The Pew Charitable Trusts

Improved Opioid Treatment Programs Would Expand Access to Quality Care

State policymakers should prioritize patient-centered care, tailored services, and a choice of FDA-approved medications

Overview

Drug overdose deaths have skyrocketed during the COVID-19 pandemic. According to provisional data, there were more than 100,000 fatalities in the 12-month period ending June 2021—a 20.6% increase over the previous 12 months.[1]

To address this crisis, states should expand their treatment offerings and remove unnecessary regulations so that more people can access lifesaving treatment for opioid use disorder (OUD). Although medication is the most effective treatment for OUD, only a fraction of the people who need medication receive it: In 2020, just 11% of the 2.7 million people with OUD in the U.S. received medication for opioid use disorder (MOUD).[2]

Much attention has been given to expanding treatment using buprenorphine, one of the three FDA-approved medications for OUD, in primary care and other settings.[3] But less has been paid to opioid treatment programs (OTPs)—the only facilities where all forms of MOUD can be offered, and the only care setting where methadone is available.

Methadone was first approved for the treatment of OUD in the 1970s and for decades was the only FDA-approved medication to treat OUD.[4] Research conducted in the years since its approval has reinforced methadone's safety and effectiveness in reducing overdose deaths, illicit opioid use, and the transmission of infectious diseases such as hepatitis C and HIV—while improving retention in care compared with treatment without medication.[5]

Opioid treatment programs have been historically stigmatized and siloed from the rest of the health care system, despite providing effective treatment.[6] They were originally authorized by federal regulations in the 1970s during the Nixon administration's "war on drugs," with the primary goal of reducing crime in Black communities, including the use of illegal drugs and behaviors thought to be caused by drug use.[7] Unfortunately, these regulations, based on treatment programs serving predominantly Black clients, still include punitive rules that reflect a distrust of patients—such as observed daily dosing, regular urine drug screens, and limits on access to take-home medication—rather than encouraging a collaborative setting in which the provider and patient work in partnership.[8]

Further, OTPs are not evenly distributed across the country.[9] Counties with highly segregated Black and Hispanic/Latino communities have more OTPs per capita than other counties, while predominantly White communities have more buprenorphine providers than communities that are predominantly Black or Hispanic/Latino.[10] The result is that communities of color are disproportionately subjected to stringent treatment requirements, such as having to come in person to receive methadone doses—rules that can negatively affect the lives of OTP patients by requiring daily travel over long distances or trips to a clinic during times that may conflict with work schedules and child care responsibilities.[11] Because methadone is usually administered as a liquid, these rules are often referred to as "liquid handcuffs."[12]

Although the federal government sets minimum basic standards for regulating OTPs, states have the discretion to establish additional policies. According to the American Society of Addiction Medicine, these additional state rules often are not evidence-based[13]—meaning that even when people with OUD can access an OTP, they may have markedly different experiences in getting the medication they need or the related services they require, depending on where they access care. These differences across states can exacerbate racial disparities in treatment access and retention.

In order to promote high-quality, effective, and equitable addiction care, state officials should implement policies that ensure that OTPs are accessible, patient-centered, and integrated with medical and mental health care, and that they offer services tailored to their patient populations.

OTPs should be accessible to all patients in need

Patients with OUD should have access to the medication that works best for them as soon as they are ready to engage in treatment. For some, this means having a nearby OTP so that they can receive methadone. Yet, in many states, particularly in their rural areas, these services are out of reach.[14] For example, Wyoming has no OTPs, so people must go to another state to receive methadone.[15]

In other cases, access is hindered by state regulations that prevent or discourage new OTPs, such as prohibiting OTPs near schools, requiring new OTPs to obtain a certificate of need (a legal document demonstrating public need for new facility services), or requiring licensure by the state board of pharmacy, a level of oversight not required by the federal government.[16] West Virginia law even prohibits new clinics from opening at all.[17]

The flip side is represented by Indiana, which has set an example that states with restrictions that discourage new OTPs should follow: After lifting its moratorium on new OTPs in 2015, the Hoosier state is now actively working to open new sites so that no one is more than an hour's drive from a facility.[18]

In addition to opening new sites, OTPs can extend their reach by establishing medication units that can offer dosing and urine screens, but not drug counseling.[19] These sites can make treatment more convenient for patients

who receive dosing daily or multiple times a week by providing medication in additional locations. States can help OTPs open these sites by creating a regulatory pathway to do so. For example, Ohio regulations allow medication units in homeless shelters, jails, prisons, local boards of public health, community health centers, residential treatment providers, small counties, and counties in Appalachia.[20]

Mobile methadone is another way to provide dosing close to where people live or in sites where they otherwise could not access it. For example, in Atlantic City, New Jersey, a mobile methadone treatment unit provides care to people in the Atlantic County jail.[21]

