A registered nurse at a clinic in Maine dispenses methadone at a dosing window. *Jack Milton/Portland Press Herald via Getty Images*

Opioid Treatment Programs: A Key Treatment System Component

State and federal policy changes would increase access to FDA-approved medications and improve care

Overview

The most effective treatments for opioid use disorder (OUD) are the three prescription medications approved by the U.S. Food and Drug Administration (FDA)—methadone, buprenorphine, and naltrexone—that are proved to increase a patient's treatment retention and reduce illicit use and the risk of overdose.[1] The only facilities legally able to offer all three medications are opioid treatment programs (OTPs), a critical component of the U.S. substance use treatment system that are regulated by the federal Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA), as well as state agencies, and are certified to administer any FDA-approved medication for the treatment of OUD.[2] As of March 2021, there were 1,816 OTPs in the United States, and in March 2019, the last year for which data is available, approximately 409,000 patients were receiving methadone treatment at OTPs—the only health care setting where this medication can currently be accessed.[3]

Despite the key role OTPs play and the large number of people in need of treatment, federal, state, and local jurisdictions restrict the availability and accessibility of medications for opioid use disorder (MOUD) at OTPs. To ensure that comprehensive OUD care at OTPs reaches populations in need and is integrated into systems delivering other health care services, such as primary care, state and federal policymakers can take the following steps:

Eliminate burdensome restrictions on the establishment of new OTPs.

- State lawmakers can reduce zoning restrictions and other legal hurdles that prevent the creation of new OTPs.

Improve OTP integration into broader initiatives to reform health care delivery.

- State behavioral health agencies should incorporate OTPs into new health delivery system reforms that serve Medicaid enrollees with complex needs, including OUD.

Facilitate the adoption of new OTP models that bring medications to underserved populations and reduce barriers for initiating methadone.

- State behavioral health agencies should help establish medication units, which are offsite facilities affiliated with an OTP that can dispense medications, and extend OTP services in homeless shelters, prisons, rural communities, and other harder-to-reach settings.
- Federal and state policymakers should enable patients to receive medication while they await placement in an OTP.

Expand take-home dosing and treatment in new settings.

- Federal and state policymakers should allow OTPs more flexibility to dispense methadone for use at home (e.g., distributing one month's worth at a time) so patients do not have to return to a clinic every day to receive their treatment.
- Federal policymakers should allow methadone to be distributed in pharmacies, primary care offices, and other community care settings.

Improve OTP access for patients with Medicaid or Medicare.

- Congress and state policymakers should ensure Medicaid permanently covers all medications for OUD.
- Congress, the Centers for Medicare and Medicaid Services (CMS), and state policymakers should increase the number of OTPs that accept Medicare and Medicaid, including by amending payment policies to incentivize their participation in the programs.

Introduction

To understand the need for new rules that can expand access to OUD treatment, it is important to outline how existing federal regulations impede the establishment of new OTPs and inhibit access to MOUD at these facilities.

Regulation of methadone and OTPs

Methadone was first approved for the treatment of OUD in the 1970s, and for decades was the only FDA-approved medication available to treat this disease.[4] Evidence shows that methadone reduces overdose deaths, illicit opioid use, and the transmission of infectious diseases, such as hepatitis C and HIV, and decades of research have demonstrated its safety and effectiveness.[5] However, under federal regulations for the treatment of OUD, methadone is generally only available through an OTP.[6]

Methadone is further restricted by stringent regulations on where the medication can be taken. Typically patients must travel to an OTP to receive medication on a daily or near-daily basis, especially early in their treatment.[7] Under certain circumstances, laws and regulations allow patients to receive take-home doses of medication.[8]

Federal regulations also outline dosing, including initiation.[9] For example, the initial dose cannot exceed 30 mg and may not be increased to more than 40 mg total on the first day of treatment; once a patient is stabilized, typical daily maintenance doses range from 60 to 120 mg, which routinely creates sufficient tolerance to minimize the euphoric effect of other opioids a patient may consume.[10] In contrast to strict regulations on methadone used for the treatment of OUD, no special federal regulatory provisions apply to the use of methadone for the treatment of pain: Any health care practitioner with a controlled substance license from the DEA may prescribe it for pain.

