Factors that Influence Access to Medication-Assisted Treatment

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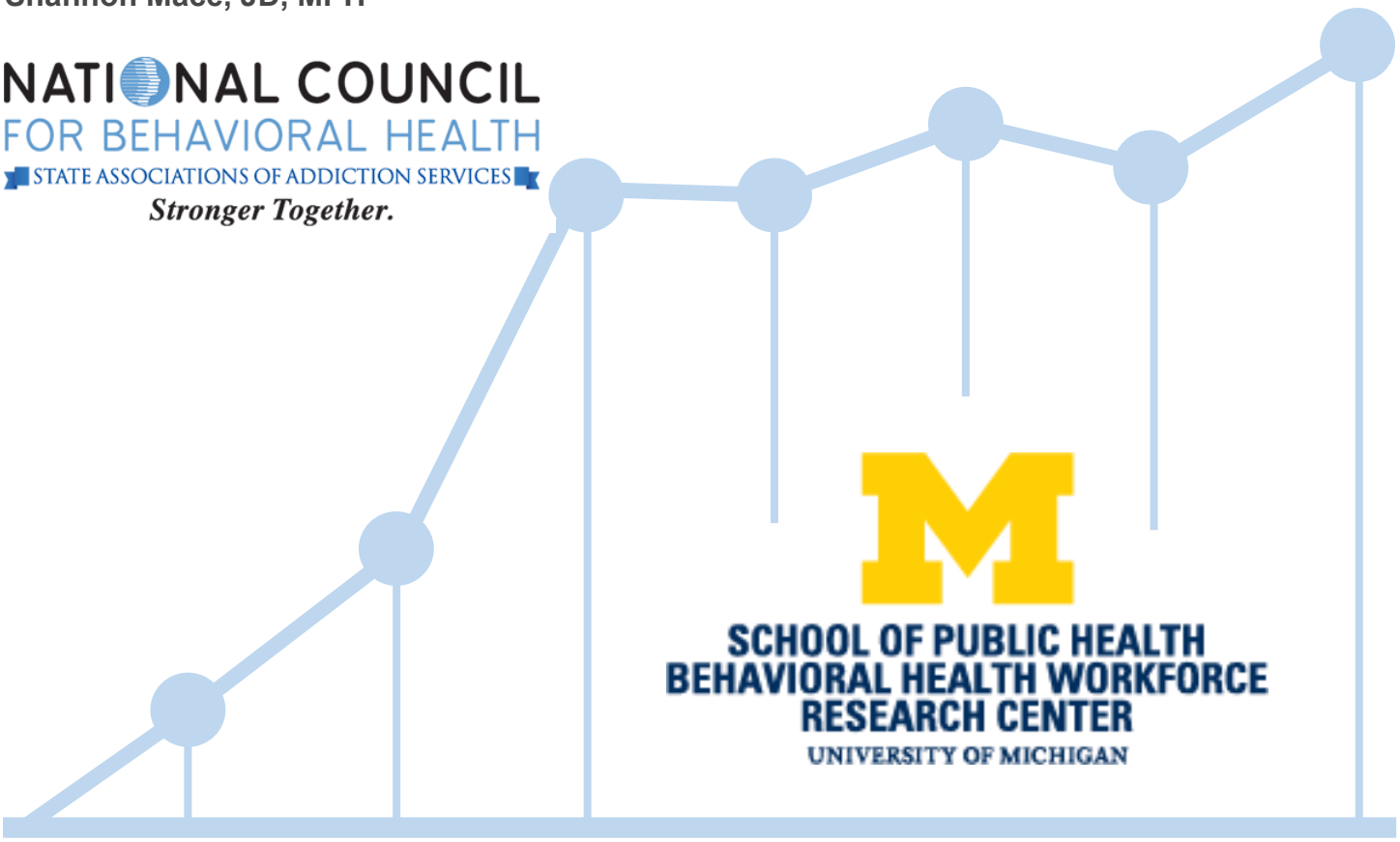

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Key Highlights

Evidence-based services and treatment exist to address opioid use disorder and other substance use disorders (SUDs), yet only approximately 20% of individuals with opioid use disorder receive treatment each year. Accessing evidence-based treatment is critical to help people with SUDs improve health outcomes and achieve long-term recovery.

Quantitative and qualitative data were collected from State Opioid Treatment Authorities, Single State Agencies, and behavioral health providers across the country to better understand systemic, social, and economic factors that impact access to medication-assisted treatment and other SUD treatment. Data related to organizational culture, provider perceptions and attitudes, access to Medicaid and other insurance coverage, and state-specific initiatives to address the opioid epidemic were collected, analyzed, and discussed.

States are engaging in prevention and treatment, as well as recovery support and harm reduction efforts. The important benefit of peer professionals in SUD treatment was emphasized, as was the importance of addressing stigma and insurance coverage as barriers to SUD treatment.

Introduction and Background

Each day, approximately 130 people in the U.S. die from opioid overdose.[1] The current opioid epidemic has contributed to a decrease in the average national life expectancy each year since 2015.[2] In 2017, an estimated 2.1 million people aged 12 years or older had an opioid use disorder (OUD).[3] The opioid epidemic affects individuals and families across socioeconomic status, gender, race and ethnicity, age, and geographic setting.[4] The opioid epidemic's devastation to families and communities is immense, with total economic costs estimated at $504 billion.[5]

Evidence-based practices (EBPs) to prevent, treat, and help people recover from OUD and other substance use disorders (SUDs) across a continuum of care and treatment settings exist; however, only approximately 20% of individuals with OUD receive treatment each year.[6] Access to evidence-based treatment and other services for OUD improves health outcomes and fosters long-term recovery.[7]

Substance Use Disorder Treatment

The 2016 *Surgeon General's Report on Alcohol, Drugs, and Health*[7] defines SUD treatment as "a service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability." The DSM V classifies SUD into three severity categories: mild, moderate, and severe. Whereas mild SUDs often respond to brief motivational interventions and supportive monitoring, more severe and chronic SUDs often require specialty treatment and continued post-treatment support.[7] In 2018, The Office of the Surgeon General and the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a Spotlight on Opioids from the Surgeon General's Report, in order to provide opioid-related information.[8] To address the spectrum of SUDs, including OUD, a continuum of care offers an array of service options, including prevention, early intervention, treatment, and recovery support.

Medication-Assisted Treatment

The use of medications in conjunction with psychosocial and recovery support services to treat OUD, an intervention often referred to as medication-assisted treatment (MAT), is an effective option for treating individuals with SUDs, including OUD.[7,9] Three U.S. Food and Drug Administration (FDA)-approved medications currently used to treat OUD are methadone, buprenorphine, and naltrexone. Methadone can only be provided within SAMHSA-certified and Drug Enforcement Administration–regulated opioid treatment programs (OTPs). In 2002, physicians became eligible to prescribe buprenorphine in non-specialty settings, provided they complete requisite training and obtain an SAMHSA waiver. Unlike

methadone and buprenorphine, both opioid agonists, the newer extended-release naltrexone is an opioid antagonist and not a controlled substance; thus, it can be prescribed by any licensed prescriber but requires 10–14 days of detox before administering. In 2000, Congress passed the Drug Addiction Treatment Act (DATA), which permits qualified physicians to treat narcotic dependence with schedules III –V narcotic-controlled substances that have been FDA approved. DATA-waived physicians may treat 30 or 100 patients at any one time, depending on individual authorization from the Center for Substance Abuse Treatment. Table 1 provides an overview of the FDA-approved medications for OUD and the requirements for who may prescribe or dispense the medication.

