Date: September 18, 2025

To: Senate Interim Committee on Health Care
Senate Interim Committee on Early Childhood and Behavioral Health
Senate Interim Committee on Human Services
House Interim Committee on Behavioral Health
House Interim Committee on Health Care
House Interim Committee on Early Childhood and Human Services

From: Annaliese Dolph, Director, Alcohol and Drug Policy Council

Alcohol and Drug Policy Commission Report and Recommendations in Accordance with House Bill 4002 (2024) Section 11

The Alcohol and Drug Policy Commission (ADPC) is an independent state government agency created by the legislature in 2009 to improve the efficiency and effectiveness of substance use services for all Oregonians. The ADPC accomplishes this through a comprehensive substance use prevention, substance use disorder treatment and recovery support services plan for the state, in cooperation with fourteen participating state agencies.[1] ORS 430.221 – 223.

The 2024 legislature charged the ADPC with a study of barriers to and best practices for: (a) youth accessing opioid use disorder (OUD) treatment; and (b) increasing access to Medications for Opioid Use Disorder (MOUD) treatment. The bill also requires the ADPC to create a youth strategic plan in conjunction with the System of Care Advisory Council (SOCAC) and strategies to remove barriers to MOUD treatment. The ADPC provided a preliminary report in September 2024. The ADPC and SOCAC are each finalizing five-year plans by January 1, 2026.

The following document serves as the ADPC final report directed by HB 4002 (2024), Section 11. The study examines access and barriers to MOUD across the state and provides sets of recommendations for the legislature, funding opportunities, and potential state agency actions to positively impact MOUD access and as a result improve the health outcomes of Oregonians experiencing the impacts of Opioid Use Disorders.

For questions or more information, please contact Annaliese Dolph, Director, Alcohol and Drug Policy Commission at annaliese.dolph@oha.oregon.gov.

[1] Participating state agencies include the Department of Corrections, the Department of Human Services, the Oregon Health Authority, the Department of Education, the Oregon Criminal Justice Commission, the Oregon State Police, the Oregon Youth Authority, the Department of Consumer and Business Services, the Housing and Community Services Department, Youth Development Oregon, the Higher Education Coordinating Commission, the Oregon State Lottery Commission, the Oregon Liquor and Cannabis Commission, the Oregon Department of Veterans' Affairs or any state agency that administers or funds alcohol or drug abuse prevention or treatment services.

Executive summary

HB 4002 (2024) is most often cited for recriminalizing drug possession and promoting deflection programs in Oregon. However, HB 4002 also included several provisions to increase access to treatment, in particular access to Medications for Opioid Use Disorder (MOUD). The bill prohibited prior authorization, expanded Certified Community Behavioral Health Clinics (CCBHCs) and funded grants to counties and tribal governments to expand access to MOUD in jails.

HB 4002 also directed the Alcohol and Drug Policy Commission (ADPC) to study barriers and best practices for increasing access to opioid use disorder (OUD) medications; and youth access to opioid use disorder treatment, with a preliminary report due by September 2024 and final report by September 2025. This report details the ADPC study, findings and recommendations to improve access to MOUD, an evidence-based, highly effective treatment for opioid use disorder. This Final Report includes a Glossary and Appendix detailing unique barriers to care by clinical site.

It is important to note that the overall effect of the HB 4002 policy changes may not be recognized for years to come due to the lag in data collection, the temporary nature of some programs, like Jail MOUD, and evolving treatment services. Yet, if Oregon's access to MOUD improves at its current rate (2020-2023), we may see only a 10% increase of access over the next 10 years. This leaves 2-3 out of every 10 Oregonians who seek access to MOUD without it. As such, significant improvements to MOUD access rates will require a strategic approach involving a combination of efforts that seek to increase capacity and bolster existing access points in specialty SUD and the health system more broadly.

Findings:

- Oregon's prevalence of OUD and access to MOUD are simultaneously increasing but treatment needs continue to outpace the capacity of the treatment system.
- Youth experiencing OUD face a strong disparity in their inability to access MOUD throughout the continuum of care.
- Geographic disparities in access are observable as it relates both to access to MOUD as well as the rates of denials for these medications.
- Oregon CCOs apply quantity limits to MOUD. While a common practice, the rationale provided for these policies differs across payors, even when the same conclusion is reached, leading to challenges in communicating and understanding policies across providers and patients alike.
- While HB 4002 prohibits prior authorizations (PA) for these medications, there remains some use of prior authorization policies applied specifically to Long-Acting Injectable forms of medications.
- Stigma is a prevailing and prominent factor in MOUD access that may be responsible for decreased patient interest, decreased prescriber willingness, or organizational capacity for such supports.
- Providers may be unwilling to provide MOUD due to the increased financial risks associated with purchasing MOUD before seeking reimbursement (known as "buy and bill") as denials or delayed payments are discovered only after care (including medication) has been

provided. MOUD restrictions placed on the "pharmacy benefit" may consequently restrict access to patients whose providers have the ability take these financial risks to support low barrier access.

- Both "buy and bill" and "specialty pharmacies" are essential pathways to access MOUD as each pathway is essential for different use cases.
- Methadone approval appears to result in delayed payments more frequently than other medications whereas Naltrexone results in the highest rates of denials.
- While rates of denials were low overall, it is important to note that between 3% and 7% of individuals seeking MOUD experience these denials[2]. These denials may decrease the effectiveness of MOUD by disrupting continuity, diminishing motivation to adhere to medication regimens, or by impacting provider willingness to engage.

Recommendations:

To support increased access and availability of MOUD, the ADPC proposes the following recommendations:

Legislative Recommendations:

- Require all payors that receive public dollars to maintain a minimum of at least one form of each specific MOUD and administration method (e.g. sublingual, injectable, and oral) on its formulary to avoid utilization management derived clinical care practices.
- Remove current siting requirements placed on Opioid Treatment Programs (OTPs) and prohibit zoning requirements placed on SUD providers that exceed those placed on other health care settings.
- Prohibit pharmacies operating within Oregon from implementing or maintaining policies that restrict access to MOUD, such as requiring in-person visits with prescribers, restrictive time limits on visit to prescription drop off, or other means that may render a legal prescription unfillable.
- Prohibit quantity limits placed on MOUD without a manufacturer created dosing device. For those medications with dosing devices (LAIs, overdose reversal devices), quantity limits should ensure compliance with other statutory requirements such as early refill allowances.
- Prohibit leaseholders or other property managers referencing sober housing law from implementing or maintaining any policy or practices (i.e. unwritten policies) that would disproportionally impact those who are prescribed MOUD compared to those who are not prescribed MOUD.

State Agency Recommendations:

- OHA should amend CCO contracts to include a requirement that payors, via the Delivery System Narrative (DSN), report information necessary to demonstrate ability or efforts to provide MOUD coverage to consumers served by its health plan.
- OHA should develop a payment mechanism (and include in contracts) that allows for the reimbursement of withdrawal management (WM) and costs of MOUD (i.e. cost of medication only) separately to support increased access for those receiving WM services.

- OHA should develop a potential funding model, administered by the authority or established within CCO contracts, that provides an ability for MOUD providers to receive financial support to purchase medications that require administration by a healthcare provider to decrease burden of "buy and bill" and facilitate access where specialty pharmacies may not be accessible, or where utilization of a specialty pharmacy would increase access barriers.
- Amend OARs and regulatory processes across state agencies to ensure providers operating residential or other living environments (such as supportive housing programs) do not negatively impact access to MOUD by requiring that access occurs during specific time frames (e.g. during recreational time, family visiting time, etc.).
- State entities responsible for maintenance of "fee schedules" should update rates at least once every 90 days to facilitate the use of appropriate reimbursement value for providers that utilize "buy and bill" processes.
- OHA should amend Certificate of Approval (COA) rules that prevent Hospitals and EMS settings from hiring and service delivery by professionals such as CADCs or Peers who may support increased access to SUD evaluation and care navigation respectively.
- OHA should accelerate efforts related to rule making, fee scheduling, and reimbursement of Co-Occurring service delivery.
- OHA should update OARs to clarify telehealth service delivery allowances, including ensuring rules are updated to reflect current federal law and existing service rules to reflect operational differences between in person and telehealth service providers.
- OHA should implement the 1115 waiver Carceral Benefit program to support transitions from carceral settings to improve care continuity for those re-entering the community.
- When identified after sufficient data exists, the CJC should disseminate best practices for Oregon based Jail and Detention settings that describe a baseline of minimum care to those experiencing withdrawal symptoms and for those who are at risk for overdose to be informed and offered MOUD options or extend the requirement to connect/ provide MOUD as is required in community BH programs.
- In line with the 2023 evaluation, CCBHC clinics and the state program should continue to identify opportunities to integrate MOUD into care and streamline access for those seeking SUD related medications, including adolescents experiencing OUD.
- Board of Pharmacy and other agency partners should prioritize the implementation of changes to pharmacist prescribing made allowable by SB 236 (2025).
- Department of Corrections should identify a mechanism to increase access to other BH services for those who receive MOUD.
- Carceral settings operated by DOC and OYA should ensure a menu of options exist as it relates to MOUD as opposed to a single medication type.

Recommendations for legislative and other funder investment opportunities:

- Provide funding for technical assistance and training for existing health practitioners and their employers to adopt MOUD prescribing protocols to implement such protocols.
- Funding to support expansion of EMS MOUD programs throughout Oregon. Such funding may include cost of training and implementation support, incentives for implementation, and capacity building funds such as initial support to cover costs of medication stock.

- Provide funding for addiction medicine fellowship programs to increase capacity of addiction medicine doctors.
- Provide funding for an SUD care coordination network. Such a network should be capable of facilitating linkages of care from Emergency Departments to other community-based care providers such as behavioral health or MOUD prescribers at minimum.
- Provide funding for specialty SUD programs to hire and establish capacity for MOUD prescribing. Such funding could also benefit efforts to integrate SUD and Mental Health Services as SUD programs express challenges building capacity with existing SUD reimbursement rates as it relates to mental health related prescribing.
- Fund Certified Alcohol Drug Counselor Supervisor (CADC) positions at an adequate level for OYA to (1) Offer at least one permanent CADC supervisor per facility with additional staffing based-on population and (2) Increase participation in the current MOUD pilot.
- Develop a comprehensive regional School Treatment and Recovery Program, including: Screening, brief intervention and assessment; ASAM level 1 treatment services for co-occurring disorders; and peer-led recovery supports and groups.
- Expand Recovery Schools to statutory maximum of 9 and provide that a recovery program is accessible to every ESD in Oregon.
- Maintain current Jail MOUD program funding administered by the Criminal Justice Commission (CJC).
- Provide funding to DOC to support MOUD medication costs to ensure program sustainability and ongoing access.

ADPC Prospective Actions:

- ADPC treatment committee, in collaboration with agency partners, should draft a memo to clarify the prescribing practices within withdrawal management programs.
- Conduct annual claims analysis to monitor efforts to improve access to MOUD and other treatment options as well as related trends, ensuring decision making is data driven.

Contents

Background

HB 4002 (2024), directed the ADPC to study barriers and best practices for:

1. Increasing access to opioid use disorder medications; and
2. Youth access to opioid use disorder treatment.

The bill requested recommendations to reduce barriers to treatment access and to address obstacles encountered by providers seeking to provide these services. The ADPC is also directed to provide a strategic plan to improve youth access to opioid use disorder treatment, increasing the number of OUD treatment providers, and expanding the capacity of the opioid use disorder treatment system of the state. HB 4002 directed the ADPC to provide preliminary recommendations by September 2024 and a final report by September 2025.

The ADPC submitted the Alcohol and Drug Policy Commission (ADPC) Preliminary Report and Recommendations in Accordance with House Bill 4002 Section 11 to the legislature on September 20, 2024.

The ADPC submits this final report to the legislature in accordance with HB 4002 (2025).

The ADPC is also directed by statute to develop the comprehensive substance use prevention, substance use disorder treatment and recovery support services plan for the state. ORS 430.223. The ADPC develops the comprehensive plan every five years, with biannual reviews of metrics and other indicators of progress by July 1 of each even-numbered year reported to the Governor and the legislature. With the passage of HB 2929 (2025), the comprehensive plan must address substance use prevention and youth substance use disorder treatment and recovery strategies to reduce substance use disorders among individuals who are up to 26 years of age and their families.

Strategies included in the HB 4002 Preliminary and Final reports may be included in the 2026-2030 Comprehensive Plan if prioritized by the ADPC to address access to treatment. However, the Comprehensive Plan addresses the substance use prevention and substance use disorder care continuum as a whole, including primary prevention, early intervention and the treatment continuum, recovery services and supports, and harm reduction services.

September 2024 Preliminary Report and 2025 Legislation

The ADPC submitted the Preliminary Report to the legislature on September 20, 2024. The ADPC also presented the Preliminary Report recommendations to the Joint Interim Committee on Addiction and Community Safety Response (JICACSR) on September 24, 2024.

At the request of JICACSR Co-Chair Representative Kropf, three bills were drafted for the 2025 legislative session – HB 2502, HB 2506, and HB 2507. HB 2502 and HB 2506 were both amended and approved by the Joint Committee on Addiction and Community Safety Response (JCACSR) during the legislative session. Both bills remained in Ways and Means at the conclusion of the legislative session. However, three provisions originally introduced in HB 2502 were included in HB 3321 and HB 2929, in line with the Preliminary Report, and building a foundation for future strategic

planning work: 1) Assessment of school-based capacity for substance use prevention and screening, 2) ADPC/SOCAC statutory charge for strategic planning in the youth SUD continuum, and 3) funding for OHSU's ECHO Program for youth substance use prevention and treatment.

Where other legislation passed that may influence or address barriers to MOUD, it will be noted in this report. For instance, SB 236 (2025) amended statutes to allow pharmacists to prescribe and dispense MOUD, as was intended within HB 4002.