Federal regulations also require OTPs to provide counseling and a range of assessment and treatment services.[11] Specifically, OTPs must require that patients complete a full medical examination within the first 14 days of admission and participate in regular assessments. Each patient must have a treatment plan, which outlines requirements for education, vocational rehabilitation, employment, and other supportive services that a patient needs. Many OTPs also offer other health care and ancillary services, such as screening and treatment for HIV and viral hepatitis; formal arrangements with primary care providers for the treatment of other physical health conditions; family planning; and transportation assistance.[12]

While OTPs are the only place patients can obtain methadone for addiction treatment, many of them also provide buprenorphine and naltrexone. Of the nearly 1,700 OTPs that responded to the National Survey of Substance Abuse Treatment Services in 2019, 536 offered all three medications for OUD.[13] Although both naltrexone and buprenorphine may be prescribed in non-OTP office settings, such as primary care clinics and hospitals, buprenorphine is subject to special regulatory requirements.[14] Per federal law, clinicians practicing outside of OTPs may prescribe buprenorphine for OUD only if they apply to SAMHSA for a waiver, which impedes access to this medication.[15]

OTP integration and accessibility

While each form of MOUD should be accessible to meet an individual's treatment needs, the location of OTPs and access to these medications vary, with significant correlation to the racial or ethnic composition of the community.[16] One study found that, in 2016, counties with highly segregated African American and Hispanic/Latino communities had more treatment facilities providing methadone per capita, while counties with highly segregated White communities had more facilities providing buprenorphine per capita.[17] The same investigation proposed the root cause: "As heroin use and crime became increasingly racialized in the media and political discourse in the early 1970s with the beginning of the War on Drugs, OTPs were primarily targeted to urban African American communities with the goal of reducing crime."[18]

Today, methadone access remains siloed, both geographically and within the health care system. OTPs tend to be concentrated in urban areas: The estimated average drive time to an OTP for people living in rural areas is six times greater than for those living in urban areas.[19] In addition, only 9% of OTPs are located in facilities that provide residential treatment—settings where more than 80,000 patients received treatment for substance use disorder in 2019[20]—and 9% are in facilities that provide hospital inpatient treatment.[21] While no federal regulations prevent OTPs from operating in other settings where many individuals may receive health care treatment, such as primary care and community health centers, correctional facilities, and hospitals, OTPs are rarely physically integrated with or located near these facilities. For example, nearly 2 in 3 community health centers now provide medication for OUD, thanks in part to federal grant support in recent years, but only 7% of these health centers are certified as OTPs to provide methadone.[22]

The lack of OTP integration into primary care is especially challenging in rural parts of the country, where there is limited access to stand-alone OUD treatment providers. Federally qualified health centers (FQHCs) play a major role in delivering primary care in rural areas of every state, serving approximately 1 in 5 rural residents across the U.S., regardless of their ability to pay.[23] However, according to a 2018 survey conducted by George Washington University and the Kaiser Family Foundation, nationwide nearly half of community health centers provide medication-based treatment for OUD, while only 16% provide treatment with methadone.[24] The dearth of OTPs in many parts of the country, along with the limited integration of OTPs into other care settings, means many patients are unable to access the full range of medications for OUD. Lack of integration also creates barriers to coordinating patient care.

Federal Regulatory Flexibilities During the COVID-19 Pandemic Create Opportunities for Long-Term Improvement

Under the COVID-19 public health emergency declared by then-U.S. Secretary of Health and Human Services Alex Azar in January 2020, federal agencies implemented regulatory flexibilities intended to reduce unnecessary in-person contact for patients.[25] This fundamentally changed how care can be delivered by OTPs by:

- Allowing states to request blanket exceptions so OTPs have the option to provide 28 days of take-home methadone for stable patients, and up to 14 days for patients who are less stable yet still able to safely manage this medication, as determined by the OTP.[26]
- Suspending required in-person consultation for the initiation of buprenorphine and allowing OTP providers to meet with patients via video conference or telephone instead.[27]

State and federal policy changes can expand access to OTPs and improve care

The following 10 recommendations would make it easier for new OTPs to open, improve the care delivered through these programs, and expand access to high-quality treatment for OUD.

Eliminate burdensome state restrictions on the establishment of new OTPs.

Recommendation 1: State lawmakers should remove moratoriums and other legal barriers preventing OTPs from opening.

