Traditional approaches to drug use and addiction have resulted in an addiction treatment system that exists separately and apart from the rest of health care. This siloed approach is partially responsible for inadequate care for the majority of Americans with substance use disorder (SUD) and exacerbates existing inequities for Black, Indigenous, and people of color (BIPOC) communities.

In the 12-month period ending in October 2021 (Ahmad et al., 2022), drug-related overdose deaths in the United States claimed 105,000 lives. In 2020, Black individuals in our country experienced the largest percentage increase in overdose mortality rates. And, for the first time since 1999, overdose death rates among Black people were higher than rates among White people. The highest rate of overdose mortality in 2020 was in American Indian and Alaska Natives (Friedman & Hansen, 2022).

Developing an effective response to addiction and to drug user health requires an integrated approach that includes health care, housing, education, and employment services. An effective response relies upon a range of strategies, one that includes preventing conditions that lead to the development of SUD, employing harm reduction, and supporting services to sustain recovery. In this document, we will discuss three focus areas: (1) increasing access to health insurance coverage, (2) low-barrier treatment for SUD, and (3) evidence-based treatment in the criminal legal system when arrest cannot be avoided.

**Health Insurance Expansion and Reducing Barriers to Coverage**

The Affordable Care Act (ACA), together with Medicaid expansion and parity requirements, increased access to health insurance coverage for many Americans. However, as of February 2022, 12 states have not yet adopted Medicaid expansion (Kaiser Family Foundation, 2022). Expansion within these states would provide Medicaid coverage to 2 million Americans who are currently uninsured (Garfield & Orgera, 2021).

Medicaid is an important tool to expand access to quality health care (Center on Budget and Policy Priorities, 2020) and comprehensive SUD treatment (Bailey et al., 2021). However, even in the states where Medicaid expansion has occurred, racial disparities in access to health care (ASPE, 2022),...
negative economic and health effects from the COVID-19 pandemic (ASPE, 2022), and barriers to accessing SUD treatment persist. Only 10% of people who needed treatment for an SUD in 2019 received it (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020a), and access to medications for opioid use disorder (MOUD) is even more limited. See Figure 2 for potential policy strategies for expanding health insurance and reducing barriers to coverage.

**Expanding Low-Barrier Access to Treatment**

Accessing quality SUD treatment remains out of reach for too many people, yet regulatory revisions necessitated by the COVID-19 pandemic have allowed us to reimagine the future of addiction treatment. Flexibilities during the COVID-19 public health emergency include telehealth-initiated buprenorphine (Dooling & Stanley 2021a) and expanding eligibility for take-home methadone (Dooling & Stanley 2021b). These regulatory changes have shown positive outcomes for adherence in treatment (Amram et al., 2021; SAMHSA, 2022) and are an important illustration of the need for public policy to reflect research and best practices.

Providing quality, compassionate care is critical for people with SUD who have increased risk for other medical conditions such as arthritis, chronic pain, heart disease, diabetes, and hypertension (Scott et al., 2016). People who inject drugs are also at increased risk for HIV (CDC, n.d.) and Hepatitis C (Canzater, 2018). Furthermore, individuals often experience stigma when they seek and receive care within the health care system, resulting in a reluctance to obtain other needed services (Fong et al., 2021; Paquette et al., 2018).

Stigma, along with other structural legal issues and regulatory barriers, often makes access to treatment for opioid use disorder (OUD) difficult. Opioid agonist medications, methadone and buprenorphine, are safe and effective treatments for OUD and reduce the risk of death by up to 50%; however, only about 11% of people with an OUD receive these medications (SAMHSA, 2021a).

Although buprenorphine is available in office-based settings, methadone treatment often requires daily trips to a licensed opioid treatment program (OTP) for supervised dosing (SAMHSA, 2021b). Barriers to methadone treatment include variability in state laws regulating OTPs (Jackson et al., 2020), state moratoriums on new OTPs, and a lack of Medicaid insurance coverage within OTPs (The Pew Charitable Trusts, 2021a).

These multiple regulatory barriers, along with existing racial inequities must be addressed in any plan to expand access to MOUD. Black
patients are 77% less likely to receive buprenorphine and are more likely to receive methadone, which poses significantly greater access issues (The Pew Charitable Trusts, 2020). Studies have found that OTPs are more commonly found in Black and Hispanic/Latino communities, while access to buprenorphine is more prevalent in White communities (Goedel et al., 2020). See Figure 3 for potential policy strategies for expanding access to low-threshold services.

**Expanding Access to Treatment for People Involved in the Criminal Legal System**

The criminal legal system has long been a common, yet ineffective, means to address drug use in the United States. Despite the growth of the prison industrial system in the name of the war on drugs, access to evidence-based health care and treatment within this system is limited. Courts, probation, and parole systems often limit the types of treatment accessible to justice-involved individuals with SUD. The prohibition on federal health benefits (including Medicaid) while an individual is incarcerated exacerbates this lack of access to quality care (Rohde et al., 2022). Most correctional facilities do not provide MOUD despite evidence that it reduces risk of death, drug overdose, re-arrest, and reincarceration (Evans et al., 2022; Ranapurwala et al., 2018; Westerberg et al., 2016). Individuals leaving incarceration are between 10 and 40 times more likely to die of an overdose than the general population (Berg, 2019; Binswanger et al., 2007).