ADPC HB 4002 Workgroups and Other Agency and Partner Efforts

The ADPC HB 4002 workgroup continued to meet through 2025 to study barriers to access to MOUD. The workgroup engaged in a series of discussion exercises to identify best practices, policies that may impact access, and determine how best to prioritize efforts to maximize benefit. Additionally, the group supported ADPC staff in identifying literature for review, as well as Subject Matter Experts to interview, to identify areas of interest that may be observable via claims analysis or other data sources. Furthermore, the Oregon Youth Addiction Alliance (an ADPC and System of Care Advisory Committee collaboration originating from the 4002 workgroup) met to address youth SUD systems of care adjacent to medication treatment.

These workgroup meetings are a primary source of information for this report. Workgroup members provided insights into the practical realities of care providers and those seeking care, as well as other factors that may be difficult to parse from health data alone. These insights proved essential to understanding the historical context for the state of OUD care in Oregon and the challenge of balancing access improvement with efforts to maintain existing access points.

OHA also funded a pilot to promote access to MOUD in the community by EMS when a need is indicated, such as following an overdose. This pilot project with Bridge (also known as Cal Bridge) and OPHI (Oregon Public Health Institute) sought to provide supports and training to Emergency Departments (federally funded) and EMS programs to implement buprenorphine protocols, establishing or increasing prescribing in these settings. While this pilot was time and geographically limited, the ADPC participated in feedback sessions and incorporated insights where appropriate in this report.

All Payor All Claims Analysis

The ADPC contracted with Comagine Health for an All Payor All Claims analysis to understand potential reimbursement challenges, and to ensure its recommendations were addressing existing disparities. This analysis provides an overview of factors such as prevalence of OUD, access to care, access to medication, and other factors to assist with this study. Due to the nature of this dataset having a year (or more) delay in availability, this exploration of claims data was supplemented by a survey of CCO policies to capture any changes that occurred since the passing of HB 4002, which aimed to increase access to MOUD.[3]

[3] The ADPC seeks to conduct a claims analysis annually as one strategy that will be included in the upcoming statewide comprehensive plan. When the 2024 data is available, impacts of changes made during that year, including those resulting from HB 4002, may be observable.

Findings

Payor Related Factors

HB 4002 (2024) directed the ADPC to identify obstacles that may be encountered when seeking reimbursement for MOUD such as:

> A) Requirements to use specialty pharmacies and/or the practice referred to as "buy and bill" where providers purchase medication in advance and later seek reimbursement after the medication is administered.
>
> B) Limiting coverage of MOUD to specific forms of medications.
>
> C) Imposed quantity limits.
>
> D) Obstacles identified from insurance claim denial information relevant to MOUD.

To study these areas of interest, the ADPC analyzed MOUD health insurance claims data. The ADPC also engaged CCOs to learn about the policies that may be in place for the majority of those seeking OUD treatment. These informational explorations resulted in the follow key findings:

Acronym	Term
LAI	*Long Acting Injectable*
MOUD	*Medication for Opioid Use Disorder*
OUD	*Opioid Use Disorder*
SUD	*Substance Use Disorder*

Table 1- Commonly used MOUD Acronyms

- Youth experiencing OUD face a strong disparity in their inability to access MOUD.
- Oregon's rate of OUD and access to MOUD are both rising but needs continue to outpace capacity.
- Most CCOs apply quantity limits to MOUD. While these quantity limits appear to be similar across CCOs, the rationale for these limits differs. Some indicate this reflects best practice prescribing while others indicate this limit serves to avoid prescribing for pain management under the guise of OUD treatment.
- Remaining prior authorization policies appear to be applied specifically to LAIs and do not appear to be placed on other forms of MOUD by any payor.
- Methadone approval appears to result in delayed payments more frequently than other medications whereas Naltrexone results in the highest rates of denials.
- There is an uneven application of utilization management placed on the pharmacy benefit compared to the medical benefit of MOUD (e.g. no or less limitations if provided directly by the prescriber). This means providers are more likely to utilize a "buy and bill" method as opposed to access involving a pharmacy, such as a specialty pharmacy. Both pathways of access appear essential to retain access. Not all providers can take on the increased financial risks associated with purchasing medications before seeking reimbursement as denials or delayed payments are discovered only after care (including medication) has been provided.
- There exists some geographic disparity both in terms of rates of denial and access itself.

The following sections detail specific findings and analysis of the payor claims and policies that support the above conclusions.

All Payor All Claims Analysis

ADPC contracted with Comagine Health to analyze All Payor All Claims data related to MOUD pharmacy and medical claims from 2016 to 2023. The claims data indicates that Oregon's access to MOUD improved over 20% between 2016[4] and 2020 but improvements have since slowed. While this initial increase of access is a positive trend and demonstrates the cumulative efforts of policy changes, provider effort, and other factors, it also underscores a prevailing truth about Oregon's SUD care system: Treatment needs continue to outpace the capacity of Oregon's SUD care system (see figure 1). It also underscores the additional barriers young people (age 17 and under) face with respect to identification, assessment, and initiation of treatment. The claims data also shows that while insurance denials do have some impact on access, these denials themselves are likely not the most significant barrier to accessing MOUD, given denial rates are largely below 1%[5]. Rather, access challenges may be the result of factors occurring either upstream of these utilization decisions at a policy level or downstream at a community level.

If Oregon's access to MOUD improves at its current rate (2020-2023), we may see a 10% increase of access over the next 10 years, which could still mean 2-3 out of 10 Oregonians who seek to access MOUD may be left without it. As such, significant improvements to MOUD access rates will require a strategic approach involving a combination of efforts that seek to increase capacity and bolster existing access points in specialty SUD and the health system more broadly.

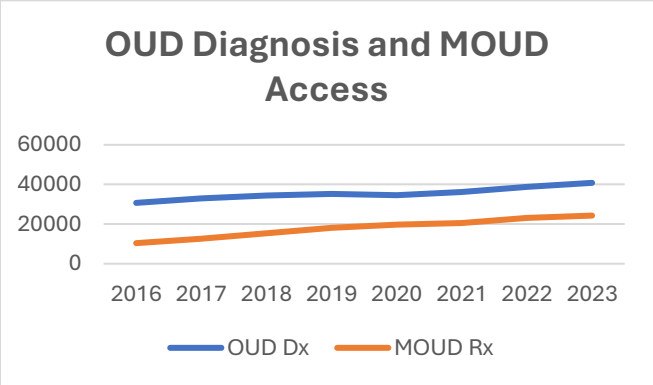

Figure 1: Prevalence of OUD and Individuals receiving MOUD

While there are some limitations[6] to claims data, this dataset also enabled the ADPC to understand other important information such as care disparities. For example, there exists a significant disparity for youth with OUD and their access to MOUD when compared to other age groups (8% access compared to 51%). Available data did not show that denials at a payor level alone were responsible for this disparity, indicating that barriers exist outside of care denials. Denial rates appear consistent regardless of a patient's gender, race, or ethnicity, indicating that care denials themselves are not increasing known disparities. It is worth noting that this figure is impacted by the already known disparities that exist related to diagnosis and treatment access. As

[4] Available claims data is limited to services submitted for reimbursement from 2016-2023.
[5] Statewide MOUD claim denial rates have not surpassed 1% since 2016 when these rates were 1.55%.
[6] APAC data does not include reason for denial or retroactive claim denials. Additionally, populations below 10 individuals are not reported, so some information may be more challenging to address in more rural areas. Information within the APAC data has a delay of ~1 year as claims may be submitted, amended, or finalized throughout the year.

such, this is only indicative of those who have received a diagnosis and received care related to their OUD.

There were regional[7] differences[8] in denial rates, but the disparate denial rates are not mirrored in payor specific denial data. This may indicate prevailing provider level issues that occur when submitting these claims or providing these services, resulting in higher denials for a given geographic area. Even before receiving the claims analysis, the workgroup noted that a lack of institutional knowledge among providers directly affects the care options ultimately presented to patients. Workgroup members indicated that care providers often present the least burdensome option for care based on several factors such as historical experiences with payors, knowledge of local pharmacy practices, distance to providers, or even information made available publicly about care access. Demystifying MOUD access and highlighting low denial rates may shift care plans and willingness to prescribe medication.

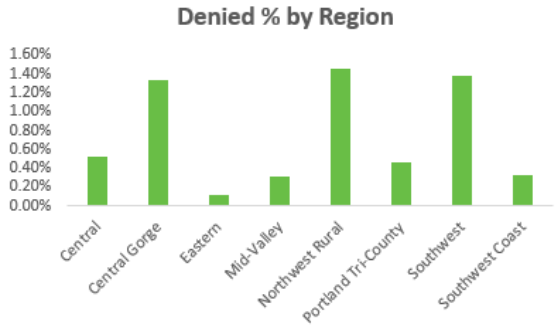

Figure 2- MOUD Denials by Region

This analysis was initiated both to see the differences these policies may create regarding access, but also to create a "baseline" of access to monitor the impact future policy changes may have on MOUD. This will hopefully improve both the ADPC and other agencies' ability to make informed decisions related to these medications in future years.

Findings:

- Access improved most drastically between 2016, when 66.19% of Oregonians experiencing an OUD did not receive MOUD, and 2020 when this gap decreased to 43.11%. While access improved until 2020, the rate at which access improved slowed after that, failing to keep up with the rate at which OUD grew. The current claims analysis does not include claims since HB 4002 (2024) passed.
- Most MOUD access is provided to those over the age of 26 (~89.6%) and only .1% of individuals who have received MOUD are under the age of 18.
- While youth do represent a smaller proportion of those diagnosed with an OUD, there is a clear disparity when examining MOUD access (8% access versus 51% access for other age groups).
- MOUD denial rates fluctuate from year to year. Denial rates were at their highest (1.55%) of claims submitted in 2016 and in subsequent years have been lower, not reaching above .62%.[9]

[7] As some areas of Oregon that are less populated are often suppressed when examining data due to small sample sizes, Comagine separated the state into geographic regions to better include small population groups within the data.
[8] Highest rates of MOUD denials occur in the Central Gorge, Northwest Rural, and Southwest regions of Oregon.
[9] From 2017 to 2023 these rates were .49%, .38%, .62%, .38%, .47%, .37%, and .55%.

- While overall rates of denials were low, between 3% and 7% of individuals seeking MOUD experience these denials. Medication continuity is essential to effectiveness. Subsequent denials after the initiation of medication may negatively impact patient outcomes.
- Methadone appears to be the most frequently denied service (6% to nearly 15% of individuals experience a denial depending on the year).
- In episodes where a denial occurred and no record existed of a subsequent claim in the following 7 days (e.g. no access to MOUD was acquired in a reasonable time period), commercial insurance providers maintain the highest percentage of denials with no subsequent claim (77% of MOUD denials) compared to Medicaid (40%) and Medicare Advantage (11%).
- Dual enrolled individuals experience the majority of denied claims that were followed by a separate, paid claim for the same day of service (i.e "day 0" of care). This appears to be the result of administrative processes that ensure a specific payor reimburses for the service (e.g. Medicaid vs Medicare coverage). It is not possible to determine whether this has any impact on the time to receive the service, but it does not appear to impact reimbursement.[10]
- Those with an OUD[11] on or prior to the service in which MOUD is prescribed experience slightly higher rates of denial than those receiving MOUD after an opioid overdose or diagnosis code related to opioid use, but no formal OUD.
- There does not appear to be a major difference between generic and brand name medications as it related to rates of denial. There are no current generic LAIs on the market, but generic forms of other medications do exist.
- No significant difference exists between insurance denials for those living in rural versus urban areas (.5% and .53% respectively). There is variability among counties, with MOUD claims being denied as infrequently as .03%[12] of the time (Union County) but as frequently as ~2% (Columbia and Hood River Counties). These rates are not exclusively reflective of the CCOs that provide coverage for these same counties, meaning this is not attributable to a specific payor but may be the result of factors at the provider level.
- OHP Open Card was the Medicaid payor with the highest rate of MOUD denials (1.88% of its total claims) and one commercial payor had a noticeably higher rate (3.25% denial rate).
- As has been evidenced throughout the country[13], this data appears to demonstrate that recent federal changes that sought to improve access, such as the removal of the X-Waiver

[10] Confirmed via informational interviews with leadership from two organizations' multisite MOUD provider organizational staff who receive reimbursements from a variety of payors.
[11] Important to note some differences exist between the DSM described OUD and the previously used Abuse or Dependence criteria.
[12] Areas with lower rates of denials may exist but fall below a threshold where privacy can be maintained for these regions' data to be viewed independently.
[13] Payel Jhoom Roy, Katie Suda, Jing Luo, MyoungKeun Lee, Joel Anderton, Donna Olejniczak, Jane M Liebschutz, Buprenorphine dispensing before and after the April 2021 X-Waiver exemptions: An interrupted time series analysis, International Journal of Drug Policy, Volume 126, 2024,104381,ISSN 0955-3959, https://doi.org/10.1016/j.drugpo.2024.104381.
(https://www.sciencedirect.com/science/article/pii/S0955395924000665)

requirement for Buprenorphine prescribers in 2021[14], have not increased access[15]. Those analyzing prescribing trends nationally have noted that while individuals receiving prescriptions have increased, the number of prescribers themselves have not, signaling that other actions aside from removing barriers to prescribing may be needed.

CCO Policies

ADPC requested MOUD related policy information from Oregon CCOs[16] in 2024 and again in 2025 to identify what, if any, differences exist across CCOs as well as what changes occurred since the passing of HB 4002 to ensure accuracy of its final report. These informational requests revealed both similarities and differences among CCOs. After reviewing the information provided via self-report, the following appears to be a snapshot of current CCO[17] policies in the state:

- **15 of 15 CCOs** report *no limits placed on methadone access within OTPs*.
- **15 of 15 CCOs** reported *placing no limits on medications* provided through medical benefits (e.g. received direct from provider).
- **14 of 15 CCOs** *maintain all dosages of buprenorphine on their formulary* or have no additional restrictions in place.
- **9 of 15 CCOs** place *quantity limits[18] on buprenorphine*.
- **9 of 15 CCOs** *maintain injectable buprenorphine on their formulary* or have no restrictions on these medications.
- **4 of 15 CCOs** *require some form of prior authorization[19] for Long Acting Injectables (LAI)[20]*.
- **3 of 15 CCOs** *place quantity limits on LAIs*.