In some states, burdensome laws or regulations prevent the establishment of new OTPs, slowing the opening of new opioid treatment programs across the country. Regulatory barriers take various forms, such as zoning restrictions—implemented in 22 states—that prohibit facilities from being established in certain locations, which complicates access to care.[28] A review of state regulations as of 2017 identified 10 states that require a certificate of need—a legal document demonstrating public need for new facility services that requires approval by local governing authorities.[29] This type of restriction is unique to OTPs and separate from processes applying to other types of health care facilities.

Since the 2017 review, some of those states have taken legislative action to lower barriers to establishing OTPs. For example, in 2019, Louisiana passed legislation requesting that the Department of Health issue regulations to

allow establishing new OTPs.[30] In addition, the legislature asked that the regulations focus on establishing OTPs that offer all three forms of MOUD, provide services for patients enrolled in Medicaid, are in rural areas with high rates of overdose deaths, or are integrated within community health care settings.[31] Similarly, in 2018, Indiana allowed the establishment of nine additional OTPs, prioritizing those that are integrated into other health care settings such as hospitals.[32]

Other barriers to establishing OTPs may include state and pharmacy board regulations that are more restrictive than federal law, such as requiring new facilities to obtain a license from the board of pharmacy or requiring a pharmacist to be on staff.[33] For instance, New Mexico administrative code stipulates that OTPs must have a license from the Board of Pharmacy to be eligible to receive approval to operate from the Department of Health.[34] And as of 2017, nine states required that OTPs employ a pharmacist.[35] These requirements go beyond federal regulations, which do not mandate a pharmacy board licensure or pharmacist on staff and allow methadone administration by an appropriately licensed pharmacist, registered nurse, licensed practical nurse, or any other health care professional authorized by federal and state regulation to administer or dispense opioid medications.[36]

Improve OTP integration into health care coordination frameworks.

Recommendation 2: State behavioral health agencies and Medicaid programs should integrate OTPs into broader delivery system reforms.

In 2010, the Affordable Care Act established a new Medicaid model allowing states to reimburse providers for care coordination and health promotion services for Medicaid enrollees with complex health care needs, including those with OUD.[37] This enabled states—under a CMS initiative—to reimburse OTPs that serve as "health homes," which address behavioral issues and other patient health needs.[38] A number of states—including Maryland, Michigan, Rhode Island, and Vermont—have implemented a health home model that incorporates OTPs.[39] Implementation differs by each state, but one effective approach is the use of a "hub-and-spoke" system.

Hub-and-spoke maximizes the appropriate use of care settings. It involves treating individuals with acute needs in specialized settings, known as hubs, then transferring them to community-based settings, known as spokes, when they are stable. Advantages of this approach are that hubs are reserved for patients with more complex needs and waitlists are reduced.[40] A key component of the hub-and-spoke system is care teams that may consist of nurses and counselors who help coordinate care.[41] In Vermont, the first state to adopt this type of delivery system, OTPs serve as hubs.[42] In this system, hubs are staffed by certified addiction specialists, and spoke providers can consult with them and transfer patients back if they become less stable.[43] Moreover, the importance of incorporating OTPs in the hub-and-spoke system is underscored by their ability to provide all three forms of MOUD. In 2016, the Vermont treatment network contributed to the state achieving the highest per capita treatment capacity for OUD patients in the country: 10.56 people in treatment for each 1,000 residents.[44] The state also saw a 64% increase in physicians waivered to prescribe buprenorphine between 2012 and 2016.[45]

Fueled by Opioid State Targeted Response federal funding, other states such as California and Washington have been adopting a version of hub-and-spoke. In the first 18 months of the program, Washington's model resulted in nearly 5,000 individuals starting on MOUD, of whom 19% received methadone.[46] California's model initiated 9,511 new patients on MOUD within its first 15 months, with the majority of hub patients (84.7%, or 4,667 individuals) receiving methadone at OTPs.[47] Preliminary results also showed more spokes began to help initiate patients on buprenorphine treatment, leading to a 94.7% increase in the average monthly number of patients starting buprenorphine at these sites between August 2017 and October 2018.[48]

To integrate typically isolated service delivery systems, state behavioral health and Medicaid agencies should consider the OTPs as health homes and adopt a version of the hub-and-spoke model that fits their respective state's health care system. As California and Washington did, states can explore applying for federal funding to support this initiative.

Facilitate the establishment of medication units and access to interim methadone at the state level.

Recommendation 3: State behavioral health agencies should help establish medication units, nonmobile dosing sites affiliated with OTPs.