Until recently, federal rules did not permit the establishment of any new mobile methadone units. However, the Drug Enforcement Administration in 2021 established new rules that will allow OTPs to add mobile services for the first time since 2007.[22] To help providers deliver this care where needed, states should revise any regulations that may serve as barriers to the establishment and use of mobile units, ensure that Medicaid will reimburse for mobile treatment, and provide financial resources to cover startup costs of mobile units.[23]

Some people also face financial barriers to accessing OTP services. Medicaid is the largest insurer for people with substance use disorders, with federal law requiring states to cover methadone and other medications for OUD through September 2025, unless the state certifies to the U.S. secretary of Health and Human Services that doing so is not feasible because of provider or facility shortages. Nonetheless, two states—Mississippi and South Dakota—have no OTPs that accept Medicaid.[24] States should cover methadone in their Medicaid programs without exception, and OTPs should accept this payment so that people with OUD do not have to choose between paying for necessary care and paying for other needs such as housing and transportation. Once methadone is covered, policymakers can act to increase OTP participation in Medicaid by ensuring that reimbursement rates are adequate—or even requiring facilities to accept Medicaid as a condition of licensure, as Massachusetts has done.[25]

OTPs should provide patient-centered care

People with OUD vary in their goals, how their body responds to medication, and what they need from treatment providers. But too often, OTP care takes a one-size-fits-all approach that offers a single medication at a dose too low to reduce opioid cravings, an assumed goal of abstinence from all illicit substances, and strict treatment rules that create high barriers to care by punishing noncompliance with discharge from care or requiring additional visits to the clinic to receive medication.[26]

Instead, OTPs should provide care that is guided by a patient's needs and preferences—and based on shared decision-making with the provider.[27] This patient-centered care should prioritize:

- A choice between all FDA-approved medications for OUD.
- Clinically effective doses.
- Low-barrier, flexible treatment that does not create restrictions beyond those stipulated by federal regulations.

A choice between FDA-approved medications

Given that patients have varying treatment needs and may respond to each medication differently, it is important that patients and providers have a choice of medications available at OTPs. But although nearly all OTPs provide methadone, the two other FDA-approved medications for OUD—buprenorphine and injectable extended-release naltrexone—are less readily available. Nearly a fifth of OTPs nationally did not offer buprenorphine in 2020, while just six states offer buprenorphine at all of their facilities.[28] In addition, only 39.5% of OTPs provide naltrexone.[29]

It is especially important to offer buprenorphine since research shows that, like methadone, it is effective at reducing fatal overdoses. Some patients with OUD prefer it to methadone because they feel it is less stigmatizing or has fewer side effects.[30]

Clinically effective doses

As with other medications, MOUD dosage matters. If the dose is too low, the patient will not experience reduced drug cravings and reduced drug use and may drop out of treatment.[31] One study found that more than 40% of methadone patients receive a dose that is, on average, too low to be effective—a problem found to be more common at programs that primarily serve Black patients.[32]

To address this issue, Pennsylvania requires OTP physicians to review dose levels at least twice a year[33]—providing clinicians and patients an opportunity to check in and adjust the dose if necessary.

Low-barrier, flexible treatment

Many states create additional restrictions on treatment beyond federal regulations, resulting in practices that are not evidence-based and make it harder for patients to remain in treatment. To address this problem, states should examine their OTP rules and ensure that they:

- **Prohibit OTPs from discharging patients from care for continued drug use.** Some programs terminate patients for continued drug use, a practice known as administrative discharge. However, research demonstrates that continuing MOUD is safer than suddenly stopping medication.[34] If a patient continues with substance use, federal guidelines recommend avoiding administrative discharge—and re-evaluating the treatment plan instead.[35]

- **Require urine drug screens no more than the federally mandated eight times per year, and do not require observed urine collection.** Although urine drug screenings can provide valuable clinical information about ongoing substance use, they can also be degrading, particularly when clinicians observe patients producing the sample.[36] Early data from a Bronx OTP that suspended urine drug screenings because of the COVID-19 pandemic also suggests that, contrary to a widely held belief, these tests are not necessary for patient safety. In a month and a half with no urine drug screenings, not one of the OTP's 3,600 patients had a fatal overdose.[37]

- **Do not require a government ID to receive treatment.** Making services contingent on having a government ID can pose a barrier to treatment for many people who face challenges obtaining such an ID, including undocumented immigrants, people experiencing homelessness, people recently released from prison, and transgender people whose ID may not match their gender.[38] OTPs can verify their patients' identities in other ways: For example, OTPs in California can provide patient identification cards that include the individual's photo, a unique identifier, and a physical description.[39]

- **Require OTPs to offer counseling based on a patient's needs and desires, rather than a set counseling schedule.** Federal guidelines require OTPs to "provide adequate substance abuse counseling to each patient as clinically necessary."[40] The amount of counseling needed and desired by individual patients will vary. Research shows that strict counseling requirements can reduce retention in treatment and that medication without counseling can be effective.[41] States should allow clinicians and patients to come to a shared decision about counseling, rather than dictating standard requirements.