Table 1. Pharmacotherapy for Opioid Use Disorder[10]

Medication	How it Works	Frequency of Administration	Route of Administration	Who May Prescribe or Dispense
Methadone	Full agonist: binds to and activates opioid receptors in the brain that were activated by the drug, but in a safer and more controlled manner. Reduces the symptoms of withdrawal and cravings.	Daily	Orally as liquid concentrate, tablet, or oral solution of diskette or powder	SAMHSA-certified outpatient treatment programs dispense methadone for daily administration either onsite or, for stable patients, at home.
Buprenorphine	Partial opioid agonist: binds to and activates opioid receptors but with less intensity than full agonists.	Daily tablet or film (also alternative dosing regimens)	Oral tablet or film is dissolved under the tongue	Physicians, nurse practitioners, and physician assistants with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.
Probuphine (buprenorphine implant)		Every 6 months	Subdermal	
Sublocade (buprenorphine injection)		Monthly	Injection (for moderate to severe opioid use disorder)	
Naltrexone (injection)	Antagonist: binds to and blocks the activation of certain receptors on cells, preventing a biological response.	Monthly	Intramuscular injection into the gluteal muscle by a physician or other healthcare professional	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.

Barriers to Access

A range of barriers and challenges exist related to accessing MAT and other SUD treatment and services. In 2011, Knudsen et al.[11] analyzed data collected from 250 administrators of publicly funded SUD programs across the U.S. The majority of respondents (63%) who did not offer medication to treat SUDs were asked to rate the importance of 18 barriers related to implementing MAT. The identified barriers could be grouped into categories including: regulatory challenges (e.g., prescriber mandates, state-level regulations), financial challenges (e.g., organizational costs, patient costs), staff experience and expertise, organizational norms and attitudes (e.g., incongruence with treatment philosophy), individual provider attitudes, and perceptions about patient's clinical appropriateness or readiness to receive MAT. The most commonly reported barriers included factors related to state regulations and costs (e.g., cost for

ancillary services such as laboratory tests).

Similarly, in a 2018 multi-method study of providers conducted by Attermann and colleagues,[12] barriers to MAT implementation and utilization included: regulatory barriers, financial and operations barriers, inadequate workforce training and education, lack of MAT providers, disparities in MAT program access, and negative perceptions associated with OUD treatment. The authors noted that attitudes or behaviors by healthcare providers have the potential to lead to a lack of access to care, underutilization, and social marginalization. Beyond the practice setting, providers in the study who were eligible to prescribe/dispense medications to treat OUD consistently highlighted how patient characteristics, including low motivation and a prior history of diversion, negatively impacted the providers' willingness to treat a patient with MAT. The reluctance to treat perceived challenging populations of patients with OUD are informed by beliefs that prevent providers from adopting MAT at their health facilities, reducing patient access to necessary treatment. The shortage of knowledgeable providers was also seen as a barrier to MAT implementation, as well as the shortage of community-based MAT providers, often leaving few choices for referrals for those seeking MAT treatment.

A review of the literature identified evidence that supports these published findings related to barriers to adopting medications within SUD treatment programs. The following sections focus primarily on organizational culture and provider attitudes and patient insurance status; however, a range of other barriers, including state and federal regulatory challenges, exist.

Organizational Culture and Provider Perceptions

Organizational culture and provider perceptions and attitudes have been identified as important factors that influence the adoption and implementation of MAT within SUD treatment settings.[11,13,14] In 2011, Knudsen et al.[11] found that more than 37% of SUD treatment provider respondents ranked "there are better alternatives to using medications as part of substance abuse treatment" and nearly 30% ranked "medications for treating substance abuse are inconsistent with the center's treatment philosophy" as "important" or "very important" barriers. Furthermore, approximately 20% identified, "using medications to treat addiction is substituting one drug for another," and "our counselors do not support the use of MAT" as top barriers. These responses illustrate the ways in which organizational cultural norms, perceptions, and misperceptions about clinical processes and effectiveness, and individualized provider opinions and biases impact the adoption of MAT within provider organizations. Additionally, Haffajee and colleagues[15] identified provider stigma as one of six persistent workforce barriers contributing to the underutilization of buprenorphine. The researchers found that stigma is often explicitly cited as a barrier by providers and is most likely under-reported in the research. Negative perceptions among providers include that the patient population is difficult, deceitful, noncompliant, and likely to divert buprenorphine.

In 2018, relying on evidence that links stigma to increased social distance, discrimination, and other harm, Ashford et al.[16] conducted the first published analysis of implicit and explicit bias elicited from hypothesized stigmatizing terms and non-stigmatizing terms with 1,288 participants. Study participants completed implicit bias association tasks and a vignette-based social distance measure. Study results showed that the terms "substance abuser," "addict," "alcoholic," and "opioid addict," were strongly negatively associated. Additionally, the term "recurrence of use" had a greater positive association than "relapse" and "pharmacotherapy" was more strongly associated with the positive than "medication-assisted treatment." The researchers recommended that the terms "substance abuser," "addict," "alcoholic," and "relapse" should not be used or used sparingly.

Roman and colleagues[13] conducted a study in 2011 assessing barriers to MAT adoption, including medications for alcohol use disorder and buprenorphine, through the analysis of National Treatment Center Study data comparing adoption rates across publicly and privately funded treatment centers. Study results showed differences in rates of adoption based on organizational characteristics, including treatment ideology. The findings revealed that "treatment ideology significantly influences adoption of medications for alcohol use disorder." This affirmed previous research findings conducted at the institutional and provider levels.[14,17] Programs that place a greater emphasis on 12-step ideology are less likely to rate SUD medications as effective and acceptable for use in treatment. Additionally, counselors in recovery and those that hold 12-step ideology are less likely to rate SUD medications as effective and acceptable for use in treatment.[17] This is based on a longstanding misunderstanding about the

discrepancies between MAT and abstinence, with the untrue cultural assumption that someone cannot be practicing abstinence-based recovery while taking methadone or buprenorphine.

Patient Insurance Status and Prior Authorization

Insurance coverage for MAT and other SUD treatments varies widely by payer and by state. Utilization rates of inpatient and outpatient OUD treatment are highest among non-elderly adults with Medicaid compared with individuals with private insurance or no insurance.[18] In 2016, non-elderly adults with OUD insured by Medicaid were approximately twice as likely than individuals with private insurance or who were uninsured to receive OUD treatment (43% vs 21% and 23%). Within outpatient settings, 39% of non-elderly adult individuals with OUD that received treatment had Medicaid, 17% had private insurance, and 16% were uninsured. Within outpatient mental health centers, the utilization disparity by insurer status grows wider and 24% of non-elderly adults with OUD who received treatment had Medicaid, compared with only 3% who had private insurance and 7% who were uninsured.[18]

The importance of Medicaid as it relates to access to MAT has also been studied at the state level. The expansion of Medicaid eligibility in certain states has led to a significant increase of the utilization of buprenorphine for OUD treatment. Wen et al.[19] compared Medicaid spending on buprenorphine and buprenorphine prescriptions between states that expanded Medicaid eligibility and those that did not. States that expanded Medicaid eligibility were associated with a 70% increase in Medicaid-covered buprenorphine prescriptions and a 50% increase in buprenorphine spending. Another study conducted by Sharp and colleagues[20] analyzed the impact of Medicaid expansion on access to MAT medications and found that per-enrollee rates of buprenorphine and naltrexone prescribing expanded by more than 200% in states that expanded eligibility compared with less than 50% in states that did not expand. The researchers concluded that the newly Medicaid-eligible population was no more likely to be prescribed opioid medications than the pre-expansion population, but was more likely to access treatment for SUDs.