Under federal regulations, medication units may offer dosing and urine screens but not counseling.[49] Because many individuals receive dosing daily, a medication unit might be in a more convenient location for patients, such as a community health center or pharmacy. Medication units increase the number and types of providers offering MOUD, and help reach underserved populations, such as those in rural areas. They are a way to integrate methadone into community-based settings under existing federal regulations.

Ohio has successfully established medication units through a change to administrative rules to explicitly state that OTPs may voluntarily establish medication units and specify their allowable locations—including homeless shelters, jails, prisons, boards of public health, federal qualified health centers, and Appalachian counties as defined by the Appalachian Regional Commission.[50] This has allowed the state to integrate medication units into rural parts of the state and key treatment settings.

Recommendation 4: State policymakers should facilitate access to interim methadone as patients wait to enroll in more comprehensive services.

Interim methadone treatment allows an OTP to provide the medication to individuals for up to 120 days as they await placement in a methadone program.[51] Counseling and other services that are typically required to be offered through the OTP are not required while an individual is receiving interim methadone treatment. Federal regulations allow this option in state-run and nonprofit facilities. To establish this type of treatment, a program must receive approval from SAMHSA and the state's chief public health officer, and patients must receive comprehensive services within 120 days of requesting treatment.[52] Research suggests that when standard treatment, which includes counseling, is unavailable, interim methadone should be widely available.[53]

In Vermont, a university received federal grant funding to pilot a telehealth intervention aiming to provide interim medication treatment to patients on an OTP's waitlist.[54] The project used a locked, portable, automatic pill dispenser to store buprenorphine and allow patients access to doses during a predetermined window of time.[55] A pilot study found that those in this interim treatment group showed a significant reduction in the use of illicit opioids at 12 weeks, compared to those on the OTP waiting list who did not receive treatment.[56]

To ease the adoption of interim methadone treatment, the federal government should consider updating regulations to eliminate the requirement that OTPs receive approval from SAMHSA and the state's chief public health officer before offering interim treatment.

Consider updates to federal and state regulations to expand methadone take-home dosing and to facilitate access to treatment in new settings.

Recommendation 5: Federal policymakers should consider options for increasing access to methadone through relaxed regulatory requirements, such as increasing access in office-based settings or expanding take-home dosing.

Recommendation 6: State policymakers should align their state OTP regulations for take-home dosing with federal regulations.

Federal regulations limit when patients can obtain methadone doses to take unsupervised at home, known as take-home dosing.[57] This contributes to barriers to access. For patients who must travel long distances to reach OTPs, getting there daily can be burdensome, and clinic hours may conflict with work schedules and child care

responsibilities.[58] Federal take-home rules include limits on the number of take-home doses a patient may receive based on their time in treatment, with only a single dose permitted per week during a patient's first 90 days of treatment.[59] The number of take-home doses a patient is eligible to receive gradually increases based on time in treatment until the patient has been in treatment for two years. Although federal regulations specify the maximum number of take-home doses a patient may receive, the OTP medical director is required to approve a patient's use of take-home medication.[60] Medical directors must consider eight criteria in determining whether a patient should be permitted take-home doses. Some of these criteria, such as "stability of the patient's home environment and social relationships," are inherently subjective, which may introduce bias in who is approved for take-home privileges.

During the public health emergency to address COVID-19, SAMHSA and the DEA relaxed federal requirements around methadone to include greater flexibility for take-home dosing and limiting face-to-face contact at treatment facilities.[61] Many states provided guidance on adopting the new federal flexibilities.[62] Guidance included allowing take-home dosing for patients diagnosed with COVID-19, those at higher risk of dying if they contracted COVID-19, and for stable patients, who could be further along in their recovery.

Although increased flexibility remained in place as of July 2021 and evidence was still accumulating, there have been no reports of widespread medication diversion or misuse specifically tied to more flexible take-home dosing policies. Quantitative and qualitative evaluations of the impact of regulatory flexibilities during the pandemic could support and influence long-term federal regulatory changes, such as increasing access in office-based settings or allowing more flexible take-home dosing. According to a report by authors at the George Washington University Regulatory Studies Center, these flexibilities could be made permanent through regulatory changes without the need for legislative action by Congress.[63]

Separate from the temporary take-home flexibilities allowed by federal and state governments during the pandemic, some states have their own long-standing methadone take-home rules. Although they may not put in place take-home rules that are less restrictive than federal requirements, states may have policies that are more restrictive. A recent regulatory review identified 12 states that prohibit take-home dosing during the first

30 days of treatment and seven states that prohibit this practice during the first 90 days.[64] This approach is inconsistent with OTP best practices and SAMHSA recommendations for take-home dosing as crucial to keeping patients in treatment.[65]

State regulators and lawmakers should make their take-home dosing regulations no more restrictive than federal regulations. For example, Ohio's rules for take-home dosing align with and cite federal regulations that permit one take-home dose per week during the first 90 days of treatment.[66] If federal take-home dosing regulations are loosened, states should update their rules to match.

