians dosage flexibility		**Washington** permits providers to prescribe buprenorphine at up to 32 milligrams per day, allowing for higher doses with prior authorization.[79]

D. Create sustainable financing

Financing for state SUD treatment systems comes from a mix of Medicaid, Medicare, private insurance, federal block grants, and other discretionary funds and state allotments. Medicaid is by far the largest—and, as an entitlement program, the most stable—source of funding. In 2019, Medicaid spent an estimated $23 billion in federal and state dollars on opioid-related services alone, with the federal contribution representing more than half.[80] Federal discretionary grant funding for OUD from a variety of agencies came in at just under $10 billion in 2019, with the largest amount from SAMHSA in the form of the Substance Use Prevention and Treatment Services block grant and from SOR grants (funded at $2 billion and $1.4 billion, respectively, in fiscal 2023).[81] State allotments from opioid legal settlements and judgments are a recent addition and estimated to provide more than $50 billion to states and localities over a period of years.[82] Because grant funding is not as reliable as entitlement funding, some states are trying to sustain treatment systems for the long term by leveraging Medicaid to pay for direct treatment services and using grants to supplement what Medicaid typically does not pay for, such as infrastructure costs for building upgrades, mobile units, electronic administrative systems, and workforce training. There are numerous ways to do this, including using Medicaid to: (1) cover a wider range of prevention, treatment, harm reduction, and recovery support services, (2) reimburse a wider range of providers, including peer recovery specialists, and (3) reimburse for telehealth services to increase access to—and retention in—treatment. In addition, as Medicaid reimbursements have been traditionally lower than that of Medicare and commercial insurance, some states are raising Medicaid reimbursement for OUD-related services to ensure an adequate provider network.[83]

Policy options to create sustainable funding include:

Option 1	Policy Lever(s)	State Example
Set a competitive Medicaid reimbursement rate	**Medicaid:** Amend fee-for-service payment rates and/or require MCOs to increase rates by a certain percentage or to create a minimum floor rate. For instance, in recent 1115 waiver approvals, CMS has required states to increase Medicaid provider payment rates for primary care, behavioral health, and obstetrics care to at least 80% of the Medicare fee-for-service rate.[84] **Legislative action:** Pass laws to fund a Medicaid payment rate increase.	**Virginia's** Addiction and Recovery Treatment Services reform, which involved initial legislation and subsequent Medicaid policy reforms, established enhanced SUD treatment rates on par with commercial payers.[85] Higher rates helped in part to increase the number of providers offering and patients receiving buprenorphine. Research found that the program led to a 21% relative decrease in hospital emergency department visits and decreases in inpatient hospitalizations for people with OUD.[86]

Option 2	Policy Lever(s)	State Example
Reimburse for more prevention, treatment, recovery services in Medicaid	**Medicaid:** Use SPAs to fund optional services such as care management (targeted case management option), recovery support services (rehabilitation services option), and family support services for people with co-occurring mental illness (health home option).	See **Vermont** hub and spoke program (section A2) funded with health home SPA.

Option 3	Policy Lever(s)	State Example
Reorganize OUD delivery systems and expand eligibility for OUD services	**Medicaid:** Apply for Medicaid temporary waivers: 1915b waiver for SUD treatment systems through managed care; 1115 waiver to experiment with new OUD delivery systems and expanded eligibility.	**Virginia's** 1115 waiver demonstration included the expansion of SUD treatment benefits to cover a comprehensive care menu based on ASAM criteria.

Option 4	Policy Lever(s)	State Example
Reimburse buprenorphine providers for telehealth services at the same rate as in-person services[88]	**Medicaid:** Change rules and managed care contract language to ensure competitive reimbursement for telehealth. **Legislative action:** Pass laws to ensure that telehealth services payment is comparable to that of in-person services in public and private health plans.	In 2021, **Arizona** enacted legislation that all health plans "must provide coverage for health care services that are provided through telehealth" at the same reimbursement level as in-person services.[89] The law also requires reimbursing providers for "behavioral health and substance use disorder services ... if provided through telehealth using an audio-only format."