[14] https://www.samhsa.gov/substance-use/treatment/statutes-regulations-guidelines/mat-act
[15] The temporary exemption was in effect from 2021 until 2023 when the x-waiver requirement was permanently removed as part of the Consolidated Appropriations Act.
[16] Oregon CCOS include Advanced Health, AllCare Health, Cascade Health Alliance, Columbia Pacific CCO, Eastern Oregon CCO, Health Share of Oregon, InterCommunity Health Network CCO, Jackson Care Connect, PacificSource CCOs (Central Oregon, Columbia Gorge, Lane, Marion/Polk), Trillium Community Health Plan (Southwest, Tri-County), Umpqua Health Alliance, and Yamhill Community Care.
[17] If a CCO response to the survey included multiple groups, the most restrictive response was used to describe the CCO policy (e.g. CCO provided 4 regional responses but is considered a single CCO per public facing information such as the OHA website).
[18] Rationale for quantity limits included preventing prescribing for something other than MOUD (e.g. doses exceeding 32mg assumed to be prescribed for pain management) to catching prescriber error.
[19] There appears to be a variety of functions placed on these prior authorizations, and it was noted that these differ both in function and in semantics from one payor to another. Correspondence with payors has indicated there exists discrepancy in how the PA limits described in HB 4002 should be applied.
[20] One justification for the application of prior authorizations in the context of LAIs stems from concerns about patient safety. It is worth noting that these medications do come with an additional FDA placed REMS (Risk Evaluation and Mitigation Strategies) requirement. These requirements are placed when a specific safety concern exists, such as a patient's reaction to a medication following administration. This added risk mitigation safety net may indicate payor safety guards may be placing unnecessary barriers on care to accomplish requirements set forth by the FDA. https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rems/whats-rems

The following changes occurred between the 2024 and 2025 informational requests:

- **5 of 15 CCOs** *added LAIs to their pharmacy formulary*.
- **6 of 15 CCOs** *removed or lowered restrictions placed on medications accessible via pharmacies*.
- **1 of 15 CCOs** *removed a quantity limit placed on one form of MOUD since the previous year*.
  1 of 15 CCOs *added a quantity limit to all but one form of MOUD which they reported the year prior had no quantity limits*.

Delayed Payments

While this informational request was beneficial to understanding the policies that may impact MOUD access at a payor level, more information was needed to understand the impact of these policies on access. There was one other area of focus identified by the workgroup that could be a barrier to access. Beyond denials, delayed approval of claims or reimbursements to providers may possibly decrease interest in prescribing due to financial risk assumed by those who do so. To identify such examples where financial impacts may be felt by providers, the time from claim submission to approval was also analyzed. A claim was determined to be delayed if it was initially denied but later approved. There are a variety of factors that contribute to delayed claims ranging from clerical errors made by providers to the need for denial and subsequent payment from a secondary payor in the case of individuals dually enrolled in Medicare and Medicaid. Additionally, it is worth noting the impact the COVID-19 pandemic had on claim reimbursement that is visible within the data (see figure 2).

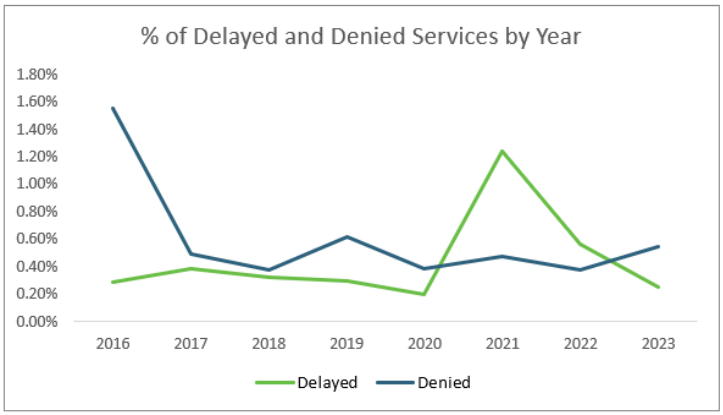

Figure 3- % of MOUD claims Delayed/ Denied (2016-2023)

Of claims that are initially denied but approved, 92% of these are the result of being directed to a secondary payor. The remaining 8% of these claims were paid as a different service code. It is not known whether either of these examples has a detrimental impact on care or providers or if this is managed as a "background" process. However, delays in payment can be a challenge to providers, as they often have already provided care and/or medication and find themselves in a troubling

> ***"We are likely looking at a goal that can only be achieved, at the earliest, within 10 years, but if we keep waiting, 10 years is always going to be 10 years away."***
>
> *-HB 4002 MOUD Workgroup Member*

scenario in which they have been impacted financially by providing care they believed to be medically necessary. While not visible via claims analysis, those interviewed who provided long acting injectables via the "buy and bill" method noted similar concerns when treating individuals and later discovering their claim was retroactively denied.

Carceral Availability

Medication access for those receiving MOUD within Oregon's Jails and State Prisons cannot be seen within claims analysis as these medications are not covered by insurance. However, it is important to note access rates within these settings as well as the intersection of these provider types. For example, 56% of carceral settings report leveraging a current partnership with a community-based organization to provide MOUD, meaning that changes in capacity within the community setting (e.g. workforce shortages) could impact access within carceral facilities. OYA seeks to expand MOUD access but staffing and implementation challenges exist. Furthermore, increased MOUD utilization (such as the current effort to switch to LAIs) within carceral settings could result in an increased need for community settings due to those re-entering the community needing to maintain continuity of care. As such, an aligned strategy for increasing MOUD access throughout the state appears crucial to the success of these efforts and their ability to bridge the gaps that exist between those settings that have prioritized MOUD access and those who are at other stages in the implementation process.

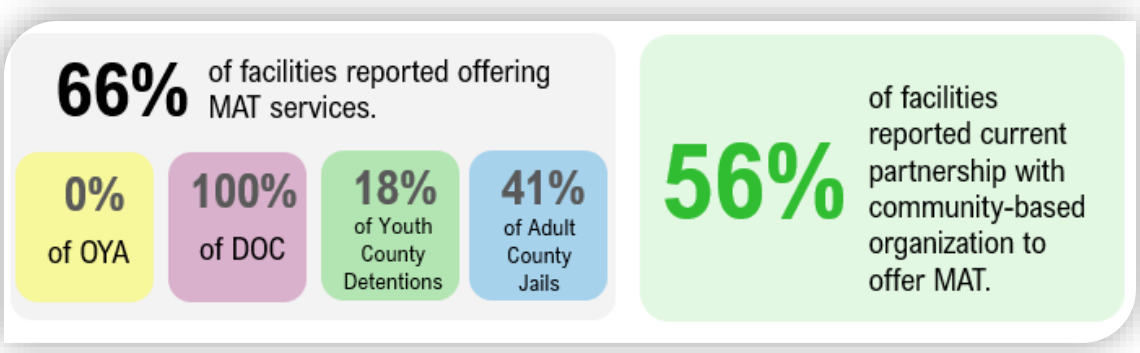

Figure 4 2- Example of interconnectivity of the carceral and community MOUD care systems as of winter 2024.

Conclusions

This analysis was initiated both to see the differences these policies may create regarding access, but also to create a "baseline" of access to monitor the impact of policy changes. This will improve both the ADPC and other agencies' ability to make informed decisions related to these medications in future years. Through this analysis, we can observe that the prevalence of those experiencing OUD as well as access to MOUD has continued to increase year over year since 2016. While this increased access is a positive trend and demonstrates the cumulative efforts of policy changes, provider effort, and other factors, it also underscores a prevailing truth about Oregon's SUD care system: treatment needs continue to outpace capacity. It also underscores the additional barriers young people face with respect to identification, assessment, and initiation of treatment.

Ultimately, the most significant improvements to medication access may rest with the authority of the federal government in this highly regulated space. While this limits potential state actions, such as broader access to methadone[21], this also provides clarity for what may be addressed via state policy levers with the goal of decreasing gaps, decreasing time to access, and creating conditions where adoption of evidenced based clinical practices are more likely to occur.

As such, the workgroup identified that potential improvements may require a combination of the following:

- Legislative Actions
- Budgetary Considerations
- Funding Opportunities
- Agency Actions
- ADPC Actions

The workgroup also noted that while these solutions may improve MOUD access, any solution may need added resources or some adaptations when applied to areas of Oregon where resources may be scarce, such as rural or frontier communities. As such, the workgroup vocalized that prioritizing these under-resourced areas may be essential to increasing access to MOUD equitably. While under-resourced areas of Oregon should be prioritized, implementation of services in these areas may also experience the most "change management" issues due to stigma. "NIMBYism" or other efforts rooted in stigma may result in challenges opening new programs or concerns among health providers about potential impacts on their practice. Stigma may also impact a community member's personal choice to seek out MOUD.

Examining the Continuum

As MOUD is not accessed via a single setting and MOUD access is inconsistent across settings, the workgroup, beginning in 2024 and into the first half of 2025, dedicated time and effort to examine access points for MOUD across the healthcare landscape in Oregon. While some of the root issues and potential solutions may have multi-setting benefit, those contributing to this study felt it important to highlight the ways these approaches could have a ripple effect of benefits as it relates to access.

For each setting described in this section, the workgroup sought to explore factors that promote or inhibit MOUD access such as prevailing staffing practices, reimbursement, regulations, and practical realities of care. Additionally, a focus was placed on how the experience of those seeking medication in these settings may be related to their ability or interest in accessing MOUD in that setting, which may be the result of prevailing society stigma, program policy, or other factors. A detailed description of MOUD availability and related factors refer to Appendix 2.

This information was gathered through a combination of group discussions, informational interviews, and other publicly available information. It is important also to highlight that this information describes the "typical" operating practices and there may exist programs that exceed

[21] https://www.congress.gov/bill/118th-congress/senate-bill/644

the offerings outlined by funding requirements, administrative rules, or other guidelines that encourage downstream service delivery throughout the state.

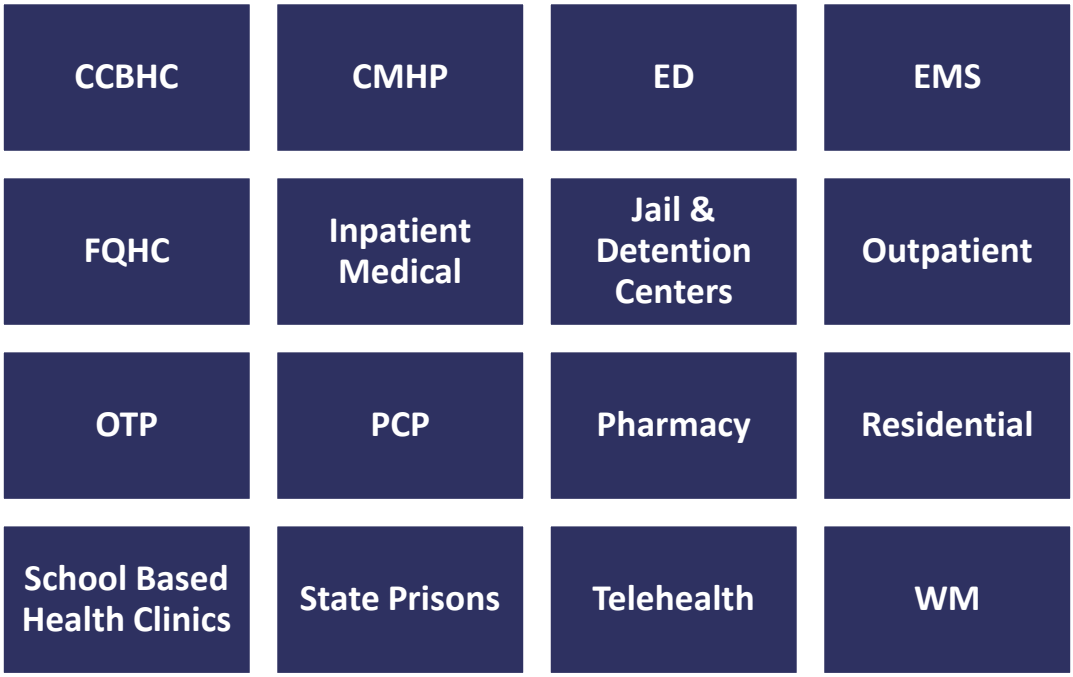

Figure 5- Settings of Interest

Although MOUD access is possible in each of the above settings, workgroup members agreed that settings may have unequal potential for access; each setting comes with its own unique challenges and needs. Beyond simply identifying potential systems level improvements, one workgroup member remarked "we are likely looking at a goal that can only be achieved, at the earliest, within 10 years, but if we keep waiting, 10 years is always going to be 10 years away."

This challenge requires some prioritization and staging of efforts for maximum benefit. Workgroup members provided the following ranking to support prioritization within future decision making.

This ranking represents the group's collective understanding of MOUD access, barriers to access, level of utilization, factors that influence implementation, population needs, and risk. Settings were grouped by similarity in these factors (e.g. Jail and Prison were combined to create "Carceral Settings") as some actions may simultaneously impact similar settings. This grouping resulted in 16 settings being grouped into 9 care groups.

In this ranking, settings listed highest were expected to have the most potential to increase MOUD access, and those at the bottom of the list were expected to have the least potential by comparison. Workgroup members also ranked each care group by how challenging improvements to access may be on a scale of 1 (most challenging) to 9 (least challenging). "Challenge" was reflective of a wide range of factors such as staffing availability, provider reluctance, prevailing stigma, setting culture, implementation progress, community concern, financial barriers, and regulatory barriers.