- **Do not assume the goal of MOUD is to discontinue medication.** There is no scientific consensus that long-term use of MOUD is harmful. In fact, research shows that long-term treatment can lead to better outcomes in employment, health, and criminal justice involvement, while conversely there is a high overdose risk in the period immediately after discontinuing treatment.[42]

- **Do not impose additional barriers to receiving take-home doses.** Patients often must travel daily to the OTP to receive their medication. Take-home doses allow patients to consume their medication at their convenience, as with any other prescription medication, without having to go to the clinic each day—thus providing patients with more flexibility in balancing work, education, and child care needs.

  Federal take-home rules include limits on the number of take-home doses a patient may receive based on their time in treatment, with just a single take-home dose per week permitted during a patient's first 90 days of treatment if they meet specific "stability" criteria such as not using other substances or missing OTP appointments.[43] Some states prohibit clinics from providing even this limited autonomy in the first months of treatment.[44]

  But the federal government eased these requirements during the COVID-19 pandemic to allow people to continue treatment at a time of social distancing, and early research shows that methadone diversion during this period has been minimal.[45] However, not all OTPs took advantage of these relaxed rules.[46] To the extent permissible under federal law, states should enact these flexibilities, encourage their providers to offer them to patients, and remove all state-level regulatory barriers to receiving take-home doses, including those requiring patients to meet a definition of "stability" beyond what is in federal rules and those triggering automatic loss of take-home privileges because of a positive drug screen.

- **Allow patients flexibility as to when and where they receive their medication.** This includes requiring OTPs to be open on weekends and outside of regular business hours and creating rules around "guest dosing"—which allows patients to receive methadone from another OTP and continue to receive medication when they travel.

OTPs should provide integrated medical and mental health care

People with OUD often have other health problems. One study found that, after "drug overdose and disorder," the leading causes of death among people with OUD served by a large health system included cardiovascular disease, cancer, and infectious disease.[47] Patients need integrated care to address these health problems, yet OTPs are rarely physically integrated with or located near primary care providers. Although almost 2 in 3 community health centers now provide medication for OUD, only 7% of them are certified as OTPs to provide methadone.[48]

The COVID-19 pandemic has made integrated care more urgent than ever. Patients with OUD and other substance use disorders are more susceptible to COVID-19 than those without, in part because of high rates of other health conditions,[49] and they also face a greater risk of hospitalization and death than those without substance use disorder. The risk of hospitalization and death is even higher for Black COVID-19 patients with substance use disorder than for White COVID-19 patients with substance use disorder.[50]

OTPs should also provide mental health services on-site or work closely with mental health providers. From 2015 to 2017, 1 in 4 adults with OUD had, in the past year, a co-occurring serious mental health disorder—defined as a condition resulting in "serious functional impairment substantially interfering with or limiting one or more major life activities."[51] Yet fewer than half of OTPs (46%) in the U.S. provided mental health services in 2020 for their patients, and 26 states failed to offer mental health services at more than half of their OTPs in 2020.

To provide whole-person care, states and OTPs have a range of options. They can:

- **Establish fully integrated sites that provide both primary care and OTP services.** For example, VIP Community Services in the Bronx is both an OTP and a Federally Qualified Health Center (FQHC),[52] which is a type of provider that receives federal funds to provide primary care services in underserved areas. These providers often offer mental health services as well.

- **Place medication units in sites that offer primary care or behavioral health services.** For example, Ohio's medication unit regulations specifically cite FQHCs as allowed locations; in Iowa, UCS Healthcare has partnered with non-OTP substance use treatment facilities to open medication units on-site.[53]

- **Develop team-based care payment models in OTPs to incentivize integrated services without requiring facilities to have additional on-site services.** One way to do this is through a Medicaid health home, which allows states to reimburse providers for care coordination and health promotion services for Medicaid enrollees with complex health care needs, including those with an OUD.[54] Maine, Maryland, Michigan, Rhode Island, and Vermont have OTPs as health homes.[55]

Regardless of the pathway they choose, states should design these integrated services carefully to ensure that the services support the goals and desires of OTP patients, rather than create another one-size-fits-all system in which all patients are required to engage in primary care and mental health services to receive medication for OUD. For example, payment models should not incentivize providers to steer patients to services they don't want. This is especially important because people who use drugs often report having negative experiences with medical providers, such as being shamed for their drug use or receiving inappropriate treatment.[56]

To avoid these pitfalls, state policymakers should engage patients early in the process of designing integrated services to make sure that OTPs can offer integrated care to those who want it—and continue to focus on providing lifesaving medication to those who don't.