For as long as criminal legal responses are used to address a public health crisis, providing Medicaid within correctional facilities may improve outcomes for individuals with SUD by establishing quality care standards, improving the coordination of care post release (Khatri & Winkelman, 2022), and expanding access to SUD treatment (Legal Action Center, 2022a). Efforts to inform the judiciary branch (National Judicial Opioid Task Force, 2019) and litigation over (U.S. Department of Justice, 2022) access to quality health care and treatment in these settings has recently gained momentum. See Figure 4 for potential policy strategies to expand access to treatment in the criminal legal system.

**Conclusion**

Given the severity in the number of overdose deaths, it is increasingly difficult to argue that the overdose crisis is not a societal issue. Moving beyond the individualistic approach requires structural solutions. Implementing policies that provide access to quality health care and evidence-based treatment for people who use drugs and people living with addiction must be prioritized. Scaling up innovative programs and best practices will help meet the needs of individuals most at risk for overdose and other negative health outcomes. Legislation, litigation, and regulation are powerful tools that we can use to craft a health care and treatment system that provides individualized, low-barrier, and evidence-based care to people who use drugs that centers the importance of quality outcomes and the social determinants of addiction.
The American Rescue Plan Act of 2021 increased health insurance Marketplace subsidies and provided FMAP incentives to states that have not expanded Medicaid if they elect to do so (ASPE, 2022).

The Mental Health Parity and Addiction Equity Act of 2008 seeks to enact equitable insurance coverage for mental health and SUD care, but enforcement remains limited. To fulfill the promise of this act, federal and state governments must oversee and hold health insurance plans accountable (The Kennedy Forum, n.d.).

Increasing rates of overdose deaths involving methamphetamine suggests a need for expanding health care coverage for treatment of stimulant use disorders. Although still too limited, California recently received a waiver from CMS to launch the first federally approved contingency management program—and evidence-based treatment for stimulant use disorder (California DHCS, 2021; SAMHSA, 2020b).

Requiring patients to obtain approval for a prescribed health service or medication remains a significant barrier in accessing SUD treatment. Parity requirements prohibit the discriminatory use of prior authorization; however, not all patients with SUD are protected, and standards vary across state laws (Legal Action Center, 2020a).

This cost reduction strategy requires patients to try a less expensive treatment option and “fail” first before their insurance plan authorizes a more expensive treatment or medication. This practice is permitted by Centers for Medicare & Medicaid Services (CMS) despite the risks for patients and conflicting evidence on cost savings. Prohibition, implementation of standards, and regulatory oversight for step therapy policies are state-level strategies to ensure patients have access to timely, quality health care (Legal Action Center, 2020b).
Figure 3. Policy Strategies to Expanding Access to Low-Threshold Services

Person-Centered Treatment
The Imani Breakthrough Project is a church-based recovery program centering the social determinants of health into a faith-based, and culturally informed harm reduction SUD treatment that includes access to MOUD (Bellamy et al., 2021).

Integrated Care
Certified Community Behavioral Health Clinics (CCBHCs) integrate mental health and SUD. There are currently more than 430 CCBHCs operating in 40 states, the District of Columbia, and Guam (National Council for Mental Wellbeing, n.d.).

Evidence-Based Treatment
The Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS), created by Shatterproof, is a navigation platform connecting people with individualized, quality care for SUD. ATLAS currently operates in a select number of states but is planned to expand nationally (Shatterproof, 2022).

Low Barrier Buprenorphine
Washington State’s Low Barrier Buprenorphine program (The PEW Charitable Trusts, 2021b) and Missouri’s Medication First models provide flexible access to buprenorphine. These models have been shown to be an effective strategy towards expanding access, improving retention, and reducing the costs of treatment (The PEW Charitable Trusts, 2021c).

Healthcare Provider Training
Providing comprehensive training to health care providers on SUD prevention and treatment is an important strategy to support patients who use drugs, expand access to evidence-based treatments, and integrate substance use services with health care (SAMHSA & Office of the Surgeon General, 2016). The REACH (Recognizing and Eliminating disparities in Addiction through Culturally informed Healthcare) training program is working to increase the number of racial and ethnic underrepresented minority (URM) addiction specialists and the number of addiction specialists who trained to work with racial and ethnic URM patients with SUD (REACH, n.d.).

Removing the X-Waiver
In 2021, SAMHSA revised its regulation to allow health care professionals to prescribe buprenorphine without the required waiver from the Drug Enforcement Administration (DEA) for 30 or fewer patients (SAMHSA, 2021d).

Flexible Methadone
In 2021, the DEA released new rules reversing a moratorium on approval for new methadone vans that provide the opportunity for additional access to MOUD (El-Sabawi et al., 2021). Recent guidance put out by SAMHSA, extending methadone take-home flexibilities, indicates the agency is considering regulatory strategies to make them permanent (SAMHSA, 2022). Legislative action can also be taken to make these flexibilities permanent and to expand access to methadone in pharmacies.
Quality Health Care
Several states have proposed Section 1115 waivers requesting authority to waive the Inmate Exclusion Policy (Haldar & Guth, 2021) to use federal Medicaid funds during incarceration. Legislative action can also be taken to amend the Social Security Act that prohibits the use of federal funds within correctional facilities.

MOUD Access
A number of states have required or encouraged access to MOUD in correctional settings through executive action or legislation (Weizman et al., 2021) and a recently published model law provides an evidence-based framework for implementation (Legislative Analysis and Public Policy Association, 2020).

The Right to Care
Litigation brought against jurisdictions has revealed that denying access to MOUD in correctional facilities constitutes violations of Title II of the Americans with Disabilities Act and the Rehabilitation Act (Legal Action Center, 2022b).
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Acknowledgment: This brief was developed in collaboration with the O’Neill Institute for National and Global Health Law.