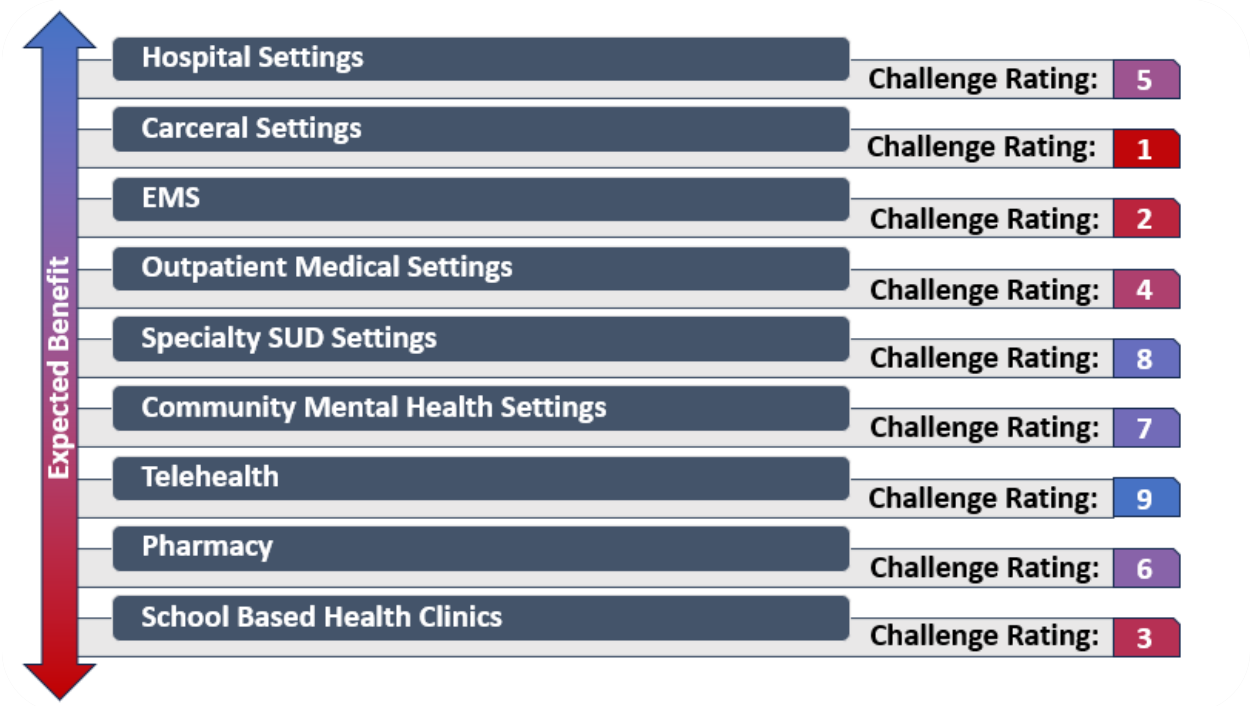

Figure 3- Graphic Summarizes the MOUD workgroup's prioritization based on benefit/challenge of access improvements

The Appendix 2: Setting by Setting Exploration figure provides a snapshot of each setting's staffing, reimbursement, barriers, patient experience, available MOUD, and recommendations to provide the reader with as holistic of a view of MOUD access as possible. Some settings also include youth/adolescent specific issues and opportunities as identified by the OYAA – these youth specific considerations are only included where the OYAA concentrated their study. Youth/adolescent specific recommendations are included with all other recommendations but only reflect adjusted preliminary legislative recommendations for the setting in 2026, including those that were not achieved in HB 2502 (2025). Additional adolescent/youth specific recommendations will be presented in the 2026-2030 ADPC Comprehensive Plan. *Please see the recommendations section beginning on the next page or executive summary for a brief overview of recommendations.*

A Note on Stigma[22]

Throughout the study, the stigma surrounding MOUD was a prominent factor in each discussion. Its impacts can be observed throughout the continuum, appearing to impact all settings. Substance use disorders are more stigmatized than other behavioral health disorders, and this stigma results in impacts on individuals, providers, programs, and policies.[23] The prevalence of stigma also leads to an increased differential in perspective of treatment and criminal justice policies, barriers to employment, barriers to housing, and an increased potential for social isolation. For the individual, this may be observable in ways that lead to delays in seeking care, decreased engagement in services, and other impacts such as shame, rationalization, or lowered self-esteem, which have been shown to decrease recovery outcomes.

[22] Examples observed throughout the study include:

- Statements by providers who worry that MOUD access may become their primary service area.
- Beliefs held by individuals (notably prominent within carceral settings) who are in positions of authority that utilizing MOUD is "trading one addiction for another."
- Statements by medical providers who expressed an unwillingness or hesitancy to treat SUDs for young people, even when willing for adults.
- Examples of policies that inhibit patient decision making or informed consent of these medications (e.g. duration limited prescriptions only being provided for withdrawal management).
- Definitions of recovery that exclude those who utilize MOUD to maintain recovery goals.
- Perspectives surrounding MOUD that differ from other medications for other conditions, such as when comparing insulin access for those who receive treatment for diabetes.

[23] https://www.recoveryanswers.org/assets/1.-Webinar-2.-AAAP-ORN-Stigma-FINAL-JF-KELLY-6-30-21.pdf

Recommendations

Expanding access to MOUD within Oregon requires a multi-faceted approach to address the multiple factors that impede access. The provided recommendations have been made in alignment with the 3 primary aims of the ADPC:

1) Decrease prevalence of substance use.
2) Decrease deaths resulting from substance use.
3) Decrease disparities relating to substance use.

While these medications are not a panacea for addressing OUD, increasing access to them has been shown to positively impact a community's ability to reduce substance use through effective prescribing. Additionally, medications that decrease the risk of overdose decrease deaths. MOUD can be provided throughout a person's recovery journey, contributing to lasting benefits of treatment and other SUD related care.

The recommendations included below describe a spectrum of needed improvements that involve payors, providers, the ADPC itself, and the legislature. Youth-specific recommendations focus on gaps identified in the preliminary report. As discussed more thoroughly in the appendix, OYAA found that adolescent substance use supports - particularly in identification, therapeutic treatment, and recovery supports - are underdeveloped and need support to expand and support MOUD as an effective treatment modality. The OYAA found that these supports may be most accessible and effective outside of a traditional behavioral health setting, with a focus on schools and carceral settings. To increase access to OUD treatment, medications, and programs the ADPC recommends the following actions:

Legislative Recommendations:

LR-1: Require all payors who receive public dollars to maintain a minimum of at least one form of each specific MOUD and administration method (e.g. sublingual, injectable, and oral) on its formulary to avoid utilization management derived clinical care practices.

LR-2: Remove current siting requirements[24] placed on OTPs and prohibit zoning requirements placed on SUD providers that exceed those placed on other health care settings.

LR-3: Prohibit pharmacies operating within Oregon from implementing or maintaining policies that restrict access to MOUD, such as requiring in person visits with prescribers, restrictive time limits on visit to prescription drop off, or other means that may render a legal prescription unfillable. As these policies are said to avoid inappropriate prescribing, an MOUD specific policy prohibition may still support their intent while also meeting concerns about pharmacy responsibility.

LR-4: Prohibit quantity limits placed on MOUD without a manufacturer created dosing device. For those medications with dosing devices (LAIs, overdose reversal devices), quantity limits should ensure compliance with other legislation such as early refill allowances.[25]

[24] ORS 430.590

[25] Long acting injectables and overdose reversal medications come as a pre-dosed medication whereas other forms of MOUD have greater variability that changes at the prescriber level due to understanding of best

LR-5: Prohibit leaseholders or other property managers referencing sober housing law from implementing or maintaining any policy or practices (i.e. unwritten policies) that would disproportionally impact those who are prescribed MOUD compared to those who are not prescribed MOUD (or are prescribed medications that are not for the treatment of OUD).

State Agencies Recommendations (SAR):

SAR-1: OHA should amend CCO contracts to include a requirement that payors, via the DSN (Delivery System Narrative), report information necessary to demonstrate ability or efforts to provide MOUD coverage to consumers served by its health plan. Such information should include quantitative information relating to contracted providers, regional availability, and consumer utilization such as access rates at the start and end of each reporting cycle. Without such reporting, it is unclear as to how CCOs are accountable for legislative changes made in HB 4002.

SAR-2: OHA should develop a payment mechanism (and include in contracts) that allows for the reimbursement of withdrawal management and costs of MOUD (i.e. cost of medication only) separately to support increased access for those receiving WM services[26]. Currently, the costs of providing these medications are assumed to be included within the day rate for these services and as care is provided on site, resulting in a net loss for each patient treated with a long acting injectable.

SAR-3: OHA should develop a funding model, administered by the authority or established within CCO contracts, that provides an ability for MOUD providers to receive financial support to purchase medications that require administration by a healthcare provider to decrease burden of "buy and bill" and facilitate access where specialty pharmacies may not be accessible, or where utilization of a specialty pharmacy would increase access barriers. Utilizing a Prospective Payment Model wherein care census is estimated and monthly rates are received by the provider to meet the costs of providing such services could be an example for such a funding model.

SAR-4: Amending OARs and regulatory processes to ensure providers operating residential or other living environments (such as supportive housing programs) do not negatively impact access to MOUD by requiring access occurs during specific time frames (e.g. during recreational time, family visiting time, etc.). The workgroup suggests updating OARs to include language that behavioral health providers shall provide adequate referral to MOUD if interest is expressed *and outcomes of such referral be documented via attestation* that efforts to connect qualifying individuals to MOUD were unsuccessful, successful, deferred to a later date, or declined.

SAR-5: State entities responsible for maintenance of "fee schedules" should update rates at least once every 90 days to facilitate the use of appropriate reimbursement value for providers that utilize "buy and bill" processes.

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practices, which may be a result of a variety of factors, including changes to the drug supply, meaning these quantity limits could minimize provider ability to make individualized care decisions.

[26] Inpatient hospital services are said to have similar challenges relating to the costs of MOUD provision and bundled care payments.

SAR-6: OHA should work to remove COA requirements placed on Hospitals and EMS settings that prohibit hiring and service delivery by professionals such as CADCs or Peers who may support increased access to SUD evaluation and care navigation respectively.

SAR-7: OHA should accelerate efforts related to rule making, fee scheduling, and reimbursement of Co-Occurring service delivery. This enhanced rate is indicated to be a supportive factor for increasing the feasibility of hiring and retaining staff needed to provide holistic co-occurring support, which includes prescribing capacity.

SAR-8: OHA should update OARs to clarify telehealth service delivery allowances, including ensuring rules are updated to reflect current federal law and existing service rules reflect operational differences between in person and telehealth service providers. Establishing telehealth specific rules and providing guidance on certification of SUD specialty telehealth programs may support increased access.

SAR-9: OHA should implement the 1115 waiver Carceral Benefit program to support transitions from carceral settings to improve care continuity for those re-entering the community.

SAR-10: When identified after sufficient data exists, the CJC should disseminate best practices for Oregon based Jail and Detention settings that describe a baseline of minimum care to those experiencing withdrawal symptoms and for those who are at risk for overdose to be informed and offered MOUD options or extend the requirement to connect/ provide MOUD as is required in community BH programs.

SAR-11: In line with the 2023 evaluation, CCBHC clinics and the program should continue to identify opportunities to integrate MOUD into care and streamline access for those seeking SUD related medications, including adolescents experiencing OUD.

SAR-12: Board of Pharmacy and other agency partners should prioritize the implementation of changes to pharmacist prescribing made allowable by SB 236 (2025).

SAR-13: Department of Corrections should identify a mechanism to increase access to other BH services for those who receive MOUD.

SAR-14: Carceral settings operated by DOC and OYA should ensure a menu of options exist as it relates to MOUD as opposed to a single medication type. While the switch to LAIs is beneficial to operational processes, including those that are concerned with medication diversion, concerns were raised from workgroup members and from those contacted during carceral engagement efforts that a singular medication option may dissuade those from seeking care, especially one that requires injection.

Recommendations for legislative and other funder investment opportunities (FO):

FO-1: Provide funding for technical assistance and training for existing health practitioners to adopt MOUD prescribing protocol and their employers to implement MOUD protocols. Such funding may be used for consult services, training, or implementation of MOUD protocols to pharmacists, nurse practitioners, physicians, and others who are able to prescribe and/or administer MOUD.

FO-2: Funding to support expansion of EMS MOUD programs throughout Oregon. Such funding may include cost of training and implementation support, incentives for implementation, and capacity building funds such as initial support to cover costs of medication stock. Such support should also include integration with EDs or other parts of the care continuum to ensure continuity of care.

FO-3: Provide funding for addiction medicine fellowship programs to increase capacity of addiction medicine doctors.

FO-4: Provide funding for a SUD care coordination network. Such a network should be capable of facilitating linkages of care from Emergency Departments to other community-based care providers such as behavioral health or MOUD prescribers at its minimum. This may require significant changes to or diverted funds from currently state funded phone lines or web-based provider directories to shift them from a primarily informational service to one that provides a direct linkage from one provider to another. Services offered by such a program should be able to:

- Schedule intake appointments directly with referral organizations
- Monitor current utilization of "bed" or program availability in programs with high demand and lower capacity such as residential or withdrawal management.
- Support the addition of new programs to the coordinated network.

FO-5: Provide funding for specialty SUD programs to hire and establish capacity for MOUD prescribing. Such funding could also benefit efforts to integrate SUD and Mental Health Services as SUD programs express challenges building capacity with existing SUD reimbursement rates as it relates to mental health related prescribing.[27]

FO-6: Fund 2 Certified Alcohol Drug Counselor Supervisor (CADC) positions so that (1) OYA offers at least one permanent CADC supervisor per facility with more based on population and (2) OYA increases participation in MOUD pilot.

FO-7: Design and pilot a comprehensive regional School Treatment and Recovery Program, including: Screening, brief intervention and assessment; Level 1 treatment services for co-occurring disorders; and peer-led recovery supports and groups

FO-8: Expand Recovery Schools to statutory maximum of 9 and provide that a recovery program is accessible to every ESD in Oregon.

FO-9: Maintain current Jail MOUD program funding administered by the Criminal Justice Commission (CJC).