OTPs should offer services tailored to the populations they serve

Beyond medication, OTPs are required by federal rules to offer counseling, vocational, and educational services.[57] In planning these programs, OTPs should consider the unique needs of their population: Treatment environments can influence whether individuals remain in treatment, and seeing individuals who share a similar culture or experiences can help build trust and comfort, which is optimal for engagement.[58] However, as with integrated medical and mental health services, patients should not be required to participate in these services.

State officials should work with their OTPs to help them offer services that meet the needs of a variety of patients:

- **Pregnant people.** Rates of opioid misuse and OUD among pregnant people have risen since the early 2000s, which has contributed to adverse maternal and neonatal outcomes.[59] Although the pregnant/postpartum population may require specialized care, the percentage of OTPs that had a tailored program for pregnant/postpartum people in 2020 varied widely from state to state—and ranged from 0% in Nebraska and South Dakota to 100% in Alaska, Idaho, Mississippi, and Montana.

- **Veterans.** According to a discussion paper from the National Academy of Medicine, veterans are more likely than the general population to have risk factors for OUD and overdose.[60] They also face specific treatment challenges such as high rates of post-traumatic stress disorder.[61] However, less than a quarter of OTPs nationwide offer veteran-specific services.

- **LGBTQ clients.** According to a national survey, people who describe themselves as lesbian, gay, or bisexual were more likely to have misused opioids in 2019 compared with the general population.[62] Research suggests that specialized treatment that addresses homophobia and other concerns unique to this population can improve substance use treatment outcomes.[63] Still, four states (Hawaii, Idaho, Louisiana, and South Dakota) have no OTPs with LGBTQ-specific services.
- **Adolescents.** According to the American Academy of Pediatrics, MOUD is appropriate for adolescents with OUD.[64] These young people also benefit from tailored services involving their families in treatment. Yet only 4.7% of OTPs nationwide offer adolescent-specific programming,[65] perhaps at least in part because federal Health and Human Services regulations prohibit OTPs from serving patients under 18 unless they "have had two documented unsuccessful attempts at short-term detoxification or drug-free [nonmedication] treatment within a 12-month period."[66]

And although OTPs should also provide culturally sensitive care that respects patients' beliefs, languages, and communication needs, many do not provide services in languages other than English. Although fewer people in Montana speak a language other than English compared with Nebraska, North Dakota, and South Dakota, in 2020 all Montana OTPs provided services in multiple languages while in North Dakota only one did, and in Nebraska and South Dakota none did.[67]

On the other hand, Massachusetts has made culturally and linguistically appropriate services a focus of its substance use treatment system through ongoing provider training, investing in a diverse workforce, and helping providers strategize on how to effectively manage their budgets while engaging the communities they serve.[68]

Conclusion

OTPs' treatment and services vary widely across the country, and there are many opportunities to expand their reach and improve the quality of services they provide. State policymakers should work to implement these changes to ensure access to quality, patient-centered care for all of their residents.

Endnotes

1   F. Ahmad, L. Rossen, and P. Sutton, "Provisional Drug Overdose Death Counts," National Center for Health Statistics, accessed Nov. 6, 2020, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

2   Substance Abuse and Mental Health Services Administration, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health" (2021), https://www.samhsa.gov/data/sites/default/files/reports/ rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf.

3   The Pew Charitable Trusts, "Policies Should Promote Access to Buprenorphine for Opioid Use Disorder" (2021), https://www.pewtrusts. org/en/research-and-analysis/issue-briefs/2021/05/policies-should-promote-access-to-buprenorphine-for-opioid-use-disorder.

4   Federal Register: 37 Fed. Reg. 26701 (Dec. 15, 1972). 37, https://www.loc.gov/item/fr037242/; Substance Abuse and Mental Health Services Administration, "Advisory: An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence" (2012), https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4682.pdf; Substance Abuse and Mental Health Services Administration, "Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families" (2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006.pdf.

5   R.P. Mattick et al., "Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence," *Cochrane Database of Systematic Reviews,* no. 2 (2014), https://doi.org//10.1002/14651858.CD002207.pub4; R.P. Schwartz et al., "Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995-2009," *American Journal of Public Health* 103, no. 5 (2013): 917-22, https:// www.ncbi.nlm.nih.gov/pubmed/23488511; C. Timko et al., "Retention in Medication-Assisted Treatment for Opiate Dependence: A Systematic Review," *Journal of Addictive Diseases* 35, no. 1 (2016): 22-35, https://pubmed.ncbi.nlm.nih.gov/26467975; J.I. Tsui et al., "Association of Opioid Agonist Therapy With Lower Incidence of Hepatitis C Virus Infection in Young Adult Injection Drug Users," *JAMA Internal Medicine* 174, no. 12 (2014): 1974-81, https://www.ncbi.nlm.nih.gov/pubmed/25347412.