State Medicaid programs' coverage of MAT and other SUD treatment services vary. In 2018, all state Medicaid programs reimbursed for some form of buprenorphine, buprenorphine–naloxone, oral naltrexone, and extended-release naltrexone and also some form of naloxone: Only 42 state Medicaid programs reimbursed for methadone for MAT, 37 states covered implanted buprenorphine, and 33 states covered extended-release injectable buprenorphine. In addition to differences in coverage, state Medicaid programs vary regarding whether the medications are "preferred status," thus requiring prior authorization and other requirements, including that the patient receive psychosocial treatment with medication.[21]

Access to MAT among individuals with Medicare coverage is challenged by a lack of coverage for methadone to treat OUD and a shortage of Medicare providers that are waivered to prescribe buprenorphine. It is estimated that the Medicare-eligible population has one of the highest and fastest growing prevalence rates for OUD.[22] Approximately 300,000 Medicare-insured patients have an OUD, yet only 81,000 Medicare enrollees are receiving buprenorphine–naloxone therapy.[23] Medicare Part D plans must include coverage for Part D drugs when medically necessary for the treatment of opioid dependence. However, Medicare Part D does not pay for outpatient OUD treatment using methadone, because it cannot be dispensed upon a prescription.[24]

Prior authorization presents another potential treatment barrier. Prior authorization is a requirement that physicians obtain approval from health insurance plans before prescribing a specific medication (benefits are only paid if the care has been preapproved by the insurance company). Restrictive prior authorization practices cause unnecessary delays and interference in care decisions. In a recent study of behavioral health workforce implementation challenges related to MAT, prescribers (e.g., addiction specialists, primary care physicians) rated prior authorization as the strongest barrier to the use of buprenorphine for OUD.[25] States are working to remove prior authorization for OUD, however. For example, in 2019 Arkansas signed into law Arkansas Act 964 that requires all health insurers and the Arkansas Medicaid program to remove prior authorization to FDA-approved OUD medications that have been shown to support recovery, reduce healthcare costs, and save lives, including buprenorphine, methadone, and naltrexone.

Given the dramatic increase in opioid-related overdoses, the need for greater access to SUD treatment is significant. Although the use of medications in conjunction with psychosocial and recovery support

services (MAT) and other SUD treatment services have been around for decades, these treatments remain underutilized. Findings from a recent study by Larochelle et al.[26] examined patients who had a nonfatal opioid overdose and found that just 30% of patients received any medication for OUD in the year after overdose. This statistic points to the continuation of the OUD treatment gap shown by national data. A range of barriers to accessing MAT and other SUD services exist, including behavioral health workforce shortages, organizational culture and norms, provider perceptions and attitudes, and insurance status, among others.

The current research focused on:

1. the ways in which organizational culture and provider perceptions and attitudes affect access to MAT and other SUD treatment;
2. how Medicaid and other insurance coverage impact access to MAT and other SUD treatment; and
3. state-specific initiatives in place to address the opioid epidemic and other SUDs.

Methods

To better understand factors that may influence access to MAT and other SUD treatment services, and state-specific initiatives designed to combat the opioid epidemic and SUDs, data were gathered using a mixed methods approach. First, the research team conducted a literature review of peer-reviewed articles, white papers, briefs, public press, and guidance documents to understand the major barriers and facilitators related to accessing MAT and other SUD treatments as well as state-specific initiatives. The literature review was critical for building the survey and themes to investigate via state-level case studies. Study researchers then collected quantitative and qualitative data through an electronic survey tool and conducted qualitative interviews by telephone. The Health Sciences and Behavioral Sciences Institutional Review Board at the University of Michigan found all activities of this study to be exempt.

Data Collection

An electronic survey tool was designed and used to collect data regarding the barriers to access to MAT and SUD treatment services more broadly. National Council team members drafted a 17-item survey tool designed to be completed in 10 minutes or less. Prior to dissemination, the online survey was reviewed by Behavioral Health Workforce Research Center experts and pilot tested by three National Council team members not involved in the research project. Qualtrics, an electronic research platform,[27] was used to securely collect data.

In the Spring of 2019, the survey tool was distributed via e-mail to State Opioid Treatment Authorities (SOTAs) and Single State Authorities (SSAs) within each state. SOTAs regulate the establishment and ongoing operation of MAT programs statewide. SSAs oversee Substance Abuse Prevention and Treatment Block Grants issued by SAMHSA and funding for substance use programs in their state. Participation in the survey was voluntary and no incentives were offered or given for participating. The survey was available online for 1 month with several electronic reminders sent to encourage participation.

Additional qualitative data were collected through key informant interviews to better understand themes regarding patient access to MAT and SUD treatment services more broadly. Participants included representatives from organizations offering SUD treatment services, including MAT. Participation in the key informant interviews was voluntary and participants were offered a $25 gift card incentive. The same interview tool was used across participants.

Data collection efforts were designed to address the following topics:

1. current programs and activities (prevention, treatment, recovery support, and harm reduction) to address the opioid epidemic;
2. factors that influence access to MAT and SUD treatment services more broadly (e.g., negative perceptions associated with SUD treatment, Medicaid and other insurance coverage);

3. efforts being utilized to combat these issues; and
4. state-specific initiatives in place to combat the opioid epidemic and SUDs in general.

Data Analysis

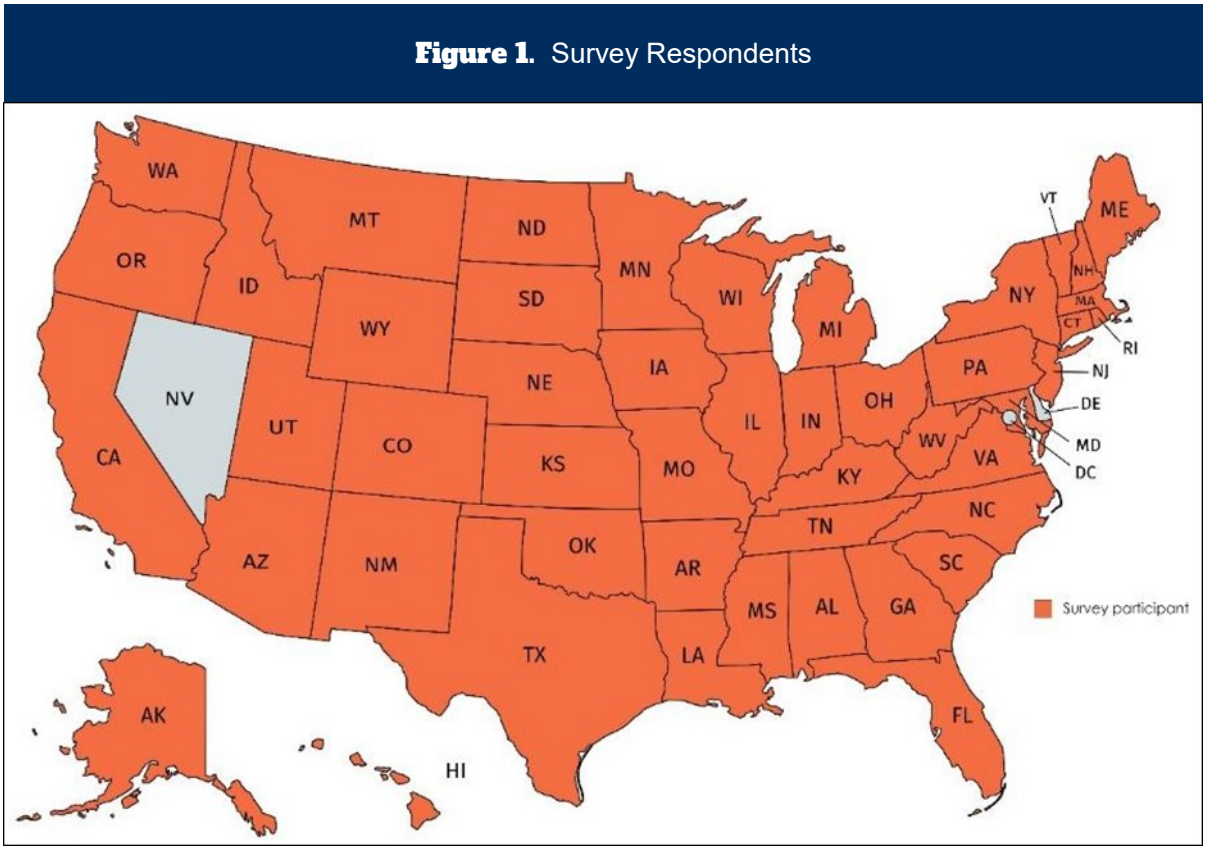
Quantitative data generated from the survey were analyzed with SPSS software. Univariate methods and frequencies were used to analyze the data and extract the most useful information. Information collected during the qualitative interviews was recorded and transcribed. *NVivo*, an electronic qualitative data analysis software tool, was used for data analysis. A thematic analysis was performed to identify common themes shared across respondents.