Another strategy to increase access to methadone is for the federal government to make it available in other settings, such as pharmacies and primary care offices.[67] This approach has been in place in other countries for decades—including Canada, Ireland, and Australia—and is shown to increase methadone treatment capacity.[68] For instance, after lawmakers in Australia approved less restrictive policies to allow physicians to provide methadone, the country's treatment capacity increased from 2,000 to 15,000 providers between 1985 and 1995.[69] U.S. federal policymakers should consider adopting a similar approach to expand access to methadone treatment beyond the highly regulated OTP setting.

Leverage federal funds to improve access to mobile methadone.

Recommendation 7: State behavioral health agencies should apply for federal funding to pay for mobile units to expand availability of methadone in rural and criminal justice settings.

In June 2021, the DEA finalized regulations to authorize OTPs to operate mobile units.[70] This change follows a moratorium the agency placed on authorizing mobile units in 2007, which resulted in a decline in the number of mobile units. As of June 2021, only eight OTPs nationwide were operating mobile units.[71]

Mobile units can greatly expand access to treatment by offering or continuing methadone for individuals in correctional settings, where populations suffer high rates of substance use disorder, including OUD.[72] For example, an OTP in Atlantic County, New Jersey, brings its mobile methadone van to the county jail to continue treatment for individuals who were stable on methadone when they entered jail, and to provide medication to individuals who are incarcerated and newly seeking treatment.[73] In fact, the mobile model has been adopted as an effective way to bridge access to care for OUD, including the provision of buprenorphine to people exiting jails.[74] In Baltimore, a mobile unit makes buprenorphine treatment available directly outside the discharge doors of a local jail.[75] Allowing OTPs to have mobile units would enable more patients access to the full spectrum of medications for OUD.

Mobile units can also help to close the gap in treatment access in rural areas, where OTPs are few and far between, and patients report traveling long distances can impede work and inhibit their ability to stay on treatment.[76] Six states and Puerto Rico have used mobile units, also called "methadone vans," to reach patients unable to travel for treatment.[77]

Now that the DEA has finalized regulations, states should consider applying for a range of federal grants to acquire vans and other resources needed to establish mobile units. With its focus on rural communities, the United States Department of Agriculture's website has a list of grant opportunities across the federal government that states may use to address the opioid crisis.[78] For example, Michigan used funding from the federal government's State Opioid Response grant to fund mobile units that prescribe buprenorphine both to people living in rural areas and those in urban areas with limited transit options.[79] In addition, state and local governments that have received opioid settlement funds and are interested in acquiring mobile units may consider allocating proceeds for this purpose.

Improve OTP access for Medicaid patients.

Recommendation 8: Congress should advance legislation that makes permanent the current temporary requirement that Medicaid programs cover all forms of MOUD and ensure that all states comply.

Recommendation 9: State policymakers should ensure their Medicaid programs cover MOUD and other services at OTPs, and they should amend payment policies to incentivize OTPs to participate in the program if they do not already accept Medicaid insurance.

Federal law requires that state Medicaid programs cover all FDA-approved forms of MOUD, including methadone, from October 2020 through September 2025, unless the state certifies to the U.S. secretary of Health and Human Services this is not feasible due to provider or facility shortages.[80] State Medicaid programs have made progress in covering methadone in recent years. Of the 51 programs across all 50 states and the District of Columbia, only 38 covered methadone in 2018; in the following year, only six programs did not, but had plans to meet federal requirements to begin coverage in 2020.[81] While there has been progress, no analysis has been published demonstrating compliance with the law since October 2020, and absent the federal mandate it is not certain all states would continue to cover methadone. Congress should make permanent the requirement that Medicaid cover all forms of MOUD, including methadone, and use its authority to monitor state practices and ensure that states comply with the law. Congress can ensure that any exceptions to the requirement approved by the secretary of Health and Human Services have a time limit and are accompanied by a state action plan to address shortages of qualified providers and facilities. This could include directing the independent legislative branch agencies Medicaid and Children's Health Insurance Program Payment and Access Commission or the Government Accountability Office to analyze state Medicaid coverage policies; requesting reports on the status of state compliance from the Centers for Medicare and Medicaid Services; or holding hearings on the topic.