6   M. Herman and M.N. Gourevitch, "Integrating Primary Care and Methadone Maintenance Treatment: Implementation Issues," *J Addict Dis* 16, no. 1 (1997): 91-102; National Academies of Sciences, Engineering, and Medicine, "Medications for Opioid Use Disorder Save Lives" (2019), https://doi.org/10.17226/25310.

7   Institute of Medicine Committee on Federal Regulation of Methadone Treatment, "Federal Regulation of Methadone Treatment," in *Federal Regulation of Methadone Treatment,* eds. R.A. Rettig and A. Yarmolinksy (Washington, D.C.: National Academies Press, 1995), https://www.ncbi.nlm.nih.gov/books/NBK232105/; W.C. Goedel et al., "Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States," *JAMA Network Open* 3, no. 4 (2020): e203711-e11, https://doi. org/10.1001/jamanetworkopen.2020.3711; M. Raz, "Treating Addiction or Reducing Crime? Methadone Maintenance and Drug Policy Under the Nixon Administration," *Journal of Policy History* 29, no. 1 (2017): 58-86, https://www.cambridge.org/core/journals/journal-of-policy-history/article/abs/treating-addiction-or-reducing-crime-methadone-maintenance-and-drug-policy-under-the-nixon-administrati on/5C7779395D4B4AC7ECAB77F5D91BA455.

8   A. Pattani, "Syringe Exchanges Deemed 'Life-Sustaining' During Pa. Coronavirus Shutdown, Raising Hopes for Eventual Legalization," The Philadelphia Inquirer, March 30, 2020, https://www.inquirer.com/news/pennsylvania/spl/pennsylvania-coronavirus-syringe-exchange-life-sustaining-legalization-20200330.html; D.C. Des Jarlais et al., "Regulating Controversial Programs for Unpopular People: Methadone Maintenance and Syringe Exchange Programs," *American Journal of Public Health* 85, no. 11 (1995): 1577-84, https://pubmed.ncbi.nlm.nih. gov/7485676; V.P. Dole and M.E. Nyswander, "Methadone Maintenance Treatment: A Ten-Year Perspective," *JAMA* 235, no. 19 (1976): 2117-19, https://doi.org/10.1001/jama.1976.03260450029025; D. Frank et al., "'It's Like Liquid Handcuffs': The Effects of Take-Home Dosing Policies on Methadone Maintenance Treatment (MMT) Patients' Lives," *Harm Reduction Journal* 18, no. 1 (2021): 88-88, https:// pubmed.ncbi.nlm.nih.gov/34391436; P.T. Korthuis et al., "Patients' Reasons for Choosing Office-Based Buprenorphine: Preference for Patient-Centered Care," *Journal of Addiction Medicine* 4, no. 4 (2010): 204-10, https://pubmed.ncbi.nlm.nih.gov/21170143; J.A. Peterson et al., "Why Don't Out-of-Treatment Individuals Enter Methadone Treatment Programmes?," *International Journal of Drug Policy* 21, no. 1 (2010): 36-42, https://www.sciencedirect.com/science/article/pii/S0955395908001692.

9   H. Hansen and S.K. Roberts, "Two Tiers of Biomedicalization: Methadone, Buprenorphine, and the Racial Politics of Addiction Treatment," in *Critical Perspectives on Addiction,* ed. J. Netherland (Emerald Group Publishing Limited, 2012), https://doi.org/10.1108/S1057-6290(2012)0000014008.

10 Goedel et al., "Association of Racial/Ethnic Segregation."

11 Frank et al., "'It's Like Liquid Handcuffs'"; P.J. Joudrey, E.J. Edelman, and E.A. Wang, "Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 U.S. States," *JAMA* 322, no. 13 (2019): 1310-12, https://doi.org/10.1001/jama.2019.12562; H.S. Reisinger et al., "Premature Discharge From Methadone Treatment: Patient Perspectives," *Journal of Psychoactive Drugs* 41, no. 3 (2009): 285-96, https://pubmed.ncbi.nlm.nih.gov/19999682/; A. Rosenblum et al., "Distance Traveled and Cross-State Commuting to Opioid Treatment Programs in the United States," *Journal of Environmental and Public Health* (2011), https://www.hindawi.com/journals/ jeph/2011/948789/.

12 Frank et al., "'It's Like Liquid Handcuffs.'"

13 American Society of Addiction Medicine, "The Regulation of the Treatment of Opioid Use Disorder With Methadone" (2021), https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2021/11/16/the-regulation-of-the-treatment-of-opioid-use-disorder-with-methadone.

14 Joudrey, Edelman, and Wang, "Drive Times"; J.D. Lenardson and J.A. Gale, "Distribution of Substance Abuse Treatment Facilities Across the Rural-Urban Continuum" (Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, 2007), http://muskie.usm.maine.edu/Publications/rural/wp35b.pdf.

15 Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS): 2019" (2020), https://wwwdasis.samhsa.gov/dasis2/nssats/NSSATS_2019/2019-NSSATS-R.pdf.