Option 5	Policy Lever(s)	State Example
Use non-Medicaid funds to support SUD treatment infrastructure, training	**State agency action:** Use SAMHSA grant dollars to fund mobile SUD treatment vans that offer buprenorphine and train providers on medications for OUD. **Legislative action:** Establish a structure and the priorities for distributing opioid settlement funds.	In 2022, the **New Jersey** Department of Human Services used SAMHSA grant dollars to fund two organizations to provide mobile SUD vans.[90] **Missouri's** Department of Mental Health Medication First program used SAMHSA grant funds to train SUD providers on the value of medications for opioid use disorder as well as immediate access to them.[91] The **Michigan** Legislature created an opioid settlement structure in 2022 that directs the Department of Health and Human Services to use settlement funds to expand SUD treatment capacity by funding workforce training and infrastructure grants.[92]

E. Reduce racial inequities in buprenorphine access and provide culturally responsive and accessible care to all

Although OUD rates are fairly comparable between Whites, Blacks, and Hispanics, research finds that buprenorphine providers are less likely to be located in communities of color, that Black and Hispanic people are significantly less likely to receive buprenorphine than Whites, and that Black and Hispanic people who fatally overdosed were significantly less likely than Whites to have previously received SUD treatment.[93] Experts investigating these trends among Black people suggest numerous factors at play, including fear of reaching out for care given the greater likelihood of arrest for using illicit drugs, lack of culturally responsive or respectful care, and medical racism among providers toward Black people that has a negative effect on seeking care.[94]

Meanwhile, the Tribal Nations/Indigenous peoples population has the highest OUD rate among all racial/ethnic populations in the U.S.—more than twice the rate of White people.[95] National data on treatment access and utilization is difficult to ascertain for Tribal Nations/Indigenous peoples, although some research suggests that this population is less likely than other racial/ethnic groups to be offered buprenorphine or methadone for maintenance to support recovery.[96] Drug overdose fatalities—largely driven by opioids—are higher, and rising faster, among Black and Tribal Nation/Indigenous populations than among White and Hispanic people.[97] Some research focused on OUD rates among Tribal Nations points to long-standing underlying social factors including racism, trauma associated with the legacy of genocide and colonization, and chronic federal underfunding of the Indian Health Service, which results in poor access to treatment.[98] Efforts to improve access to quality treatment for Tribal Nations span a broader set of funding streams that include the Indian Health Service and targeted federal grant programs from SAMHSA and the Centers for Disease Control and Prevention.[99] And experts exploring treatment programs for this population emphasize that effective strategies integrate Indigenous cultural and spiritual healing practices.[100]

In addition, there are documented disparities in SUD treatment access for people with physical and/or cognitive disabilities. People with disabilities are more likely to have a co-occurring SUD and less likely to use treatment than their nondisabled peers.[101] Despite the 1990 Americans with Disabilities Act, which mandated that public and private health care providers (including SUD treatment providers) make reasonable accommodations to serve people with disabilities, research finds that access barriers exist within many SUD treatment facilities.[102]

The following are options for increasing the number of buprenorphine providers in communities of color, reducing racial disparities in access to care, and working to ensure that providers in every community are educated to provide care that is respectful and responsive to the range of cultures represented in their patient pool. For more information on how providers can make these accommodations and how states can help them, SAMHSA has published a comprehensive document titled "Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities."[103]

1. Encourage existing providers to offer buprenorphine to low-income communities and reduce racial disparities
    - **1.2 Increase buprenorphine availability in FQHCs:** FQHCs provide care to low-income people in more than 14,000 locations nationally; 62% of FQHC patients are members of racial/ethnic minority groups.[104] Yet in 2019, 36% of FQHCs did not offer medications for opioid use disorder.[105]

Option 1.2	Policy Lever(s)	State Example
Increase buprenorphine availability in FQHCs	**Medicaid:** 1115 waivers, Medicaid targeted case management option implemented through an SPA. **Legislative action:** Appropriate money for TA to FQHCs to implement medication programs for people with OUD. **State agency action:** Fund TA to FQHC staff to implement medication programs for people with OUD with discretionary funds such as SOR, opioid settlement, and other state sources.	See A1, nurse care manager model, Massachusetts