Findings

Electronic Survey Findings

The survey was completed by 59 unique organizations, representing 48 states and Puerto Rico (Figure 1). Slightly more than half of respondents identified as a SOTA (51%), with 44% identifying as an SSA. Ninety-five percent of the sample (n=56) answered all survey questions.

Figure 1. Survey Respondents



Prevention, Treatment, Recovery Support, and Harm Reduction Activities

According to SOTAs and SSAs, states engage in several prevention efforts to address the opioid epidemic. The most common efforts include school- and community-based prevention programs (86%), coalitions (e.g., with local businesses, schools, law enforcement, hospitals, public health departments, local/state government; 83%), information sharing through social media (e.g., Twitter, Facebook) and conventional media (e.g., radio, television, or print ads; 81%), and engagement in evidence-based prevention practices (e.g., Project Towards No Drug Abuse, Strengthening Families Program; 81%).

States fund several treatment efforts as well. The most common include MAT (98%); intensive outpatient programs (90%); behavioral treatment, without medications (85%); employment of peer recovery support specialists in clinical settings (83%); and treatment efforts targeting special populations such as tribal populations, veterans, homeless individuals, pregnant women, and justice-involved clients (75%).

The most common recovery support services funded by states include peer services (95%) and recovery housing (80%), while 56% fund medication-assisted recovery-specific recovery supports. The most common harm reduction efforts funded by states include the distribution of naloxone (Narcan) in communities impacted by the opioid crisis (97%) and community education activities or materials (80%).

Engaging Patients in Medication-Assisted Treatment and other Substance Use Disorder Treatment Services

The SOTAs and SSAs rated several factors impacting patient engagement in MAT and other SUD treatments on a 3-point scale (3=large impact, 2=minimal impact, and 1=no impact). The top three identified factors were social stigma (2.9), individualized stigma (2.8), and transportation barriers/distance to services (2.7). Table 2 shows the ratings of all factors.

Table 2: Factors Impacting Patient Engagement in Medication-Assisted Treatment and other Substance Use Disorder Treatments

Factor	Mean Rating (3=large impact, 2=minimal impact, 1=no impact)
Social stigma (characterized by prejudicial attitudes and discriminating behavior directed toward individuals treated for SUD as a result of the psychiatric label they have been given)	2.9
Individualized stigma (negative thoughts and feelings—such as shame, negative self-evaluative thoughts, and fear—that emerge from identification with a stigmatized group and their resulting behavioral impact—for example, avoidance of SUD treatment)	2.8
Transportation barriers/distance to services	2.7
Cultural norms (e.g., family involvement is an important focus in working with Hispanic and Native American communities; patient may not engage in treatment if a program does not have staff that included members of the same ethnic group)	2.4
Patient's inability to take time off work and/or secure adequate childcare	2.3
Patient's previous bad experiences with the treatment system	2.3
Patients do not think they need help	2.3
Too few opioid treatment programs in the state	2.3
Legislation (e.g., Ryan Haight Act)	2.2
Treatment cost (patients cannot afford treatment and/or do not have health insurance)	2.2
Wait lists for services	2.2
Patient's fear that treatment will not work	2.0
Other*	1.3

*Other factors impacting engagement include the Drug Enforcement Administration not permitting opioid treatment program satellite operations, too few rural providers, and the lack of alignment between payers and programs around issues such as preauthorization.

When asked which populations **experience** the highest prevalence of stigma against MAT and other SUD treatments (multiple responses could be selected), 64% of SOTAs and SSAs responded that pregnant and postpartum women experience the highest prevalence of stigma, followed by individuals residing in rural communities (42%), racial minority populations (37%), and tribal populations (31%). Twenty-seven percent of respondents indicated that other populations including the criminal justice population, veterans, and families involved with Child Protective Services experience the highest prevalence of stigma against MAT and other SUD treatments. When asked which populations **exhibit** the highest prevalence of stigma against MAT and other SUD treatments, 71% of SOTAs and SSAs responded that law enforcement exhibits the highest prevalence of stigma, followed by courts (56%) and treatment providers (41%).

States are using a variety of methods to address/reduce stigma related to MAT and SUD treatment in general. The most common include training staff (88%), community education (86%), changing language/terminology about substance use (e.g., eliminating the term "drug habit" and replacing it with "substance use disorder"; 86%), and disseminating information from government sources such as SAMHSA's Provider's Clinical Support System (71%).[1]

Treatment Barriers

The SOTAs and SSAs rated several factors impacting state's ability to offer MAT and other SUD treatments on a 3-point scale (3=large impact, 2=minimal impact, and 1=no impact). The top three identified factors were inadequate training in MAT and/or SUD treatment (2.5), insufficient number of DATA 2000-waivered providers to provide buprenorphine treatment (2.4), and a SUD workforce that is not ready to address the current opioid crisis (i.e., limited related knowledge, training, or experience in SUD treatment; 2.3). Table 3 describes additional ratings.

Table 3: Factors Impacting States Ability to Offer Medication-Assisted Treatment and other Substance Use Disorder Treatments

Factor	Mean Rating (3=large impact, 2=minimal impact, 1=no impact)
Inadequate training in MAT and/or SUD treatment	2.5
Insufficient number of DATA 2000–waivered providers to provide buprenorphine treatment	2.4
SUD workforce is not ready to address the current opioid crisis (i.e., limited related knowledge, training, or experience in SUD treatment)	2.3
Inability to assess MAT access gaps in the most affected areas/counties	2.2
Other*	1.7

*Other treatment barriers include the behavioral health workforce shortage, lack of regulatory oversight over DATA-waivered providers, and the large number of DATA-waivered providers who are not prescribing to capacity.

DATA 2000-Waivered Prescribers

The SOTAs and SSAs reported that 46,232 DATA 2000–waivered providers currently work across their states. The exact number of these providers prescribing at their cap is unknown, as most respondents only provided estimates. The majority of respondents (37%; n=35), however, indicated that **none** of their DATA 2000–waivered providers are prescribing at their cap, whereas 11% noted that more than half of their DATA 2000–waivered providers are prescribing at their cap. Only one respondent indicated that 100% of their

[1] Providers' Clinical Support System for Medication-Assisted Treatment (PCSS-MAT) is a SAMHSA-funded national training and clinical mentoring project developed in response to the prescription opioid misuse epidemic and the availability of pharmacotherapies to treat OUD.

providers are prescribing at their cap. One survey respondent provided exact numbers, noting that only 124 of their DATA 2000–waivered prescribers (with a capacity to treat 29,175 patients) out of 451 prescribers (27%) are prescribing at their capacity. Another survey respondent noted that they do not encourage or expect providers to work at the top of their cap because they believe a patient panel of ten in a busy PCP practice demonstrates strong penetration of MAT and allows for the embedded MAT team to support the physician in a meaningful way.