16 J.R. Jackson et al., "Characterizing Variability in State-Level Regulations Governing Opioid Treatment Programs," *Journal of Substance Abuse Treatment* 115 (2020): 108008, https://doi.org/10.1016/j.jsat.2020.108008; Substance Abuse and Mental Health Services Administration, "Federal Guidelines for Opioid Treatment Programs" (2015), https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP. For example regulations, see Ga. Comp. R. & Regs, r. 480-18-.02; La. Rev. Stat. Ann., § 40:2159; Ohio Rev. Code Ann., § 5119.371.

17 W. Va. Code § 16-5y-12.

18 B. Connolly, "How Indiana Is Working to Improve Access to Opioid Treatment Programs Across the State," The Pew Charitable Trusts, accessed Oct. 19, 2021, https://www.pewtrusts.org/en/research-and-analysis/articles/2021/07/07/how-indiana-is-working-to-improve-access-to-opioid-treatment-programs-across-the-state. Senate Bill 464, Indiana General Assembly (2015), http://iga.in.gov/legislative/2015/bills/senate/464.

19 Substance Abuse and Mental Health Services Administration, "Certification of Opioid Treatment Programs (OTPs)," last modified Oct. 19, 2021, https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program.

20 Ohio Administrative Code, Medication Units, 5122-40-15 (2019), http://codes.ohio.gov/oac/5122-40-15v1.

21 A. McBournie et al., "Methadone Barriers Persist, Despite Decades of Evidence," Health Affairs Blog (blog), *Health Affairs,* Sept. 23, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190920.981503/full/#_ftnref1.

22 The Pew Charitable Trusts, "Opioid Treatment Programs: A Key Treatment System Component" (2021), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/07/opioid-treatment-programs-a-key-treatment-system-component.

23 T. El-Sabawi et al., "The New Mobile Methadone Rules and What They Mean for Treatment Access," Health Affairs, accessed Oct. 21, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210727.942168/full/.

24 H.R. 6—Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, 115-271, 115th Congress (2018), https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-HE7D6B79AFB0447CD9D2F6F189A1586 FE; S. Doyle and V. Baaklini, "Lifesaving Addiction Treatment Out of Reach for Many Americans," February 2022, https://www.pewtrusts.org/en/research-and-analysis/articles/2022/02/17/lifesaving-addiction-treatment-out-of-reach-for-many-americans#0-many-opioid-treatment-programs; K. Orgera and J. Tolbert, "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment" (Kaiser Family Foundation, 2019), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/.

25 C.M. Andrews, "The Relationship of State Medicaid Coverage to Medicaid Acceptance Among Substance Abuse Providers in the United States," *The Journal of Behavioral Health Services & Research* 41, no. 4 (2014): 460-72, https://doi.org/10.1007/s11414-013-9387-2; Commonwealth of Massachusetts Gl Ch. 111e, § 7, https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111e/Section7.

26 E.P. Bhatraju et al., "Mortality in an Opioid Treatment Program," *Journal of Psychoactive Drugs* (2021): 1-6, https://doi.org/10.1080/02791072.2021.1909189; T. D'Aunno, S. Park, and H.A. Pollack, "Evidence-Based Treatment for Opioid Use Disorders: A National Study of Methadone Dose Levels, 2011–2017," *Journal of Substance Abuse Treatment* 96 (2019): 18-22, https://www.sciencedirect.com/science/article/pii/S0740547218302939; Reisinger et al., "Premature Discharge From Methadone Treatment"; W.L. White et al., "It's Time to Stop Kicking People Out of Addiction Treatment," *Counselor* 6, no. 2 (2005): 12, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338434/; C.M. Jones et al., "Characteristics and Current Clinical Practices of Opioid Treatment Programs in the United States," Drug and Alcohol Dependence 205 (2019): 107616, http://www.sciencedirect.com/science/article/pii/S037687161930393X.

27 G. Joseph et al., "Reimagining Patient-Centered Care in Opioid Treatment Programs: Lessons From the Bronx During COVID-19," *Journal of Substance Abuse Treatment* 122 (2021): 108219-19, https://pubmed.ncbi.nlm.nih.gov/33353790.

28 Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS)" (2020), https://www.datafiles.samhsa.gov/dataset/national-survey-substance-abuse-treatment-services-2020-n-ssats-2020-ds0001.

29 Ibid.

30 K. Cioe et al., "A Systematic Review of Patients' and Providers' Perspectives of Medications for Treatment of Opioid Use Disorder," *Journal of Substance Abuse Treatment* 119 (2020): 108146, https://www.sciencedirect.com/science/article/pii/S0740547220304037; The Pew

Charitable Trusts, "Medications for Opioid Use Disorder Improve Patient Outcomes" (2020), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes.