Despite progress on covering methadone, not all OTPs accept Medicaid as a source of payment for treatment services; in 2019, nearly 1 in 5 OTPs fell into this category.[82] This may be due to a lack of Medicaid coverage for OTP services in the state or, in states where Medicaid does cover OTP services, challenges in meeting Medicaid standards for reimbursement.[83] However, a 2019 analysis of six states showed that OUD among Medicaid enrollees is higher than the national average, and another study reported that, in 2016, there were 58,745 Medicaid enrollees aged 18 to 64 with an initial OUD diagnosis across all states.[84] States should therefore take steps to ensure that OTPs accept Medicaid insurance and that these coverage policies are updated to cover all three forms of MOUD at OTPs. While this may be a complex undertaking, several states have started taking these steps. In 2019, the Louisiana legislature passed a resolution urging the state health department to advance new regulations allowing the establishment of new OTPs, and that in developing the regulations the department consider providing new OTPs that deliver services to patients with Medicaid.[85] Massachusetts requires that licensed substance use treatment facilities provide services to residents with public health insurance programs, such as Medicaid, on a nondiscriminatory basis and report payer data to the state's Department of Public Health.[86] Since 2017, West Virginia has required that OTPs bill Medicaid and receive rejection of prior authorization or of a submitted claim or a written denial from the state's Medicaid program before directly billing a patient for opioid treatment.[87] And Vermont increased Medicaid reimbursement to OTPs by 30% and saw increases in the number of patients receiving methadone.[88]

Improve OTP access for patients with Medicare.

Recommendation 10: Congress and CMS should ensure that OTPs accept Medicare patients.

It is estimated that, by 2030, over 1 in 5 Americans will be eligible for Medicare.[89] Individuals aged 65 and older have experienced a large increase in the need for OUD treatment in recent years, and this age group, which comprised approximately 86% of the Medicare population in 2018, had larger increases in opioid overdose death rates than any other age group in both 2017 and 2018.[90] Medicare has not historically covered methadone for the treatment of OUD; however, in January 2020 it began covering the treatment at OTPs in compliance with recent changes to federal law.[91] In order for this benefit to improve access to OUD treatment, OTPs must accept Medicare payment.

While there had been no research gauging OTP participation in the Medicare program published as of late 2020, there is reason to suspect that OTPs, like other treatment facilities, will be slow to take on Medicare patients. Despite the fact that Medicare covers treatments for substance use disorders prescribed outside OTPs, one national study found that in 2016 only 13.8% of non-OTP substance use treatment facilities in the U.S. offered at least one form of MOUD and accepted Medicare.[92] The same study found that about 40% of Medicare beneficiaries reside outside of a county with one of these facilities, and that a much higher share of treatment facilities—28.6%—accepted private insurance and offered MOUD.

Congress and CMS should track OTP acceptance of Medicare payment and take action to increase uptake as needed. CMS can evaluate responses to the National Survey of Substance Abuse Treatment Services to determine which OTPs reported accepting Medicare for payment in 2020, as well as monitor Medicare insurance claims to determine what share of OTPs are actually treating Medicare patients.[93] Congress could also direct the Medicare Payment Advisory Commission or the Government Accountability Office to survey and interview OTPs to determine what barriers inhibit accepting Medicare payment for methadone services, and take appropriate action. Options could include amending Medicare payment policies to incentivize OTP acceptance or conducting additional OTP outreach to increase their awareness of Medicare coverage.

Conclusion

OTPs play a vital role in the OUD treatment landscape, particularly through their ability to provide all three forms of MOUD. However, regulatory barriers remain to expanding these programs across the nation. Given the need to increase access to MOUD, state and federal policymakers should pursue policies that permit the establishment of new OTPs, allow new mobile units, improve the care these programs deliver, and integrate OUD care within the broader health care delivery system. These actions will connect more individuals to lifesaving OUD treatment and reduce gaps in access to treatment.

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