When asked about challenges states face getting DATA 2000–waivered prescribers to use their waiver and/or prescribe to their cap, the top four reported challenges included: physicians not wanting to engage owing to the complex issues of OUD patients (e.g., OUD patients may have co-occurring mental illness and practices may not be set up to work with the population completely; 63%), DATA 2000–waivered providers not feeling adequately prepared to provide services to patients after taking the online training course (e.g., they may have follow-up technical questions about setting up their practice; 59%), physicians feeling that the additional work created by becoming DATA 2000 waivered is not worth (or is outweighed by) the financial benefit (59%), and DATA 2000–waivered providers feeling uncomfortable working with people with SUD (53%).

Opioid Treatment Programs

When asked how state OTPs impact patient access to MAT and SUD treatment services more broadly, the majority of respondents (76%) indicated that the location of OTPs is a factor (e.g., OTP sparsity in rural areas). Other impacts of OTPs include the cost of methadone treatment being prohibitive for people without insurance or who are underinsured, increased cost of medications like injectable naltrexone, DATA 2000–waivered doctors not prescribing at OTPs because of having a private practice with office-based opioid treatment, low Medicaid reimbursement, poor compensation/rates, and the lack of adequately trained staff in many OTPs.

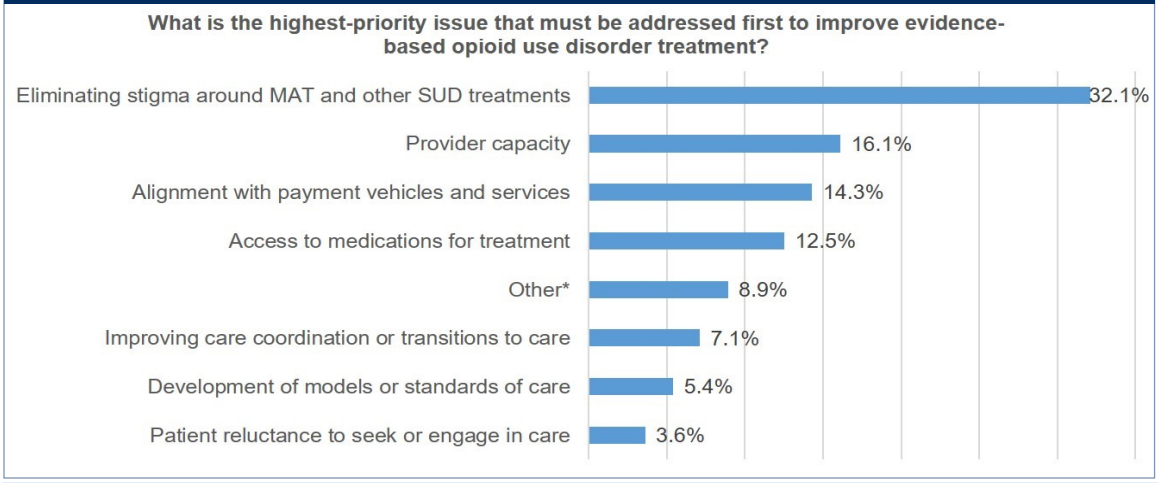
Medicaid and Other Insurance Coverage

When asked how Medicaid and other insurance coverage impacts patient access to MAT and SUD treatment services more broadly, a similar proportion of respondents identified inadequate coverage of treatment supports and staff (e.g., peer recovery coaches; 44%), inadequate coverage for transportation (42%), inadequate coverage for required medications (41%), and other factors such as lapses in timely payments, including managed care (42%), as impacts.

Highest-Priority Issue to Improve Evidence-Based Opioid Use Disorder Treatment

The SOTAs and SSAs identified the elimination of stigma around MAT and other SUD treatments as the highest-priority issue that must be addressed **first** to improve evidence-based OUD treatment (**32%**) (Figure 2).

Figure 2. Priority Issues to Improve Evidence-Based Opioid Use Disorder Treatment



*Other high-priority issues related to workforce development, including training and having better reimbursement rates.

Qualitative Findings

In addition to the nationwide survey of SOTAs and SSA, seven key informant interviews were conducted by telephone with individuals in Washington DC, Maryland, Virginia, Alabama, Nebraska, and Florida. Table 4 provides characteristics of each key informant's organization.

Table 4. Key Informant Characteristics

Type of Organization	Description of Organization/Substance Use Disorder Programming
Board of Nursing	Voluntary disciplinary alternative program and regulatory agency that promotes early identification, intervention, treatment, and rehabilitation of any registered nurse or licensed practical nurse whose competence is found to be impaired or compromised because of the use or abuse of drugs, alcohol, controlled substances, chemicals, or other substances or as a result of a physical or mental condition rendering the person unable to meet the standards of the nursing profession.
Behavioral Healthcare Organization	Provides both SUD and mental health services; services include prevention intervention hospitals, inpatient detoxification, two separate narcotic treatment programs that offer a breadth of MAT options (has offered MAT for >40 years), resident services, partial hospitalization programs, and intensive outpatient program services for those individuals who need a higher level of care.
Behavioral Healthcare Organization	Provides treatment for people with mental health issues, drug and alcohol dependencies, or intellectual disabilities; services range from inpatient and residential treatment to outpatient programs including trauma services, psychiatry, counseling, day treatment, and intensive, round-the-clock outpatient services to help people with severe mental illnesses safely remain in the community; offer all three FDA-approved MAT medications.
Behavioral Health Treatment Center	Regional behavioral health community provider that offers substance abuse, mental health and dual diagnosis education, prevention, and treatment in highly specialized programs for adolescents, young adults, and adults; offers medications for OUD in all 14 of their program sites; seven sites include bed-based programs and some overlapping sites have outpatients' programs; as a Medicaid-expansion state, Maryland has full access to all three FDA-approved MAT medications.
Family Services Organization	Statewide organization, with 18 offices across the state, that provides children services, community services, and behavioral health treatment; offers SUD services in-house including screenings as well as outpatient groups, individual, and intensive outpatient groups.
Department of Behavioral Health and Developmental Services	Policy oversight organization that funds 38 community service boards, two new behavior health authorities, and Federally Qualified Health Centers to promote recovery, self-determination, and wellness.
Department of Behavioral Health	Contracts with community-based providers to provide behavioral health services and supports.

The topics of the qualitative interview included a range of issues, but the main discussions centered around issues and opportunities related to patient access to addiction treatment.

Partnerships and Activities

In alignment with the findings from the electronic survey of SOTAs and SSAs, key informants are engaging in a number of efforts around SUD prevention, treatment, recovery support, and harm reduction.