31 American Society of Addiction Medicine, "The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder—2020 Focused Update" (2020), https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline; F. Faggiano et al., "Methadone Maintenance at Different Dosages for Opioid Dependence," *Cochrane Database of Systematic Reviews,* no. 3 (2003), https://doi.org//10.1002/14651858.CD002208.

32 D'Aunno, Park, and Pollack, "Evidence-Based Treatment for Opioid Use Disorders."

33 Commonwealth of Pennsylvania, 28 Pa. Code § 715.15.

34 National Academies of Sciences, Engineering, and Medicine, "Medications for Opioid Use Disorder Save Lives" (2019), https://doi.org/10.17226/25310; White et al., "It's Time to Stop Kicking People Out of Addiction Treatment."

35 U.S. Department of Health and Human Services, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43" (2005), https://www.asam.org/docs/advocacy/samhsa_tip43_matforopioidaddiction.pdf?sfvrsn=0.

36 C. Strike and C. Rufo, "Embarrassing, Degrading, or Beneficial: Patient and Staff Perspectives on Urine Drug Testing in Methadone Maintenance Treatment," *Journal of Substance Use* 15, no. 5 (2010): 303-12.

37 Joseph et al., "Reimagining Patient-Centered Care in Opioid Treatment Programs."

38 A.M.W. LeBrón et al., "Restrictive ID Policies: Implications for Health Equity," *Journal of Immigrant and Minority Health* 20, no. 2 (2018): 255-60, https://doi.org/10.1007/s10903-017-0579-3.

39 California Code of Regulations, tit. 9, § 10240.

40 Pattani, "Syringe Exchanges Deemed 'Life-Sustaining' During Pa. Coronavirus Shutdown."

41 M. Hochheimer and G.J. Unick, "Systematic Review and Meta-Analysis of Retention in Treatment Using Medications for Opioid Use Disorder by Medication, Race/Ethnicity, and Gender in the United States," *Addictive Behaviors* 124 (2022): 107113, https://www.sciencedirect.com/science/article/pii/S0306460321002987; National Academies of Sciences, "Medications for Opioid Use Disorder Save Lives."

42 National Academies of Sciences, "Medications for Opioid Use Disorder Save Lives."

43 Pattani, "Syringe Exchanges Deemed 'Life-Sustaining' During Pa. Coronavirus Shutdown."

44 For example, see Code of Maine Rules, 14-118-005 § 19.8.10.3; Code of Mississippi Rules 24-000-002 § 53.5.

45 B. Connolly, A. McBournie, and S. Doyle, "More Flexible Methadone Access Should Continue Post-Pandemic," The Pew Charitable Trusts, accessed Oct. 20, 2021, https://www.pewtrusts.org/en/research-and-analysis/articles/2021/04/22/more-flexible-methadone-access-should-continue-post-pandemic.

46 S.B. Hunter et al., "Clinician Perspectives on Methadone Service Delivery and the Use of Telemedicine During the COVID-19 Pandemic: A Qualitative Study," *Journal of Substance Abuse Treatment* 124 (2021): 108288, https://www.sciencedirect.com/science/article/pii/S0740547221000143; X.A. Levander et al., "COVID-19-Related Policy Changes for Methadone Take-Home Dosing: A Multistate Survey of Opioid Treatment Program Leadership," *Substance Abuse* (2021): 1-7, https://doi.org/10.1080/08897077.2021.1986768.

47 Y.-I. Hser et al., "High Mortality Among Patients With Opioid Use Disorder in a Large Healthcare System," *Journal of Addiction Medicine* 11, no. 4 (2017): 315-19, https://pubmed.ncbi.nlm.nih.gov/28426439.

48 B. Corallo et al., "Community Health Centers and Medication-Assisted Treatment for Opioid Use Disorder" (Kaiser Family Foundation, 2020), https://www.kff.org/uninsured/issue-brief/community-health-centers-and-medication-assisted-treatment-for-opioid-use-disorder/.

49 Q.Q. Wang et al., "COVID-19 Risk and Outcomes in Patients With Substance Use Disorders: Analyses From Electronic Health Records in the United States," *Molecular Psychiatry* 26, no. 1 (2021): 30-39, https://doi.org/10.1038/s41380-020-00880-7.

50 Ibid.

51 C.M. Jones and E.F. McCance-Katz, "Co-Occurring Substance Use and Mental Disorders Among Adults With Opioid Use Disorder," *Drug and Alcohol Dependence* 197 (2019): 78-82, http://www.sciencedirect.com/science/article/pii/S0376871618305209.

52 VIP Community Services, "VIPServices.org," accessed Nov. 11, 2021, https://www.vipservices.org/; VIP Community Services, "Services," accessed Oct. 20, 2021, https://www.vipservices.org/services/.

53 K. Gabbert, M. Polich, and C. Hilger, "Rural Medication-Assisted Treatment Strategies: Telehealth and Expanding the Opioid Treatment Program Footprint" (presentation, State Opioid Workshop, Sept. 24-25, 2018); Ohio Administrative Code, Medication Units, 5122-40-15 (2019), http://codes.ohio.gov/oac/5122-40-15v1.