    - **1.3 Develop CCBHC infrastructure to reduce racial disparities in treatment** (See Section A4 for policy levers and state example)
    - **1.4. Raise Medicaid reimbursement rates** (See Section D1 for policy levers and state example)
    - **1.5. Engage nontraditional providers** (See Section B2 for policy levers and state example)
2. Require all Medicaid providers to offer culturally and linguistically effective care

Option 2	Policy Lever(s)	State Example
Require Medicaid providers to offer culturally and linguistically effective care	**Medicaid:** Include requirements in managed care contracts that focus on racial equity, establish provider standards for culturally and linguistically effective care, and enforce those standards. (Since 2016, state Medicaid agencies that contract with MCOs are required to develop and post quality strategies that include plans to reduce health care disparities.) Establish health disparity outcome measures as a basis for incentive payments in Medicaid managed care.	**Pennsylvania's** Medicaid program requires its managed care plans to achieve or be working toward the National Committee for Quality Assurance Distinction in Multicultural Health Care.[106] Such plans demonstrate that they disaggregate patient data by race, ethnicity, and language and provide culturally and linguistically appropriate services; provide services in languages that patients use; collect race/ethnicity data of plan providers; and implement strategies to improve health disparities.

3. Implement value-based purchasing bonuses in Medicaid that reward reducing racial disparities in treatment access and retention

Option 3	Policy Lever(s)	State Example
Implement value-based purchasing bonuses in Medicaid that reward reducing racial disparities in treatment access and retention	**Medicaid:** Implement value-based purchasing bonuses in Medicaid that reward reducing racial disparities in accessing and staying in treatment. These can be included in Medicaid managed care contract language or in Medicaid ACO standards in states that use ACOs. **Legislative action:** Increase funding to Medicaid for financial incentives to close disparities.	**Minnesota's** ACOs, called integrated health partnerships (IHPs), are demonstration programs that serve people on Medicaid and state public insurance.[107] IHPs were launched by the state Legislature and funded with a federal Medicaid innovation grant. ACOs must propose at least one health equity performance measure tied to interventions to reduce health disparities among target populations (e.g., those with food insecurity or experiencing homelessness, people with OUD). ACOs receive additional payments if they meet these benchmarks. One IHP has created implementation benchmarks to care for those with OUD, including having care coordinators identify and create treatment plans for high-risk patients and develop community mental health and SUD treatment resource lists.[108] Although Minnesota's target populations do not focus specifically on race/ethnicity, this model can be used to develop measures to reduce disparities in care access and outcomes for a range of minority populations.

4. Diversify the provider workforce
   - **4.1 Recruit students of color into the behavioral health professions**

Option 4.1	Policy Lever(s)	State Example
Recruit students of color into the behavioral health professions	**State agency action:** Use discretionary grant programs to incentivize people of color to enter behavioral health professions through scholarships, mentoring programs, and other activities. **Legislative action:** Appropriate funds for grant programs to create scholarships for people of color to pursue a behavioral health credential, call on appropriate state agencies to develop a plan for incentivizing people of color to enter behavioral health professions.	In 2020 the **Massachusetts** Legislature appropriated $250,000 to the Department of Higher Education and the Department of Mental Health to create a mental health workforce pipeline program to diversify the behavioral health workforce through collaboration between colleges and behavioral health providers.[109]

   - **4.2 Create financial incentives to recruit and retain a diverse workforce**

Option 4.2	Policy Lever(s)	State Example
Create financial incentives to recruit and retain a diverse workforce	**Medicaid:** Through MCOs or ACOs, create financial rewards for systems that meet benchmarks for diversity in their behavioral health provider population. **Legislative action:** Pass legislation calling on Medicaid to establish and enforce benchmarks for racial/ethnic diversity in their behavioral health provider population.	In 2021, the **Oregon** Legislature passed a law requiring the Medicaid agency to develop strategies to recruit and retain people of color, Native Americans, and rural residents in behavioral health professions.[110] The law includes $60 million for incentives such as signing and retention bonuses, tuition assistance, and loan forgiveness.