Several key informants mentioned that specialty wraparound services work best in communities where everyone communicates and collaborates. Five organizations indicated that they engage with their Department of Corrections (DOC) for client referrals. One organization reported that up to 75% of their adolescent youth population comes in via criminal justice system referral and one organization had staff co-located in the local jail. Another key informant reported that up to half of client referrals come from the DOC: a number that has decreased over time owing to increasing referrals from the general healthcare system. Increasingly, organizations are establishing relationships with hospitals and emergency departments (EDs), and in one organization, multiple EDs, their personnel, and their navigators have them on speed dial knowing that they can see patients the same or next day. Another organization noted that one of the most important components of their community collaboration is work with the DOC as well as the hospital system. With their DOC, the organization has two operating correctional programs that offer Vivitrol and oral naltrexone in the jail. In partnership with local hospitals, the organization has an ED diversion hospital program, which offers Direct Connect for individuals who are admitted through the ED for things like intravenous drug use infections or opioid drug use. Those individuals are stabilized, then transferred into the organization's inpatient detox where they are inducted on MAT or detox depending on the need of the individual, and then stepped down to a resident level of care. The Direct Connect system works on a platform that is operated by nurses who work directly with the hospital to move patients from the hospital system into the organization's care regardless of the level of care (e.g., the organization provides acute care stabilization, inpatient detoxification, outpatient MAT, consultation, onsite evaluation) 24 hours, 7 days a week.

On engaging patients into treatment:

"In addiction, you have limited time to engage individuals and encourage them to take that first step into treatment. It's also important to let individuals know about the confidentiality associated with services and the partnerships. We need to be able to coordinate if they do have legal concerns because many of them do. And quite honestly, they're afraid to seek treatment if they're on probation or have a child welfare case or DCF [Department of Children and Families] is involved. We want them to know that we actually work with child welfare and DCF with the goal of reunification and stabilization and getting them to a place where they can be successful at their functioning level."

Most key informants rely heavily on peer support workers for SUD treatment, harm reduction, and recovery support. In one site, incarcerated individuals attend groups that are led by certified peers who have also been in jail but have since become healthy. Another organization sends peer recovery specialists and clinicians to areas of high concentrations of homeless populations to provide naloxone. Another organization noted that after clients graduate from their intensive outpatient program and need a support system, peers are pulled into the recovery support efforts. One site receives special funding—initially through a grant as a start-up and now through a standard municipal budget-based contract—to employ peer navigators that respond to police, first responders for overdoses, and EDs with near-24/7 response. A team of peers meets people at the site of either a chargeable drug offense, at the site of an overdose, or at the site of resuscitation in an ED to engage the patient into treatment. Two sites mentioned that they pair their peer specialists with either a social worker or a nurse. One site sends peer specialists to EDs, along with nurses, because a peer recovery specialist can "meet that individual at a totally different level than a medical professional can. They're going to have conversations that look a lot different, like '*You can do this. You can get there.'* That type of thing is so important for individuals."

On the Use of Peer Specialists:

"The 'secret sauce' is having a peer recovery specialist engaged with all the SUD services. In one region, we had a horrible problem getting postpartum women engaged into treatment. The clinical director said that in 17 years, she's only had five mothers attempt to get into treatment and zero that completed it. Mothers were bouncing across? state lines to have their babies so that Social Services would have a harder time tracking them. We used grant money to fund peer recovery specialists (who had babies while they were in treatment) that we paired with the social workers. So, when the mother had the baby and the baby tested positive, Social Services came in, but they were paired with a peer. Since then, engagement has gone up to 38%—not only regarding mothers asking for help and showing up but actually engaging in and completing treatment."

One organization described a Narcan (naloxone) initiative that they have launched following 31 overdoses in one of their communities that occurred over one weekend. Within 24 hours, the organization came together with the county to set up shop in that area and offered onsite assessments, Narcan trainings, Narcan kits, access to detox, and outreach to family members.

Hard-to-Reach Populations

Key informants noted that some patient populations are particularly challenging to reach and engage into SUD treatment. One organization highlighted three populations that are hard to reach:

1. underinsured populations, primarily owing to the lack of funding to reach and serve this population;
2. populations that speak indigenous languages because of language barriers; and
3. certain impoverished rural regions of the state that cannot access treatment or resources.

Promising Practice:

"Taking some of the pieces from the playbook of how we do assertive outreach for patients with chronic and severe schizophrenia and other SMI [serious mental illness], we've done home delivery of injectable, long-acting medication for OUD. We started out with long-acting injectable naltrexone and are now adding long-acting injectable buprenorphine, and dosing in young adult homes. So far, we are only doing this in a boutique, small-scale research grant-funded setting, but want to learn how to make it more sustainable in usual care under Medicaid reimbursement. We don't know how to do that yet but think that it has potential."

Two organizations identified young adults (aged 18–26 years) with OUD as a hard-to-reach population. Challenges include treatment engagement in general, adherence to relapse prevention medicines, and rates of relapse to heroin and benzodiazepine use. One strategy is to focus on family engagement that includes leveraging the natural kinds of influence that families might have and teaching them about medications, adherence, and how to apply their leverage using contingencies. Additionally, one organization identified youth who are using marijuana as a difficult-to-reach population. The key informant expressed that because marijuana is decriminalized in her jurisdiction, but not legalized, youth do not understand the harms of marijuana use. To engage youth, this jurisdiction is focusing on employment and career connections.

Two sites identified pregnant and postpartum women as a hard-to-reach population. To better engage this population into care, one organization collaborates with local high-risk clinics. The organization also works to help mothers know what to expect when they come in for services. The informant added, "We tell mothers that your OB-GYN, addiction medicine doctor, and counselor can make sure that you have what you need and if that is outpatient services, perfect. If that's residential, that's what we'll do. We provide a service that makes sure they get back and forth to their prenatal appointments. If they need a higher level of care, we place them in residential and they are able to stay there after the baby is born. We also do mommy talks where the perinatologists talk to our pregnant moms about specific things like the importance of staying on your medication, the importance of treatment. All of that prepares them. There's not a fear associated because they know what to expect."

Treatment Barriers

Key informants identified factors that have resulted in significant challenges in meeting the needs of individuals with SUD.

Not having enough SUD providers was often mentioned as a large barrier. One key informant added that in rural areas, it is especially difficult to find staff that are credentialed or have the experience required to run some of their groups. The same organization also noted that DATA 2000–waivered prescribers that are interested in using their waiver are hindered by limited funding. Another site noted that waivered prescribers not prescribing to their cap or needing their cap raised is an "artificial barrier": that the number of prescribers at their cap is a trivial percentage and, that instead, the focus should be on how well clients' needs are being met and how to get people into care in significant and sustained ways. Another site, that has three DATA 2000–waivered prescribers, noted that funding limitations are preventing prescribers from reaching their cap.

Treatment cost was mentioned by each key informant as a potential treatment barrier. One organization noted that because they are not within a Medicaid expansion state, their uninsured population is struggling. The same organization would like to implement MAT now but believes that they would quickly run out of funding if they did so. Another site mentioned that although Medicaid will cover doctor visits and the cost of methadone, it's a different story for suboxone. The informant noted that no doctor in their town accepts Medicaid for suboxone as doctors think that "it's just not worth the time and energy to get reimbursed on something like $60 or $70 for a doctor visit." The informant added that their communities are forced into a "methadone hole," even though it may not be the most appropriate for those with Medicaid. Another organization noted the need for solid language on helping to reframe SUD programs and MAT, not as expenses but as investments in community health that will ultimately save a lot of money.

Promising Practice:

"We are fortunate to have a one-door-fits-all treatment facility where everybody goes through the same door. We received a grant from our community foundation to remodel a building with that in mind. When patients walk through the door, no one knows what they're going to be seen for. It could be mental health, SUD treatment, or medical management. I think there's not quite as much stigma with this approach."

A key informant from a Medicaid-expansion state noted that the fiscal problem that providers face is the lengthy lag time in receiving reimbursement. An example they provided was that when providers bring a client into treatment using grant funding for same-day access, as soon as the client enrolls in Medicaid, the provider cannot draw off the grant funding. The informant added that the providers do not get reimbursed for up to 4 months—posing a real burden on the providers who run on a "shoestring budget" to begin with.