FO-10: Provide funding to DOC to support MOUD medication costs to ensure program sustainability and ongoing access.

[27] https://attcnetwork.org/wp-content/uploads/2022/02/ATTC-OCBH-report.pdf

ADPC Prospective Actions:

ADPC-1: ADPC treatment committee, in collaboration with agency partners, should draft a memo to clarify the prescribing practices within withdrawal management programs. This should provide information about the need to give patients the choice of short term MOUD access to address withdrawal symptoms or induction with the intent of a planned ongoing medication regimen that should be coordinated prior to discharge.

ADPC-2: Conduct annual claims analysis to monitor efforts to improve access to SUD treatment options as well as related trends, ensuring decision making is data driven.

Appendix 1: Glossary

Agonist- A chemical that activates receptors in the brain resulting in a response in the body such as physiological or mental changes.

Antagonist- A chemical that prevents receptors in the brain from reacting to other chemicals as is in the case of overdose reversal drugs.

APAC- Acronym for "All Payors All Claims," used in the context of this document to describe the associated dataset.

ASAM- Acronym for "American Society of Addiction Medicine." ASAM is also the prominent care planning framework used to identify substance use related care needs throughout the country and is a requirement within Oregon.

BH- Acronym for "Behavioral Health"

Buprenorphine- A partial agonist opioid used to treat opioid use disorders as well as pain.

CCO- Acronym for "Coordinated Care Organization"

Long Acting Injectables- Medications administered via injection either under the skin or within a muscle. These medications are slowly released into the blood over time, providing patients with a month or more of benefits of the active ingredient(s). Abbreviated as LAI.

Low Barrier- A model for treatment that seeks to minimize the demands placed on clients and make services readily available and accessible.

MAT- Acronym for "Medication Assisted Treatment"

Methadone- An agonist medication used to treat Opioid Use Disorders as well as to treat pain conditions.

MOUD- Acronym for "Medication for Opioid Use Disorders"

Naloxone- An antagonist medication used to reverse overdose in the event of emergencies or as a part of a daily regimen to negate the effects of opioids if consumed.

OUD- Acronym for "Opioid Use Disorder"

Outpatient- Services provided at an office or other community setting in which individuals travel to a provider but do not reside at the service location.

Overdose- Term describing an event in which an individual consumes an amount of substance or combination of substances that is toxic and overwhelms the body.

Partial Agonist- A chemical that can bind to receptors in the brain but results in lesser effects than a full agonist.

Recovery- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Residential- Services where an individual receives clinical supports on the same premises of which they are short term residents.

Sublingual- Method of administration in which the medication is placed under the tongue where it is dissolved and enters the bloodstream.

Treatment- Clinical supports and services provided to individuals based on medical necessity with the goal of assisting these individuals to achieve short- and long-term recovery goals.

Withdrawal Management- Often referred to as “detox,” these are services provided to treat the effects of substance use disorder cessation, particularly for those substances in which early abstinence may come with extreme physical, emotional, or mental impacts which can be potentially life threatening.

Appendix 2: Setting by Setting Exploration

The following section contains information about each setting identified throughout the course of the study that may provide MOUD. This is a summary based on the common experiences of workgroup members and other publicly available information. The workgroup chose to approach its work through a setting by setting framework to develop a comprehensive set of recommendations and understands that outliers may exist for which this information does not reflect their service delivery.

Certified Community Behavioral Health Clinics (CCBHC)

Staffing

To support the CCBHC goal of improving access to comprehensive substance use care, these programs may provide a variety of staffing essential to the treatment of substance use disorders such as substance use counselors, peer support specialists, MAT prescribers, primary care providers, mental health therapists, psychiatrists, and more.[28] As a result, CCBHCs are in a unique position to provide MOUD, behavioral health therapies, and other recovery support services to those whose OUD may be treatable in an outpatient setting.

Reimbursement

CCBHCs can be reimbursed via a Prospective Payment System (PPS) or via fee for service (FFS) payments depending on service. The PPS model is one in which costs are based on a clinic's allowable costs and patient encounters over the course of a year. These costs are divided by the number of encounters, and the clinic is paid each time a qualifying encounter occurs regardless of the number of services or intensity of these services. MOUD administration (oral, injectable) is a FFS qualifying service; therefore, changes to CCBHC MOUD access should be considered when rates are set by Medicaid should efforts be made to increase access to MOUD within CCBHCs.

Regulatory Barriers

Workforce members suggested there is no inherent regulatory barrier to providing MOUD. However, it was noted that the State Agency providing oversight of the CCBHCs has the ability to require prioritization of specific populations and that historically the CCBHC model in Oregon has not prioritized MOUD patients. Additionally, a memo provided by OHA addressed to CCBHCs documenting the minimum required evidenced-based practices that should be available by Oregon-based CCBHCs does not include MOUD.

Patient Experience

CCBHCs do present a unique opportunity to individuals seeking MOUD to serve as a "one stop shop" for many health and behavioral health needs. An individual could access their medications and engage in behavioral healthcare all onsite. It is worth noting that a 2023 evaluation of Oregon's

[28] OHA's CCBHC Staffing template https://www.oregon.gov/oha/HSD/BHP/CCBHC%20Documents/2025%20Staffing%20Plan%20Template%20(Corrected).xlsx

CCBHCs[29] found that "several service users indicated that requirements for the use of integrated services may apply differently to those receiving services for SUD and those with a dual diagnosis."

Available medications

All DEA approved medications for the treatment of OUD, except for methadone, are able to be prescribed by providers employed by CCBHCs.

Youth-Specific Considerations

Like other outpatient substance use providers, the Oregon Youth Addiction Alliance identified transportation and time/manner access issues for youth and adolescents seeking services from CCBHCs. Youth who need some level of substance use support are often identified through a non-behavioral health system (education/law enforcement/emergency services) in a community or where a youth is most likely to spend their time. Given that youth face inherent transportation issues (access to a driver's license/vehicle and parental willingness/ability to transport), successful referrals and initiation in assessment can be difficult. As noted with prioritized populations above, CCBHCs have not made youth a specific focus area, and OYAA members cited that providers within outpatient settings, including certified alcohol and drug counselors and certified recovery mentors, lack the milieu and trainings for supporting youth and families with co-occurring behavioral health needs. For MOUD, there is also a perception of general lack of provider willingness to prescribe to young people. With respect to integrated co-occurring outpatient providers such as CCBHCs, only about 30% saw youth under the age of 18. Members suggest increasing youth focused workforce in these settings and co-locating outpatient treatment providers in spaces in youth-focused spaces: schools, juvenile detention centers, community third spaces, and in-home care.

Recommendations

In line with the 2023 evaluation, CCBHC clinics and the program should continue to identify opportunities to integrate MOUD into care and streamline access for those seeking SUD related medications.

[29] https://www.oregon.gov/oha/HSD/BHP/Documents/CCBHC-Evaluation-Final-Report.pdf

Community Mental Health Programs (CMHP)

Staffing

CMHPs are responsible for planning and delivery of safety net services for persons with mental health and/or substance use disorder in a specific geographic area of the state under a contract with OHA or a local mental health authority. There is a large variety of staffing and contracting models in use throughout Oregon's CMHPs with some offering comprehensive SUD services (including MOUD) directly and others who refer all SUD services to external providers.

Reimbursement

CMHPs are funded through County Financial Assistance Agreements, direct contracts and Measure 110 Behavioral Health Resource Network (BHRN) funding. They may be reimbursed via Fee For Service (FFS) or CCO payments for services provided to Medicaid eligible individuals. CMHPs are frequently unable to seek reimbursement for services provided to commercial insurance carrying individuals.[30]

Regulatory Barriers

CMHPs are expected to provide a behavioral health safety net for a wide spectrum of needs. Yet, the majority of state funding to CMHPs is directed to serving individuals experiencing mental illness, particularly individuals with severe and persistent mental illness who are justice-involved. Staffing and other program planning may be designed with an emphasis on treating MH conditions as a result.

Patient Experience

There exists considerable variability in MOUD access among CMHPs. As stated in the CMHP staffing section, this is a result of whether CMHPs provide SUD services internally or externally. While there do exist CMHPs that provide co-occurring services, including MOUD, it appears that many who receive care from CMHPs would be required to find or be referred to a secondary provider for those needs.

Available medications

All federally approved medications for treatment of OUD, aside from methadone, are available within this setting. However, prescribers employed by CMHPs often are primarily focused on treating the symptoms of mental health conditions, and SUD related medications are more often accessed via third party providers as the result of a referral, if at all. Workgroup members highlighted some CMHPs in which MOUD access is an embedded and standard component of care when needed. Some CMHPs may be exploring the direct operation of an Opioid Treatment program to provide methadone. Feasibility for CMHPs to deliver this level of access may be similar to that of Primary Care Providers, who have competing demands, limited training, or limited availability meaning SUD is secondary.

[30] https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/HB%204092_OR%20CMHP%20Cost%20Report_2024.12.26.pdf

Youth-Specific Considerations

Like with other outpatient substance use providers, the Oregon Youth Addiction Alliance identified transportation and time/manner access issues related to youth and adolescents seeking services from CMHPs. Youth who need some level of substance use support are often identified through a non-behavioral health system (education/law enforcement/emergency services) in a community or where a youth is most likely to spend their time. Given that youth face inherent transportation issues (access to a driver's license/vehicle and caregiver willingness/ability to transport), successful referrals and initiation in assessment can be difficult. OYAA members cited that providers within outpatient settings, including certified alcohol and drug counselors and certified recovery mentors, lack the milieu and trainings for supporting youth and families with co-occurring behavioral health needs. For MOUD, there is also a perception of general lack of provider willingness to prescribe for young people.

Oregon data in 2023 bares out these challenges: 24,000 youth 12-17 and 124,000 young adults 18-25 were classified as needing treatment but did not receive it, while 408 youth 12-17 and 2,320 young adults 18-25 were served by the publicly funded outpatient treatment system. Members suggest increasing youth focused workforce in these settings and co-locating outpatient treatment providers in spaces in youth-focused spaces: schools, juvenile detention centers, community third spaces, and in-home care. The group is aware that CMHPs have active/robust partnerships related to mental health and suicide prevention in schools and school-based health centers – efforts that could be expanded to support a concentration in substance use.

Recommendations

Accelerate efforts related to rule making, fee scheduling, and reimbursement of Co-Occurring service delivery. This enhanced rate indicated to be a supportive factor for increasing the feasibility of hiring and retaining staff needed to provide holistic co-occurring support[31].

[31] https://attcnetwork.org/wp-content/uploads/2022/02/ATTC-OCBH-report.pdf

Emergency Departments (ED)

Staffing

EDs do provide an opportunity for community members to receive MOUD as all DEA licensed physicians can provide MOUD, and on-site pharmacies are allowed to stock all medications. The workgroup found that while these essential medical professionals are available, many factors influence prescribing habits, pharmacy stocking, or other practices throughout the hospital that impact MOUD availability at this level. Most notably, the workgroup identified that an individual's beliefs surrounding MOUD or relevance of SUD treatment to their profession often drive the availability of services more than other factors.

Reimbursement

Peer support and other navigation services are not reimbursable in the ED setting without additional site credentialling which may support "warm handoffs" or other more direct care coordination that has been shown to support outcomes. While there are protective measures in place, this duplicative process may impede efforts to expand care options, such as care navigation, embedded specialty clinicians, or other services. The rates associated with SUD care initiation are not comparable to the rates of other services commonly provided, which may contribute to challenges related to implementation and adoption of evidenced based practices.

Regulatory Barriers

Care provided by EDs is designed to provide acute care needs and typically do so in a rapid fashion. As such, medication access for ongoing care requires follow-up by other providers. While medication can be administered on-site in a hospital, a prescription for use after the hospital care episode requires travel to a third-party pharmacy as well as a provider for ongoing access. This ongoing care is likely to be a third-party entity outside the hospital system.

There is some need for additional clarity related to the requirement of a COA (certificate of approval) in non-behavioral health programs. Without this clarity, many non-behavioral health programs are unable to employ behavioral health professionals, such as peers, who can assist with connections to ongoing care and care continuity.

Patient Experience

Throughout Oregon there is wide variability of potential experiences one may have when seeking care for OUD depending on the hospital, its staff, or even the time of day that care is sought. An Oregon Health Leadership Council survey revealed that 57% percent of EDs have a provider who routinely prescribes buprenorphine. Additionally, the same percentage of EDs report not having an adequate referral system to ensure appropriate follow up care can occur, which has been cited as a reason for prescriber reluctance.[32] Due to numerous factors, patients may leave without prescribed medications and follow up care recommendations that may be challenging to navigate/ follow through on without additional support.

[32] https://ohlc.org/wp-content/uploads/2024/05/MOUD-in-the-ED-follow-up-methadone-in-the-ED-Survey-Report-01-2024.pdf

Available medications

All federally approved medications for OUD can be provided within this setting, although for a limited duration. EDs can provide all medication for the purposes of continuing access for medication regimens established prior to care as well as to establish new medication regimen that will be maintained by other care providers. For medications that can be prescribed and retrieved by third party pharmacies, these may be limited in duration as a "bridge" to follow up care (e.g. 7-day prescription to provide ongoing access between ED discharge and a follow up appointment).

Youth-Specific Considerations

OYAA did not address this setting in its initial round of comprehensive planning, but some of the discussions would apply to emergency rooms. Identification and initiation could be stifled by: lack of youth and family oriented certified recovery mentors and counselors; lack of appropriate training for working with youth and families with co-occurring disorders/medication needs; and difficulty navigating/connecting youth to appropriate community-based after care due to insurance, transportation, time/manner, wait-list, and general lack of youth/family oriented, culturally specific providers.