For more policy levers and state examples, see "State Strategies to Increase Diversity in the Behavioral Health Workforce" by the National Academy for State Health Policy.[111]

E. Expand the provider workforce

Workforce shortages of SUD treatment providers—including psychiatrists, primary care providers, and counselors specializing in SUD treatment—have been widely reported across the states, fueled in part by low reimbursement rates and staff burnout.[112] Along with the need to encourage more physicians, NPs, and PAs to prescribe buprenorphine, it's important to ensure that there is an adequate workforce to offer a package of services for patients on this medication, including behavioral health counseling and links to housing, transportation, and other needed social services to support recovery. And increasingly, peer recovery specialists—paid employees who themselves are in recovery and provide social, emotional, and practical support to people in treatment—are an important component of many care teams. Some studies show promising results in peers' ability to connect and help retain people in treatment.[113] Although credentialing requirements vary by state, peers typically have some level of formal training. Finally, along the lines of ensuring an adequate behavioral health workforce to address SUD, some states restrict the types of behavioral health counselors who can bill for SUD counseling or restrict the provision of SUD counseling to licensed specialty clinics, both of which create hurdles to primary care facilities that want to integrate counseling into their programming. In addition to the options listed below, states should review their licensing and reimbursement policies with an eye toward removing obstacles to primary care sites providing SUD counseling.[114]

Policy options to increase the SUD-related workforce include:

1. **Allowing licensed providers to work across state lines.** When the federal government declared a public health emergency for the COVID-19 pandemic, many states temporarily relaxed licensing laws and allowed providers to offer telehealth services across state lines.[115] But these allowances have been uneven across types of providers, and recently, a number of states have revoked their temporary reciprocity laws as the pandemic has eased.[115] In addition, state licensing boards for various behavioral health professions can join interstate compacts that allow practice across state lines.

Option 1	Policy Lever(s)	State Example
Allow licensed providers to work across state lines	**State agency action:** Provider licensing agencies can allow reciprocity to providers from other states that meet state licensing criteria. **Legislative action:** Pass licensing reciprocity laws for behavioral health work force.	As of 2022, **17 states** have joined an interstate counseling compact allowing licensed counselors credentialed in one state to practice in other states that have joined the compact.[116]

2. **Reimbursing for telehealth visits at the same rate as in-person visits.**
    - Policy lever: see D4
    - State example: see D4
3. **Creating competitive reimbursement for buprenorphine prescribers and other SUD treatment providers.**
    - Policy lever: see D1
    - State example: see D1

4. **Training and reimbursing for peers in medication treatment programs**

Option 4	Policy Lever(s)	State Example
Train and reimburse peers in medication treatment programs	**Medicaid:** (1) Require through managed care contract language or 1115 waiver criteria that programs offering medications for OUD formally collaborate with recovery service providers (e.g., peers and recovery community-based organizations) where available, (2) incorporate peers into any bundled reimbursement rates that apply to buprenorphine providers. **State agency action:** (1) Change rules to allow providers to use care teams that reflect the workforce available in their community, (2) develop training/career ladder programs for career recovery specialists. **Legislative action:** Appropriate money to recruit, train, support, and adequately reimburse a peer workforce.	**Tennessee's** Buprenorphine Enhanced Medication Assisted Recovery and Treatment (BESMART) program, run by Medicaid, provides enhanced benefits to practitioners offering buprenorphine. And along with enhanced benefits and clinical care and coordination support, providers contracting with Medicaid MCOs as part of BESMART must employ, contract, or partner with certified peer recovery specialists to offer patient education, treatment engagement, and recovery planning.[117]

5. **Identifying and reforming rules related to specialty SUD providers that impede offering behavioral health counseling in primary care settings**

Policy Option 5	Policy Lever(s)	State Example
Identify and reform rules related to specialty SUD providers that impede offering behavioral health counseling in primary care settings	**State agency action:** Review and assess rules concerning need for substance use facility license and/or specialty provider license with an eye toward removing obstacles to primary care sites and providers offering SUD-related counseling.	**New York** reformed licensing requirements for primary care providers to allow them to offer up to 49% of total annual visits without having to apply for an additional mental health license.[118]

Conclusion

The policy options and levers noted above describe efforts states are taking to make buprenorphine—a lifesaving medication for people with OUD—available in as many locations as possible. Dozens of state governments have champions leading these reforms across governors' offices, state legislatures, and executive agencies, each using the policy levers at their disposal as vehicles for change. State policymakers can use these options—guided by data informing treatment needs—to continue closing the treatment gap.

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