Two sites noted the challenge of effectively using peers due to difficulties receiving reimbursement. One informant added that there is a shift in wanting peer support to be more of a therapist role (given the ease of reimbursing for doing that work) and how that shift takes away other roles that peers are best equipped to do. Another informant would like the reimbursement rates for peers to be increased because peers are such an integral part of SUD treatment and recovery and their impact should not be minimized because they do not engage in medical procedures or prescribe medications.

As a workaround to issues with Medicaid and other insurance serving as a treatment barrier, one organization recommended that states work with local state agencies to make sure that they are fully aware of community needs. The informant added that states have to be creative and strategically place patients into the specific funding source that is based on that funding stream's criteria.

One key informant noted that stigma plays a big role as it relates to SUD policies. The informant added that their state has several lawmakers who are not as informed as they would like and consequently understand SUDs in antiquated and very punitive ways. The informant added that SUDs are often seen as a mark against an individual's character.

On Insurance as a Barrier to Treatment:

"Preauthorization and continued concurrent authorization are incredibly complicated. You cannot wait a week to decide whether someone can be inducted on buprenorphine or methadone when you're talking about someone who is at significant risk for overdose. You can't wait a week to find out if someone's inpatient detoxification or stabilization has been approved. You can't withhold eligibility for benefits because they had a positive drug screen and you're no longer going to pay for their medication. Again, we have to look at how we're measuring success and success looks different for everyone including your state funding and carve out dollars where you have specialty buckets of money. Sometimes, the criteria can be so stringent that you really eliminate an entire population because they don't meet the criteria."

Another organization noted that although providers should welcome patients, humanize treatments, and empower patients to make good, healthful choices to the extent that they are able to exercise autonomy, we should not lose sight of the fact stigma has a role, stating, "love the person, hate the behavior." Two informants identified stigma toward individuals receiving medication for OUD as an issue among abstinence-based 12-step programs. One informant added that traditional abstinence -based programs carry the idea that "you're just replacing one drug for another."

Another site noted that child welfare imposes a large treatment barrier owing to stigma and discrimination. More specifically, the key informant said that child welfare thinks "these parents need to come off of the medication before they get reunified with their children or they set these time limits on the length of medication. They've got expectations that if somebody is trading one drug for another, then

they're not really helping their kids out. It's a lack of awareness and understanding and some of their personal bias."

In terms of addressing stigma, organizations are creative in their approaches. One organization launched a concentrated effort that targets community members, including employers, schools, and others to educate people about substance use, prevalence rates (so that individuals know that they are not alone), and what treatment and diversion look like. The organization particularly targets employers in their outreach as they have heard employers express discriminatory ideas such as, "it's too much risk to bring these people in." The same organization also engages in multiple speaking events across the state, offers SUD education courses (continuing education courses that give continuing education credit for free) on their website, and prepares pamphlets and posters on SUD treatment options to minimize the stigma associated with SUD treatment. Another organization works with churches in the community with the message that "you can be involved with the faith-based community while receiving MAT. And in fact, you may be more involved with the faith-based community, because you're not focused on using any more."

One site mentioned that 70% of their counselor's day is spent documenting and doing treatment plan reviews and assessments. According to the informant, reducing some of that need so that they can spend more time addressing the client would be beneficial. For example, one of their methadone clinics is Commission on Accreditation of Rehabilitation Facilities accredited—leading to a substantial amount of additional documentation requirements. The site mentioned that they have good clinicians that would rather go work in private practice because the documentation requirements are not nearly as stringent and they get paid more. The informant added that reducing paperwork may improve patient access by allowing physicians to see and treat more patients.

One organization noted challenges in engaging key stakeholders. For example, to successfully implement a jail diversion program, judges must be on board. To implement programs in jails and prisons, elected sheriffs must be on board. It is important to get probation and parole, the Commonwealth attorney, the treatment facility, and the state funding agency all on the same page. The key informant noted that "in a perfect world, if every single person on that list would believe in the same exact thought process and theory, it would still be difficult to get that many people together to agree on something immediately." To remedy some of these challenges, the state leverages existing relationships. When working with a Community Service Board that wants to implement a jail diversion program, for example, the first step is to learn who already has a relationship with local law enforcement then go from there.

Addressing Stigma:

"I believe that stigma exists but I'm politically incorrect in my assessment of the priority that the field is placing on it. Yes, it is a shame, a scandal, and an abysmal problem that we treat people with [SUD] the way we treat them. The notion that we're better off getting [SUD] out of the shadows just as we should get depression and schizophrenia out of the shadows, I'm all for that. But part of this disorder is that when we talk to the general public and say, "This is just like diabetes" that's baloney. It's NOT just like diabetes and the public knows that. The reason that families stigmatize their loved ones with addiction is not without reason. Their families have been lied to, cheated, stolen from, betrayed, and lost their souls, right? That's what SUD does to people. It's horrific. So, you have to reconcile that for people with a somewhat subtler message."

A few organizations noted the challenge of working with clients in recovery homes and transitional housing—in particular, the skepticism toward and/or prohibition of using medications in these settings. One informant added, "We would never exclude someone for being on blood pressure medication or diabetes medication and say, '*Well, you can't be here because you're not managing your glucose. So, if you haven't been able to do that by now by diet and exercise you can't come to our program.*' We actually have many situations where if patients are already engaged in transitional housing, they're not allowed to be on any medications and if they are, they are refused access to those services."

Resource and Technical Assistance Needs

Key informants identified several resource and technical assistance needs. Several organizations highlighted the need for behavioral health workforce training. In terms of implementing MAT, for example, one organization noted that it would be helpful to have a how-to guide that could illustrate how MAT programs work, best practices, and step-by-step strategies to launch a MAT program. The informant added that this guidance tailored to rural settings would be particularly helpful.

Another organization requested guidance on how to implement EBPs focused on SUDs. Currently, organizations might seek out EBP vendors and use the vendor's guidelines to set up the EBP. This can be a challenge when organizations begin using the EBP and find that it does not fit their particular client demographic or funding restrictions. The informant highlighted the need for basic understanding of what it takes to implement SUD services and how to adapt EBPs to diverse populations. One informant noted that there is need for training and technical assistance specifically related to engaging youth who are touched by the opioid epidemic.

Resource and Technical Assistance Needs:

"It would be great to identify model programs in MAT that organizations could take a look at. How are they functioning? What are their policies? What worked and didn't work? That that would be very helpful in terms of getting [an MAT program] off the ground."

Key informants noted that it would be helpful to learn how and what others are doing (on the ground) when it comes to SUD treatment. One organization noted that they informally speak with other similar organizations to learn what everyone is doing related to regulations (e.g., if the organizations operate across different states). One organization mentioned that learning about EBPs and then learning strategies about how to adapt them for specific populations would be helpful.

One organization expressed a desire to learn economic analysis methods but noted a "chicken-and-egg" dilemma: "On one hand, another organization can host as many trainings and webinars as it wants, but organizations are not going to get their staff to invest time until there is a state reimbursement model that makes it worth their while. On the other hand, if that state reimbursement model goes into effect, the state won't be able to utilize it because they don't have the technical capacity or infrastructure to engage in data analytics."

One key informant noted a need for a resource that documents the value proposition of specialty SUD care to general healthcare systems. For example, an organization may not know how to deliver services at scale or how to price, market, and contract with a big hospital system who would benefit from specialized SUD services. Currently, many SUD organizations know how to treat one referral at a time, not take a population, price it, document it, scale it, market it, and package it to general healthcare systems.