Recommendations

In alignment with the September 2024 recommendations, the workgroup maintains the following recommendations:

- Establish or modify existing programs to promote linkages of care from Emergency Departments to other community-based care providers such as behavioral health or MOUD prescribers. This may require significant changes to currently state funded phone lines or web-based provider directories to shift them from a primarily informational service to one that provides a direct linkage from one provider to another. Services offered by such a program should be able to:
    - Schedule intake appointments directly with referral organizations
    - Maintain awareness display of "bed" or program availability in programs with high demand and lower capacity such as residential or withdrawal management.
    - Support the addition of new programs to the coordinated network.
- Increase availability of education or technical assistance provided to those who may be able to prescribe MOUD.
    - Provide funding for addiction medicine fellowship programs to increase capacity of addiction medicine doctors.
    - Provide funding for technical assistance and/or collaborate with federally funded technical assistance providers to ensure training priorities within the state address MOUD and OUD education.
- Modify reimbursement or establish incentives that may support workflow changes or staffing changes that increase MOUD access within EDs.

Emergency Medical Services (EMS)

Staffing

EMS teams with buprenorphine programs vary depending on funding, program design, or location. Generally, professionals working on these teams receive additional training (i.e. trauma informed care, buprenorphine specialty training) and supplies to provide buprenorphine in the field (e.g. when dispatched). For example, Multnomah County's EMS program dispatches these professionals separately from the ambulance (referred to as a "rig") whereas Clackamas dispatches staff with the ambulance as this works best for rural community members whose local EMS may be serving a wider area.

Reimbursement

It is worth noting that EMS services are only reimbursed for services if transport occurs (e.g. individual accepts transport to a hospital). As such, medications provided by EMS may be at a cost to the program, which in some cases is supported by grants or other high risk funding options.

Regulatory Barriers

At present, there is a need for additional clarity related to the requirement of a COA (certificate of approval) in non-behavioral health programs. Without this clarity, many non-behavioral health programs are unable to employ behavioral health professionals, such as peers, who can assist with connections to ongoing care and care continuity.

Patient Experience

Patient experience differs depending on which EMS team is responding. In general, a few common factors are worth considering. First, because EMS reimbursement is tied to transport, this does mean individuals may be provided with a choice to receive medication and accept transport for further care or forgo both interventions. This workflow, while coming with the benefit of encouraging potentially necessary follow up medical care, may present individuals with a care decision that feels coercive. One workgroup member who oversees an EMS buprenorphine program suggests separating medication from transport as the most likely way to achieve desired outcomes as 20-40% of people decline transport regardless of the availability of MOUD. Depending on the EMS program, individuals may be connected to follow up providers and/or engaged with via peers to support additional recovery goals.

Available medications

Most MOUD are allowed in this setting with proper training and medical orders. Sublingual Buprenorphine is available in Multnomah, Clackamas, and Marion counties via EMS as these counties have implemented such programs.

Youth-Specific Considerations

EMS was not addressed by the OYAA in the initial round of study and comprehensive planning.

Recommendations

Establish funding to support non transport calls in which MOUD or care linkages are provided.

Establish funding to support expansion of EMS MOUD programs throughout Oregon. Such funding may include cost of training and implementation support, incentives for implementation, and

capacity building funds such as initial support to cover costs of medication stock. Such support should also include integration with EDs or other parts of the care continuum to ensure continuity of care.

Federally Qualified Health Centers (FQHC)

Staffing

FQHCs may employ a wide range of professionals depending on the services offered directly by the health center (as opposed to services arranged with other providers). These professionals may include physicians, mental health practitioners, substance use counselors, peers, pharmacists, dentists, and more.

Reimbursement

FQHCs receive reimbursement via Medicare and Medicaid utilizing a prospective payment system (PPS) receiving some differential payments depending on the service (such as when meeting with new patients or completing annual exams). During the study, one workgroup participant who is a medical director for an Oregon based FQHC highlighted the need for specialty pricing (403b) to support buy and bill medication purchasing.

Regulatory Barriers

There were no FQHC specific barriers identified over the course of the study.

Patient Experience

Those seeking MOUD may find scheduling with a Federally Qualified Health Center (FQHC) to be an effective means of gaining access to MOUD in Oregon. It was reported that most of the FQHCs provide at least one form of MOUD and that at least one FQHC in each geographic area likely provides all allowable forms of MOUD.

Available medications

Aside from methadone, all federally approved forms of MOUD are available by prescription in this setting.

Youth-Specific Considerations

Federally qualified health centers and primary care in general offer an important early identification system for youth and families. Annual well-visits include screenings and brief intervention if following American Academy of Pediatrics Bright Futures. Some primary care entities, including Federally Qualified Health Centers, employ “Behavioral Health Consultants” and other certified non-licensed behavioral health staff that are part of an integrated clinical workflow and can provide additional support, referral, and system navigation for youth and families identified as having needs. These entities, especially when integrated in community settings, such as School-Based Health Centers and mobile outreach clinics, might provide one of the more accessible ways for early identification and referral (if not induction in the case that the FQHC prescribes).

Recommendations

The workgroup provided no specific FQHC recommendation but noted that physician education changes may increase prescribing across various medical providers. Targeted outreach could be provided within these settings to increase access, such as through mentorship by other FQHC medical providers, which has been said to be effective. This mentorship could be one option to consider when establishing funding for TA.

Inpatient Medical Services

Staffing

Staffing varies due to differing hospital policies, care team composition, staffing practices, and other factors. In general, established hospital workflows appear to be unique across settings and are adapted to the unique needs, understanding of billing requirements, and staffing of each facility.

Reimbursement

Services are reimbursed in a manner similar to other medical conditions. Like Emergency Departments, workgroup members shared that the reimbursement rates for SUD related services are significantly lower than that of other conditions treated, which may result in lower levels of implementation of MOUD protocols within these settings as they have potential negative budget impacts. Workgroup members also highlighted that MOUD is bundled within hospital stay costs but not at a rate inclusive of the costs of the medication, resulting in further financial impacts. As a result, prescribers have reported pressure to direct patients to seek access following care as opposed to induction during the hospital visit.

Regulatory Barriers

Existing regulations impose some limits on medications prescribed by these facilities for outpatient use. It is worth noting that these limits were not described as barriers to access. Some barriers that were identified appeared to be site specific and may be addressed via technical assistance to support MOUD implementation.

Patient Experience

The experiences of those within these settings differ greatly depending on the presenting health concern, provider experience, and hospital policies. Individuals receive differing levels of access to MOUD depending on the hospital system, attending physicians, or on-site pharmacy practices. Additionally, workgroup members indicated many who receive care in this setting may be provided with care depending on factors outside of the hospital, such as availability of MOUD following discharge. Examples of positive experiences highlighted included warm handoffs to follow up care, dedicated care navigators, embedded peer programs, and other practices that were perceived as “understanding,” “knowledgeable,” or “confident” when planning and discussing options for OUD treatment.

Available medications

All DEA approved MOUD medications can be accessed for a short-term duration in these settings, including methadone. Medications can be utilized for withdrawal management, continuation of prescriptions throughout a hospital stay, or to begin a planned regimen that extends beyond hospital discharge.

Youth-Specific Considerations

OYAA did not address this setting in its initial round of comprehensive planning, but some of the discussions would apply to inpatient settings. Identification and initiation could be stifled by: lack of youth and family oriented certified recovery mentors and counselors; lack of appropriate training for working with youth and families with co-occurring disorders/medication needs; and difficulty navigating/connecting youth to appropriate community-based after care due to insurance, transportation, time/manner, wait-list, and general lack of youth/family oriented, culturally specific providers.

Recommendations

Access challenges in this setting, aside from those that may be hospital system specific (e.g. internal policies, protocols, etc.), appear similar to those of other medical settings. As a result, the September 2024 recommendations may support improvements in these settings, particularly those related to care coordination and expansion of TA to improve provider willingness, confidence, and comfort with MOUD. Furthermore, implementation of changes to pharmacists' roles in MOUD access as directed by SB 236 (2025) may support access in this and other hospital settings.

Develop mechanism to reimburse for inpatient services and costs of MOUD (cost of medication only) to ensure costs of medications are reimbursed in addition to other necessary medical services.

Jails and Juvenile Departments

Staffing

Jail based MOUD programs in Oregon operate with significant variability and staffing practices. This variability may range from jail employed medical staff (nurses, physicians, etc.) to third party professionals contracted to provide these services on-site which may be a combination of medical and behavioral health staffing to provide access to MOUD and other services. Program differences reflect local planning decisions.

Reimbursement

Funding for jail based MOUD appears primarily funded through temporary funding streams, such as the CJC Jail MOUD grant program. This funding allowed jails to design and implement programs to support access to MOUD based on their own unique needs, partnerships, and other factors that would ensure the program could improve access. Currently without additional funding or progress towards implementing the state's carceral benefit of the 1115 Medicaid waiver, funding for these

programs is reliant on these grants or similar sources, which would cover costs for some in the last 90 days of incarceration.

Regulatory Barriers

While no setting specific barrier was identified, it is worth noting that the current funding for MOUD within this setting is impacted in some ways by federal Medicaid guidelines which prevent those who are incarcerated from receiving such benefits. Sustainable or ongoing funding streams could ensure ongoing access in this setting by supporting staffing, medications, or other related costs.

Patient Experience

The MOUD study identified that much variability exists across jail based MOUD programs that are the result of a variety of factors ranging from prevailing stigma, personal jail staff beliefs, program design, funding, community partner access, community partner collaboration, and "age" of the program itself. While grant funded technical assistance has been effective to support program implementation, those interviewed for this study did express that there may be greater work to be done to support this change as it relates to jail staff to ensure more consistent language, coordination, and support is provided to those who may benefit from MOUD. These concerns ranged from those who may refuse to be involved in MOUD access entirely to unintended and detrimental changes to medical care provided at intake to those who are awaiting MOUD.

Available medications

All DEA medications can be available in this setting with adequate partnerships and/or licensing. It is worth noting that medications offered within a county jail may be determine in relation to medications available locally to ensure continuity of care is possible. One example of such a decision surrounds the proximity by which a jail may exist to an OTP; without such a provider, methadone access within a jail MOUD program would not be conducive to those seeking continued medications upon release.

Youth-Specific Considerations

As with Jails, County Juvenile Departments vary in SUD service delivery and service referrals/linkages to community providers. In response to community needs, some juvenile departments have developed assessment and early intervention programs (including both SBIRT-based deflection and diversion) and/or provide on-site or community facilitated behavioral health support – including treatment and recovery programs. During the course of this study, juvenile detention centers were planning and assessing readiness for the 1115 carceral benefit, including assessing readiness/willingness to provide medication treatment. Two facilities in Fall of 2024were providing FDA approved medications, but many cited barriers to successful implementation of medication – including high cost of medications and lack of providers willing to prescribe to their population. Like schools and other community intervention points, OYAA finds juvenile departments well positioned to provide community deflection and diversion pathways through assessment, therapeutic early intervention and linkage to treatment. Given some of the successful partnerships demonstrated between schools, juvenile departments, providers, and community-based organizations offering peer support and family navigation, juvenile departments may offer one more ramp to effective treatment and wholistic youth recovery. While the future of the 1115

Waiver is unclear, OYAA members suggested support for these programs and expansion of in-house/community provider co-location treatment programs, including services for those in community supervision.

Recommendations

Maintain funding for Jail MOUD programs.

Establish best practices that describe a baseline of minimum care to those experiencing withdrawal symptoms or at risk for OUD to be informed of MOUD options, or extend the requirement to connect or provide MOUD.

The CJC should encourage collaboration between Jail MOUD programs and DOC to support access to lower cost medications when possible.

Outpatient SUD Programs

Staffing

Outpatient programs have varying degrees of potential to provide MOUD dependent on the level of intensity of services offered (i.e. outpatient, intensive outpatient, etc.). Each program is required to maintain a medical director or Licensed Medical Provider (LMP) who is available for consultation as described by relevant OARs, per the ASAM criteria. However, direct access to an LMP depends on the particular program or level of care. As such, most individuals seeking care at outpatient programs in Oregon do not have access to the medical staff employed by the organizations that provide their SUD treatment services, meaning MOUD, if provided, is accessed via a referral to a third-party entity in another setting.

Reimbursement

While reimbursement challenges do exist in this setting, they are more broadly related to services rendered unrelated to MOUD. Reimbursement for the provision of MOUD in outpatient behavioral health settings is similar to that of other settings described in this report. As such, this may inhibit the ability for programs to implement new services, such as increasing staffing of prescribers in these settings.

Regulatory Barriers

Per the OARs, medical staff employed in these settings can provide “health maintenance and restoration measures consistent with generally accepted principles of medicine,” and may prescribe all approved medications for MOUD, with the exception of methadone.

Patient Experience

While the experiences of individuals may vary depending on the program accessed, in general most individuals who seek MOUD in these settings must attend an appointment with an external medical provider and acquire this medication at a separate pharmacy. This needs to involve three separate

interactions that may pose too great of a challenge for some individuals who are experiencing the symptoms of opioid use disorders, as these may interfere with their ability to secure transportation, safe storage, or other necessary aspects that support regular adherence to a medication regimen.

Available medications

All DEA approved medications to treat OUD with the exception of methadone are able to be prescribed. However, the limited ability to directly access these medications in this setting, due to the reasons listed, greatly impact widespread availability in this setting.

Youth-Specific Considerations

Like with other outpatient substance use providers, the Oregon Youth Addiction Alliance identified transportation and time/manner access issues related to youth and adolescents seeking services. Youth who need some level of substance use support are often identified through a non-behavioral health system (education/law enforcement/emergency services) in a community or where a youth is most likely to spend their time. OYAA members cited that providers within outpatient settings, including certified alcohol and drug counselors and certified recovery mentors, lack the milieu and trainings for supporting youth and families with co-occurring behavioral health needs. For MOUD, there is also a perception of general lack of provider willingness to prescribe for young people. Oregon data in 2023 bares out these challenges: 24,000 youth 12-17 and 124,000 young adults 18-25 were classified as needing treatment but did not receive it, while 408 youth 12-17 and 2,320 young adults 18-25 were served by the publicly funded outpatient treatment system.[33] Members suggest increasing youth focused workforce in these settings and co-locating outpatient treatment providers in youth-focused spaces: schools, juvenile detention centers, community third spaces, and in-home care.