54 P. Boozang, J. Guyer, and J. Nysenbaum, "Using Medicaid to Advance Evidence-Based Treatment of Substance Use Disorders: A Toolkit for State Medicaid Leaders" (Manatt Health, 2019), http://www.manatt.com/Manatt/media/Media/PDF/White%20Papers/AV-Medicaid-Opioid-Toolkit-November-2019.pdf; K.L. Casper et al., "Models of Integrated Patient Care through OTPs and Data 2000 Practices" (American Association for the Treatment of Opioid Dependence, 2016), http://www.aatod.org/wp-content/uploads/2016/10/whitepaper-1.doc.

55 Centers for Medicare & Medicaid Services, "State-by-State Health Home State Plan Amendment Matrix" (2021), https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa-at-a-glance-matrix.pdf.

56 D.L. Biancarelli et al., "Strategies Used by People Who Inject Drugs to Avoid Stigma in Healthcare Settings," *Drug and Alcohol Dependence* 198 (2019): 80-86, https://www.sciencedirect.com/science/article/pii/S0376871619300699; C. McKnight et al., "Perceived Discrimination Among Racial and Ethnic Minority Drug Users and the Association With Health Care Utilization," *Journal of Ethnicity in Substance Abuse 16,* no. 4 (2017): 404-19, https://pubmed.ncbi.nlm.nih.gov/28306386; B.E. Meyerson et al., "I Don't Even Want to Go to the Doctor When I Get Sick Now: Healthcare Experiences and Discrimination Reported by People Who Use Drugs, Arizona 2019," *International Journal of Drug Policy* 93 (2021): 103112, https://doi.org/10.1016/j.drugpo.2021.103112.

57 Pattani, "Syringe Exchanges Deemed 'Life-Sustaining' During Pa. Coronavirus Shutdown."

58 Substance Abuse and Mental Health Services Administration, "The Opioid Crisis and the Black/African American Population: An Urgent Issue" (2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf.

59 A. Meinhofer, J.M. Hinde, and M.M. Ali, "Substance Use Disorder Treatment Services for Pregnant and Postpartum Women in Residential and Outpatient Settings," *Journal of Substance Abuse Treatment* 110 (2020): 9-17, https://www.sciencedirect.com/science/article/pii/S0740547219302570.

60 C. Blanco et al., "The American Opioid Epidemic in Special Populations: Five Examples" (National Academy of Medicine, 2020), https://nam.edu/the-american-opioid-epidemic-in-special-populations-five-examples/.

61 J.B. Teeters et al., "Substance Use Disorders in Military Veterans: Prevalence and Treatment Challenges," *Substance Abuse and Rehabilitation* 8 (2017): 69-77, https://pubmed.ncbi.nlm.nih.gov/28919834.

62 In 2019, the rate of opioid misuse among LGB adults 18 and over was 9.6%, compared with 5.3% of the general population aged 18-25 and 3.6% of the population over 25. E. McCance-Katz, "The National Survey on Drug Use and Health: 2019" (Substance Abuse and Mental Health Services Administration, 2020), https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretary-nsduh2019_presentation.pdf; Substance Abuse and Mental Health Services Administration, "FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency" (2020), https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

63 National Institute on Drug Abuse, "Substance Use and SUDs in LGBTQ* Populations," accessed Oct. 20, 2021, https://www.drugabuse.gov/drug-topics/substance-use-suds-in-lgbtq-populations.

64 American Academy of Pediatrics Committee on Substance Use and Prevention, "Medication-Assisted Treatment of Adolescents With Opioid Use Disorders," *Pediatrics* 138, no. 3 (2016): e20161893, http://pediatrics.aappublications.org/content/138/3/e20161893.abstract.

65 A. Hogue et al., "Family Involvement in Treatment and Recovery for Substance Use Disorders Among Transition-Age Youth: Research Bedrocks and Opportunities," *Journal of Substance Abuse Treatment* 129 (2021): 108402, https://www.sciencedirect.com/science/article/pii/S0740547221001288.

66 Pattani, "Syringe Exchanges Deemed 'Life-Sustaining' During Pa. Coronavirus Shutdown."

67 Substance Abuse and Mental Health Services Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS)"; United States Census Bureau, "2019 American Community Survey 1-Year Estimates," accessed Nov. 15, 2021, https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2019/1-year.html.

68 The Pew Charitable Trusts, "Cultural Competency a Key Component of Substance Use Treatment Services," accessed Oct. 20, 2021, https://www.pewtrusts.org/en/research-and-analysis/articles/2021/08/02/cultural-competency-a-key-component-of-substance-use-treatment-services.

For further information, please visit:

pewtrusts.org/substancemisuse