Discussion

Nationwide data collected from SSAs, SOTAs, and behavioral health providers demonstrate that:

1. Numerous efforts are being implemented across a continuum of care (prevention, treatment, recovery support, and harm reduction) to address the opioid epidemic.
2. Despite increased attention to addressing the opioid epidemic, persistent systemic, social, and economic factors continue to challenge access to SUD treatment and services, including MAT.
3. Eliminating SUD-related stigma is the highest-priority area among SOTAs and SSAs to improve evidence-based treatment for OUD.

Numerous efforts are being implemented at the federal, state, and local levels to address the opioid epidemic, through increased financing and reimbursement, training and technical assistance, and cross-agency coalitions and collaborative care strategies. Finance and reimbursement efforts include innovations in state Medicaid plans and waivers, expanded coverage of OUD medications within Medicare and commercial insurance plans, and requiring publicly funded providers to offer MAT. Survey responses show that states are funding prevention (e.g., coalitions with law enforcement and hospitals), treatment (e.g., MAT), recovery support, and harm reduction efforts at high rates. Cross-agency partnerships, linkages care and services, and collaborative care strategies were noted by many key informants, including receiving referrals from correctional facilities and collaborating with hospital systems to refer patients to a host of SUD services that are available 24 hours a day, seven days a week.

A range of systemic, social, and economic barriers to SUD treatment, including MAT, were identified by survey respondents and key informants, including the number of treatment providers, Medicaid and other

health insurance coverage, lack of stakeholder buy-in, and challenges working with clients in recovery homes and transitional housing (e.g., skepticism toward and/or prohibition of using medications for OUD in these settings). An insufficient number of DATA 2000–waivered providers was identified as a treatment barrier by SOTAs and SSAs; however, one of these respondents noted that they do not encourage or expect providers to work at the top of their cap because they believe a patient panel of ten in a busy primary care practice demonstrates strong penetration of MAT and allows for the embedded MAT team to support the physician in a meaningful way. This perspective was supported by a key informant who noted that DATA 2000-waivered prescribers not prescribing to their cap or needing their cap raised is an "artificial barrier" and that the true focus should be on how well client's needs are being met and how to get people into care in significant and sustained ways. Medicaid and insurance barriers also emerged as a common theme in survey and key informant data. SOTAs and SSAs felt that Medicaid and other insurance coverage impacts patient access to MAT and to SUD treatment services through inadequate coverage of treatment supports and staff such as peer recovery coaches. A related barrier was the effective use of peers owing to difficulties receiving reimbursement for their services. Key informants noted that there has been a shift in wanting peer support to be more of a therapist role (because of the ease of reimbursing for doing that work) and how that shift takes away other roles that peers are best equipped to do.

The elimination of SUD-related stigma was identified as the highest-priority issue that must be addressed first to improve evidence-based OUD treatment by survey respondents. Key informants agreed that stigma is a major barrier and highlighted the following resource and technical assistance needs: behavioral health workforce training, peer-to-peer learning opportunities, data analytics, and resources that explain how to establish and maintain collaborations. SOTAs and SSAs noted various populations that are most impacted by stigma, including pregnant and postpartum women followed by individuals residing in rural communities. This was supported in key informant interviews and organizations are implementing targeted outreach efforts to educate and engage these populations. One organization collaborates with local high-risk clinics that serve pregnant women to minimize the fear associated with SUD treatment and services. Another organization purposefully designed a one-door-fits-all treatment facility where everybody goes through the same door, whether for mental health, SUD treatment, or medical management. The importance and benefit of peer professionals as an integral part of SUD treatment to improve access to services and address stigma was echoed throughout the key informant interviews.

Recommendations

Barriers to the treatment of OUD and SUDs include lack of qualified treatment providers, disparities in treatment program access, regulatory barriers, financial barriers, and negative perceptions associated with treatment. Based on a review of data collected through this study and in order to improve access to SUD treatment, including MAT, the following policy and practice changes are recommended:

Strengthen the Behavioral Health Workforce

A robust and competent behavioral health workforce is critical to providing individuals with essential SUD prevention, treatment, and recovery services. Recommendations for strengthening the behavioral health workforce include:

- Identify systems-level factors that influence behavioral health workforce capacity
- Remove waiver requirements and prescriber caps for providing buprenorphine for OUD (for example, through the enactment of the Mainstreaming Addiction Treatment Act)[28]
- Identify the education and training needs of behavioral health professionals to foster addiction prevention, treatment, and recovery including the use of behavioral telehealth
- Develop technical assistance activities and peer-to-peer learning opportunities that bring together state officials from different states and municipalities to share ideas and programing

Broaden Patient Access to Substance Use Disorder Treatment

Recent studies have shown that more than 50% of adults and 35% of adolescents who received addiction treatment achieve sustained remission lasting at least 1 year.[29] Recommendations for broadening patient access to SUD treatment include:

- Engage in cross-agency collaborations related to addressing opioid misuse and SUD
    - Establish partnerships with local hospitals to provide care coordination (e.g., use of peer support specialists in EDs to work with individuals who present with an opioid overdose, connecting them to care and helping them navigate the treatment and recovery support environment)
    - Establish partnerships with Emergency Medical Services and/or law enforcement (e.g., use of peers on mobile teams to go to the site of an overdose or conduct home visits within 72 hours of a person surviving an opioid overdose)
- Develop materials and videos, place brochures in waiting rooms about medication for OUD to initiate conversations between patients and doctors, launch public service messaging, and offer trainings in cultural settings in areas that are affected by the opioid epidemic
- Increase funding, training, and technical assistance to support initiatives that engage unique populations (e.g., pregnant and postpartum women, youth, non-English speakers, indigenous populations, justice-involved individuals) through culturally tailored strategies and cross-sector partnerships
- Expand the use of nurse practitioners and physician assistants to prescribe MAT
- Consider implementing medication-first policies. The medication-first model has four principles: (1) individuals with OUD should receive pharmacotherapy as quickly as possible, ideally on the same day they are seen by a provider; (2) maintenance pharmacotherapy should be delivered without arbitrary tapering or time limits; (3) providers may offer, but should not require, individualized psychosocial services as a condition of pharmacotherapy; and (4) pharmacotherapy should only be discontinued if it worsens the patient's symptoms. In Missouri, most of the state's providers have embraced the model of rapid access to treatment and medication as an emerging and promising practice that is saving lives.[30]

Increase and Enhance Financing and Reimbursement

Like most types of health care, navigating the financing and reimbursement landscape of SUD treatment is a complex task that involves analyzing public and private payer policies on the local, state, and federal levels. Recommendations to address financing and reimbursement challenges include:

- Medicaid expansion across all states
- Lift MAT prior authorization requirements in all states
- Improve efficiencies related to Medicaid reimbursement
- Increase funding and sustainable reimbursement models for peer and recovery-based programs
- Increase funding and support for training and technical assistance to establish MAT programs, especially in rural and underserved areas.
- Develop coaching or mentorship programs to assist staff as they focus on sustainability

Minimize Stigma

Stigmatizing attitudes or behaviors have the potential to lead to a deficiency in patient access to care,

undertreatment, social marginalization, and undermining of the patient–provider relationship. There remains a level of stigma around behavioral health issues including addiction that may prevent the adoption of MAT programs. This stigmatization can lead to discriminatory practices in the delivery of primary and behavioral health care. Recommendations to minimize stigma as it relates to SUD services include:[15]

- Create multilayered activities and technical assistance programing to address stigma (e.g., assist states in developing resources to address stigma at the community and provider level, develop mechanisms for sharing best practices and materials)
- Increase education and training to overcome stigma related with MAT among abstinence-based services and support systems

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