Recommendations

Require facilitation of MOUD and proof via attestation that efforts to connect qualifying individuals to MOUD were unsuccessful, successful, deferred to a later date, or declined.

Opioid Treatment Programs (OTP)

Staffing

OTPs are required to employ a variety of medical professionals to support their service delivery, which includes the ability to prescribe all federally approved medications for OUD. These programs provide their patients with care guided by a medical director and involving the support of other professionals to monitor stability and changes to their health condition. These medical staff may

[33] 2023 National Survey of Drug Use and Health State Data Tables and Reports From the 2022-2023 NSDUH

identify health conditions outside of use disorders but due to capacity these needs are often required to be addressed in other settings.

Reimbursement

No barriers to MOUD were identified in this setting related to reimbursement practices.

Regulatory Barriers

Access is limited to those who are 18 years or older in most cases, though exceptions do exist. There are challenges to opening new OTPs, in particular state law that restricts allowable locations but also strict federal regulations and the state's capacity to license new programs.

Patient Experience

OTP patients are often subjected to stigma. These programs typically operate with very limited hours due to "good neighbor" agreements or other requirements that require individuals to access care prior to 2pm (or earlier). This may limit the ability for those who have daily responsibilities related to employment and/or childcare to access services, or it may dissuade those who are seeking services. In addition, these programs often require individuals to travel to the program site for dosing (or retrieval of "take home" doses) at a frequency greater than other programs (e.g. comparison to medication that is accessible via a 30-day prescription retrieved once per month at a pharmacy).

Available medications

All federally approved medications for OUD are allowable. This program type is one of only a few to be able to offer methadone to patients on an ongoing basis. Unlike many of the other service types described in this document, it is worth noting that this care access point also provides more supervision of dosing and as a result may be able to adjust medication dosages more rapidly than other settings to respond to patient need.

Youth-Specific Consideration

While this setting was not discussed explicitly during the OYAA's initial study and comprehensive planning, provider interviews have suggested that the milieu of OTPs might not be responsive to older adolescents (18-25). As with other types of behavioral health providers, an adult and older adult focus can mean a lack of skills and training for supporting younger people and their families with co-occurring behavioral health needs, age dynamics that can raise safety concerns, and a general, less connective experience among young patients and their families.

Recommendations

The workgroup recommends removing siting requirements (ORS 430.590) for Opioid Treatment Programs to support increased access to MOUD via this provider type. Additionally, the workgroup recommends addressing funding distribution challenges that have slowed expansion efforts resulting from Opioid Settlement investments.

Pharmacy

Staffing

Pharmacists have a variety of potential touch points as it relates to MOUD. Depending on the settings, a pharmacist's role ranges from dispensing prescribed medications and providing consultation to those receiving medications to being involved in a multidisciplinary collaborative prescribing process. These differences can be the result of a variety of factors related to regulations, organizational policy, or provider interest.

Reimbursement

There appears to be discrepancies in understanding related to the potential for reimbursement related to MOUD access by pharmacists. In one interview between hospital-based pharmacists from two different areas of the state (Central Oregon & Portland Metro one professional reported reimbursement for the same services their peer had believed to be provided at no cost. Further discussion with a metro area CCO representative indicated the service was reimbursable but likely relied on systems savvy billing specialists and a motived hospital administration to establish policies allowing for this expanded service array.

Regulatory Barriers

HB 4002 (2024) directed pharmacists to prescribe MOUD but did not include pharmacists as an eligible "provider" elsewhere in statute. This was addressed in SB 236 (2025) and the Board of Pharmacy is now engaging with community members for the rulemaking process to implement this provision.

Patient Experience

The experiences of those seeking MOUD via pharmacy differs widely. While this setting maintains its status as the most "typical" access point for MOUD as it relates to accessing all other medication, a variety of factors may directly impact patients seeking to acquire MOUD via pharmacy window. Anecdotal reports from workgroup members highlights longer wait times because of de-prioritization when filling MOUD medications by pharmacy staff, company policies that disproportionally impact those with MOUD prescriptions, and challenges related to partial filling of prescriptions due to payor quantity limits. In situations where pharmacy staff received adequate training and impacts of stigma are less present, individuals may find pharmacy to be a low barrier and supportive solution to acquiring such medications that can also include insightful consultation and advice.

Available medications

All federally approved medications with the exception of methadone are able to be provided via a pharmacy. However, differences in pharmacy ordering practices may impact availability and access, leading to wait times or other issues.

Youth-Specific Considerations

Pharmacy was not addressed by the OYAA in the initial round of study and comprehensive planning.

Recommendations

Implement changes to prescribing made allowable by SB 236 (2025). Increasing possibilities of access within this setting may increase access broadly as prescribers may feel more comfortable prescribing if access is more continuously available.

Ensure payors reimburse for consult related to MOUD, administration, or other costs that increase availability via pharmacy. [34]

Primary Care Providers (PCP)

Staffing

Primary care providers may be found throughout a variety of settings but are detailed in this section to highlight a role that primary care could play in MOUD access. These primary care teams may include a variety of professionals ranging from medical doctors to nurses to behavioral health professionals depending on the clinic.

Reimbursement

Primary care providers, when not found in other settings listed within this report, receive reimbursement via payors as they would with any other medical service, billing Medicare, Medicaid, or commercial insurance after services are rendered.

Regulatory Barriers

No regulatory barriers were identified specific to primary care providers.

Patient Experience

Patient experience may greatly differ across primary care physicians as prescribing willingness may be different depending on the provider. Some may be willing to prescribe if other behavioral health care is occurring, others may refer such care outside of their practice, while others may decline to support entirely, or a physician may be willing to assist with access regardless of the effort required.

Available medications

All approved medications for OUD may be prescribed within primary care settings, with the exception of Methadone. Workgroup members highlighted that factors that contribute to the "lower than expected" rate of MOUD prescribing in this setting may vary wildly from provider to provider but include:

- Lack of training surrounding or familiarity with substance use disorders.
- Apprehension surrounding prescribing of opioid medications related to efforts to decrease use of narcotic pain medications.
- Stigma or personal view related to those who use substances.
- SUD support requires more time, access, or availability than what may be possible in most primary care settings.
- Providers may not know the "x-waiver" no longer is required.

[34] https://www.ashp.org/advocacy-and-issues/key-issues/opioids/model-moud-prescribing-protocol?loginreturnUrl=SSOCheckOnly

- Fears that providing such care may cause their practice to move away from that of a generalist to that of a specialist.

Youth-Specific Considerations

Primary care offers an important early identification system for youth and families. Annual well-visits include screenings and brief intervention if following American Academy of Pediatrics Bright Futures.[35] Some primary care entities employ "Behavioral Health Consultants" and other certified non-licensed behavioral health staff that are part of an integrated clinical workflow and can provide additional support, referral, and system navigation for youth and families identified as having needs. These entities, especially when integrated in community, such as School-Based Health Centers and mobile outreach clinics, might provide one of the more accessible ways for early identification and referral (if not induction in the case that the primary care provider prescribes). The factors cited in Available Medications are true for youth and families with the added stigma around lifelong prescription for a young person.

Recommendations

Require Oregon based medical providers to receive education related to substance use disorders as a requirement of ongoing continuing education regardless of practice area.

Require educational institutions that provide healthcare related programs to include a minimum amount of education related to substance use disorders and their treatment.

When funding TA for MOUD, ensure adolescent/ youth/ transitional age youth focus is included.

Department of Corrections and Oregon Youth Authority facilities

Staffing

To make MOUD medication available, prisons are staffed by pharmacists, nurses, and physicians. It is worth noting that daily dosing of medications also requires the supervision and collaboration of security staff as adults in custody (AIC) in many situations are awaiting daily medications in a congregate setting.

Reimbursement

Medications and health services are paid for by the DOC and OYA agency budgets and are not reimbursable via Medicaid or other public payors. DOC does currently have access to specialty pricing of buprenorphine tablets due to a program provided by one pharmaceutical company found to be liable for the opioid crisis, decreasing the overall cost of MOUD significantly for this specific medication. Additionally, DOC has entered into other agreements that decrease costs of other available MOUD.

Regulatory Barriers

[35] https://www.aap.org/en/practice-management/bright-futures/?srsltid=AfmBOor4iVyKGAx1NsKfHgskJNfpq3XlWopksRL_sQT-M8q-eud_5y43

There were no unique regulatory barriers identified by workgroup members or agency staff interviewed for this study. MOUD in corrections settings is prioritized by related federal policies.

Patient Experience

DOC reports publicly that 100% of individuals in their custody have access to MOUD, and documents provided to the ADPC describe availability as being inclusive of 100% of DOC facilities. However, some Adults in Custody (AIC) report that medication may not be feasible for some work assignment outside of the facility. In some cases, the decision to seek access may result in transfer to another facility where medication is available, leading to greater distance from natural supports or loss of facility specific programs.

MOUD may also be offered in conditions where therapeutic treatment and recovery groups are inaccessible (program might not exist, waitlists, or facility offers MOUD to general population but treatment is a separate unit). AICs report that, without the tools of therapeutic intervention, MOUD can feel like "trading one addiction for another." Furthermore, AICs remarked that there was no clear instruction, education, or classroom support to help them understand the risks and benefits of MOUD initiation. DOC must balance risks of diversion and patient coercion with access to treatment.

Available medications

All DEA approved medications can be provided in this setting.

Youth-Specific Considerations

The OYAA identified Oregon Youth Authority (OYA) as an important bridge to treatment and potential connection to community-based treatment and lifelong recovery. Currently OYA offers assessment, group and individual Substance Use Treatment, and recovery groups at the 5 secure juvenile detention facilities. OYA offers CADCs, mental health, and medical staff to all young people and in some instances partners for some community-based treatment. In some facilities this is assisted by youth in custody certified as recovery mentors. Currently, OYA is partnering with OHSU's HRBR Clinic and Addiction Treatment Faculty to pilot youth buprenorphine induction at Oak Creek Youth Correctional Facility for girls. OYA faces similar concerns as the adult/DOC population with respect to diversion and coercion, and given the lack of willing community providers, staff are wary of not having referral and transition contacts with community-based providers at the end of a youth's stay. The geographic distribution of correctional facilities also adds barriers to transition care. OYA has limited staffing capacity to perform assessments, and to coordinate medication clinical workflows. OYAA believes these positions could expedite the expansion of treatment services, including the MOUD pilot.

Recommendations

Provide funding to DOC (and other correctional institutions) to provide LAI to AICs.

Ensure alternative medications can be made available in the event long acting injectables are contraindicated.

Fund two additional Certified Alcohol Drug Counselor Supervisor positions so that OYA offers at least one permanent CADC supervisor per facility with more based on population. This would add capacity to expand the MOUD pilot.

Residential SUD Programs

Staffing

Like outpatient programs, residential programs employ a variety of professionals to support their service delivery, and depending on the level of intensity provided (e.g. Low-intensity, High-intensity, medically managed), the level of involvement by licensed medical providers (LMP) varies. For example, an ASAM level 3.1 residential program should be able to consult with a LMP daily, whereas a ASAM level 3.7 medically managed program is required to maintain on-site or phone LMP availability 24 hours per day, 7 days per week. LMPs are not required to provide MOUD prescriptions, but programs are required to facilitate opportunities to obtain medications for opioid use or psychiatric needs, which may be provided via a third-party provider.

Reimbursement

Residential programs are reimbursed either via Medicaid FFS or CCO day rates.

Regulatory Barriers

There are no regulatory barriers to prevent patients from receiving all federally approved MOUD, provided that methadone is made available through coordination with either an external OTP or OTP within the same organization. OARs direct programs to facilitate access to medications related to OUD and psychiatric needs.

Patient Experience

When MOUD is accessed via "in-house" or third-party prescribers, individuals may have an experience like that of any other client taking a medication. Depending on the administration method, individuals may be required to be observed for a period of time, adding complexity to coordinating within the program (e.g. sublingual medications have up to a 15-minute window to be dissolved). This observation period may be impacted by prevailing stigma surrounding MOUD related to "diversion" concerns, which may have client impacts if not addressed.

Additionally, workgroup members shared anecdotal concerns relating to individuals who have sought residential services and experienced barriers to the OAR-directed access requirement. Individuals who may be seeking MOUD within this setting may find that while they are allowed to receive MOUD, the coordination required to access prescribers may be hard to prioritize among other treatment activities[36]. Alternatively, they may find that this coordination is explained prior to

[36] Workgroup members shared anecdotes from patients they have provided care to while in residential facilities where access to MOUD is restrictive in practice, departing from written policies. An example of such a "ghost policy" is for MOUD access to only be allowable during timeslots in which individuals must choose between supportive activities (e.g. family visit, community outing) and medication or other healthcare access.

admission in a way that may dissuade individuals from maintaining the medically necessary medication regimen or may dissuade them from admitting to a program for fear that their medication may be discontinued. This disparity is more challenging where a residential program is located a significant distance from a prescriber or OTP.

Available medications

All federally approved MOUD is available by prescription in this setting with the exception of methadone. However, individuals receiving care in a residential program may, through coordination with an OTP, receive methadone.

Youth Specific considerations

Some of Oregon's Youth residential settings provide or support connections to MOUD prescription. However, there are only six substance use residential facilities for adolescents in the state, and they are not geographically dispersed. The facilities face similar issues to youth carceral settings in that they have difficulty finding community-based aftercare and transition to in-community medication supports. In general, there remains a perception of hesitancy to prescribe to young people.

Recommendations

Require facilitation of MOUD and proof via attestation that efforts to connect qualifying individuals to MOUD were unsuccessful, successful, deferred to a later date, or declined.

Develop administrative rules to ensure residential programs demonstrate efforts to maintain flexibility for individuals to meet with MOUD providers in a way that is not detrimental to their treatment services and/or connection to supportive others such as family, community-based recovery supports, or other preferrable individual activities.

Schools and School Based Health Centers

Note: This section will mostly speak to School-Based Health Centers (SBHCs) (89 in the state), but some of the opportunities could be applied to other third-party licensed providers operating within and in partnership with schools. The section addresses "schools" due to the separate but related need for long-term recovery supports for young people who are prescribed MOUD (See Youth Specific Consideration for detail).

Staffing

In general Oregon's certified SBHCs are operated by a third-party medical sponsor that provides primary care, including Federally Qualified Health Centers, Local Public Health Authorities, hospital systems, and private practice pediatricians. These entities also provide or partner with community providers for mental and behavioral health services. As a result, the staffing models for school-based health centers vary. At a minimum, the Oregon SBHC Standards of Certification

Volume 4[37] dictates that SBHCs have the following providers for a minimum number of hours per week: a Medical Director (with prescriptive authority); a primary care provider (MD, DO, ND, NP, or PA); and a licensed, credentialed or certified behavioral health provider (including people certified by MHACBO or THW Commission). A few SBHCs employ Certified Alcohol and Drug Counselors or provide a strong linkage to outpatient substance use and co-occurring treatment.

Reimbursement

From 2023-2024, 74% of SBHCs were federally qualified health centers and were paid on the FQHC PPS. The standards of certification require that students are served regardless of insurance status. SBHCs must be able to bill Oregon Health Plan, including open card and Coordinated Care Organizations, and private insurance. In addition, SBHCs receive general fund grants to support capacity and unbillable services.

Regulatory Barriers

SBHCs are third party health care entities that share space via agreement with a school. Regulation of SBHCs would largely be dictated by regulation of primary care and federally qualified health centers, but local education policy set by the school board might restrict access to medications.

Patient Experience

It is unknown what the patient experience is with respect to MOUD, as the ADPC is unaware of any SBHCs that are currently prescribing. The setting is an optimal access/referral point due to the overall youth experience of having the provision of services in an accessible and youth-oriented space.

Available medications

All DEA approved MOUD except for methadone are allowable in this setting. At least one school-based health center has vocalized an interest to offer such medications if requested.

Youth-Specific Considerations

The OYAA identified education settings as one of the most important access points to alcohol and drug education, screening, and early intervention. The youth also saw it as an important place to provide treatment and recovery supports – aligning with their observations mentioned above that there are significant barriers to youth accessing traditional outpatient behavioral health settings. Among providers interviewed, professionals noted difficulty closing referrals when services were not immediately available in youth-oriented spaces or on-campus for a school setting. As noted in the HB 4002 Preliminary Report[38] – there are models in Washington in which school-based providers have created robust substance treatment services. OYAA also identified that school-based[39] treatment and recovery services (including those that are or could be offered by SBHCs)

[37]https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/CertificationStandards_v5_September%202024.pdf

[38] https://www.oregon.gov/adpc/Documents/Alcohol%20and%20Drug%20Policy%20Commission%20HB%204002%20Report%20September%202024.pdf

could significantly increase access to services, provide therapeutic alternatives to in-school discipline for substance use/possession, reduce stigma around seeking help for services, and increase education among students and staff about substance use and substance use disorder.

In addition, OYAA identified the need for treatment to be paired with lasting connection to recovery services. Providers have noted this is especially true for medication-based treatment which might not be paired with therapeutic modalities. In the HB 4002 Preliminary Report, the ADPC and SOCAC named the importance of Recovery Schools in providing recovery supports for students in Oregon Schools. The OYAA concurs, and expanding Recovery Schools so they are accessible in all regions of the state is a draft priority for the 2026-2030 comprehensive plan. As mentioned above, HB 2502 (2025) did not pass, meaning that existing recovery schools continue to lack sufficient financing to meet operating costs. In addition, economic and budgetary pressures mean that the Oregon Department of Education will not be able to open 3 additional schools in the 2025-2027 biennium as originally planned for.

Recommendations

Provide $500,000 to develop and pilot a regional school-based early intervention, outpatient treatment, and recovery program. The pilot would support regions to organize with schools, SBHCs, Education Service Districts, and other third-party primary care and behavioral health providers to develop a model of support in a limited number of communities.

Address HB 4002 preliminary recommendation/HB 2502 charge to provide financing for three additional recovery schools, and fund recovery schools up to operating expenses.

Telehealth

Staffing

Telehealth programs may employ staff from various disciplines as needed to support their service delivery but may include substance use counselors, peer professionals, mental health providers, physicians, nurses, and others.

Reimbursement

There exists a lack of certainty in the future of telehealth prescribing as it relates to MOUD, and providers expressed that there is need for further state guidance surrounding how telehealth may be reimbursed. Notably, some telehealth programs without a “brick and mortar” location are less available to Oregonians with Medicaid, as telehealth-only businesses – such as MOUD prescribers – are seemingly less compatible with the state’s existing administrative rules. This results in programs and services that are sometimes funded via non-Medicaid funding sources such as M110 while in other jurisdictions, CCOs have contracted with them and reimburse them for services. [40]

Regulatory Barriers

[40] https://start.boulder.care/eligibility/

It is unclear if federal regulations will continue to allow MOUD to be prescribed via telehealth, as this has been a changing landscape throughout the years, becoming more accessible during the COVID-19 pandemic.[41] Currently, MOUD (and other controlled substances) may be provided via telehealth as a result of another extension of COVID-19 telemedicine flexibilities, but it is unclear as to whether these changes will become permanent.[42] There is a lack of clarity in both federal and state guidance surrounding how telehealth may be reimbursed. Oregon telehealth programs without a "brick and mortar" location where patients are seen struggle to become licensed or reimbursed by Medicaid.

Patient Experience

A body of research demonstrates that those who utilize telehealth services view these services favorably.[43] For Oregonians, telehealth access to MOUD has enabled individuals to begin MOUD more quickly, as seen via the HRBR program of OHSU.[44] It has also had the benefit of supporting individuals for whom transportation is a barrier to MOUD access, especially in circumstances where a pharmacy may be more accessible than a willing prescriber in their area.

However, it is worth noting that pharmacy policies may be in place that negate these potential benefits. Payors, providers, and others have indicated that some large retail pharmacies have company policies that require individuals to meet with their providers in person, require prescriptions are filled within a specific period of days from the date these medications are prescribed, or require a paper copy of the prescription. While these policies have been said to be in place to avoid diversion or abuse of controlled medications, they are more restrictive than what is legally required and frequently unknown until after an individual is negatively impacted by these policies.

Available medications

All DEA approved medications with the exception of methadone are available for prescription. However, without the availability of a "brick and mortar" establishment, access to injectables may require a partnered or pre-arranged access via a specialty pharmacy who can administer this medication.

Youth-Specific Considerations:

As noted above, OYAA identified the challenges and barriers across behavioral health settings related to lack of workforce, culturally/age/family responsive services, and perceived willingness to treat young people. In addressing those challenges, the OYAA spoke generally about the importance of telehealth as a support in providing age-appropriate/culturally specific support when none exists locally in the settings mentioned above. This relates particularly to schools and carceral settings, where youth could get support instantly through a tablet or other device.

[41] https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates
[42] https://www.federalregister.gov/documents/2024/11/19/2024-27018/third-temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled
[43] https://link.springer.com/article/10.1007/s11606-015-3489-x
[44] https://www.ohsu.edu/school-of-medicine/general-internal-medicine/harm-reduction-bridges-care-hrbr

Recommendations

OHA should establish rules and provide guidance on certification of SUD specialty telehealth programs. This may allow such programs to bill Medicaid and free up flexible Measure 110 BHRN funding for other services that are not Medicaid reimbursable.

Prohibit policies more restrictive than federal law for MOUD access via telehealth, including policies implemented by pharmacies that would prevent prescriptions provided via telehealth from being filled.

Withdrawal Management (WM)

Staffing

Withdrawal management programs employ a wide range of SUD professionals ranging from peer mentors to medical doctors. These staff provide an array of services including case management for follow up services, counseling, peer support, prescribing, and other medical care.

Reimbursement

WM services are reimbursed at a case/ day rate that allows for the individualized services to be provided during this brief care episode. However, it was noted by the workgroup that certain medications, such as long acting injectables (LAI), are included in this day rate. This may dissuade providers from providing these medications, as they may cost as much (or exceed) the amount reimbursed at the currently provided rate.

Regulatory Barriers

WM programs are short term programs designed to treat and stabilize withdrawal symptoms so that individuals may be discharged as quickly as medically appropriate, meaning they are able to engage in services at a lower level of care and receive services that support long term outcomes. As such, availability of medications is limited to the duration of services the individual is receiving from WM services, with some flexibility to “bridge” prescriptions between care episodes (e.g. medication over a weekend between a Friday discharge and Monday appointment with a prescriber).

Patient Experience

Patients receiving MOUD in WM settings may have a variety of experiences. These medications may be provided to alleviate withdrawal symptoms solely with the goal of discontinuing the medication prior to discharge, be initiated as part of a long-term treatment plan extending beyond the WM stay, or even be provided to minimize risk of overdose following discharge. Workgroup members and key informant interviews have identified that each pathway (including no MOUD) is a valid direction for clinical decision making but added that there does exist some prescribing habits that are programmatically driven, rather than patient driven (i.e. individuals who wish for a long-term treatment plan are only offered medication for withdrawal symptoms).

Available medications

All federally available medications are available in this setting, including methadone. Services provided in this setting are short duration, and medication is provided both to alleviate symptoms of withdrawal as well as to support long term recovery goals. If the latter, a connection to a prescriber who can provide them ongoing access is needed upon discharge.

Youth-Specific Considerations:

OYAA did not address this setting in its initial round of comprehensive planning, but there are very few youth specific Withdrawal Management options in Oregon.

Recommendations

Develop mechanism to reimburse for withdrawal management services and costs of MOUD (cost of medication only) to ensure costs of medications are reimbursed in addition to other necessary WM services.

Withdrawal management programs that can provide MOUD should provide patients with the choice of both short term MOUD access to address withdrawal symptoms and induction with the intent of a planned ongoing medication regimen that should be coordinated prior to discharge.

Appendix 3: Medication Access Pathways

A variety of factors influence consumer accessibility of medications used for the treatment of opioid disorder. While access restrictions for each medication may differ due factors related to patient safety, regulation, payment structures, or other factors, we can describe medication pathways generally within three categories:

- *Medications Requiring Specialty Administration*
- *Medications Requiring Specialty Facilities*
- *Medications Accessible via Outpatient Pharmacy*

These pathways represent the primary means of access that exist across nearly all parts of the continuum. The workgroup felt it important to highlight, clearly describe, and consider these pathways for all related policy discussions.

Medications Requiring Specialty Administration

As long-acting injectable medications cannot be self-administered by the patient for safety reasons, these medications require a medical professional to provide them to the patient during a face-to-face visit (via subcutaneous or intramuscular injection). While the professional designation of this provider has some level of flexibility, it's important to note that the need for direct administration places an operational challenge on access to these medications. Typically, these medications are stocked via two primary mechanisms such as "Buy and Bill" or via Specialty Pharmacy.

These mechanisms were of great interest to the study as many who were engaged throughout the process described the need for these two mechanisms as either largely conducive of their access goals or a hinderance to their access goals. As such, this poses an interesting challenge as removing or changing these processes may positively benefit one provider but negatively impact another. To provide context for the workgroup's related recommendations, the following explanations are provided.

"Buy and Bill"

When utilizing a "buy and bill" process, providers purchase these medications in advance of a patient's visit so that it can be administered to the patient during the visit. This process requires providers and provider organizations to pay in advance without assurance that reimbursement will occur, placing potential financial strain on these entities for the benefit of the patient. After administration, the request for reimbursement is submitted to the payor.

One provider who leverages this model has indicated that they have implemented this as it is the timelier means of providing access to their patients but also shared that for them and other providers, this mechanism may be

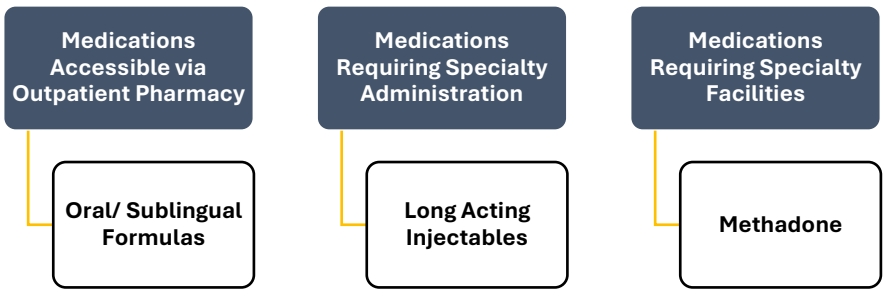

Figure 7 4- "Pathways" of MOUD access.

unsustainable. Impacts noted included retroactive denials[45], outdated fee schedules, or partial reimbursement.

Specialty Pharmacy

In this scenario, a specialty pharmacy purchases the medication and then delivers them to the medical provider who administers them. While this results in less financial risk to prescribers in comparison to "buy and bill", this may require the patient to return later or wait for delivery to occur.

Over the course of the study, it was identified that the impact on patient experience differs greatly depending on provider and proximity to the specialty pharmacy. Medical providers with an onsite partnered specialty pharmacy appeared to have the most streamlined access offering faster "turnaround" times from prescribing to administration compared to those that do not have an onsite partner. Additionally, one Oregon based provider shared success in contracting with a specialty pharmacy who was able to customize some aspects of their services to include night and weekend deliveries of medications.

Medications Requiring Specialty Facilities

Methadone when prescribed for the treatment of Opioid Use Disorder is required (outside of some exceptions) to be provided by an approved Opioid Treatment Program (OTP). Individuals travel to the clinic as indicated by their "take home status," meaning some individuals appear daily for their medication and over time can earn "take home" doses. They return when a "refill" is needed. These services are reimbursed following submission of a claim.

Medications Accessible via Outpatient Pharmacy

Medications such as oral or sublingual forms of Buprenorphine and other MOUD that were not mentioned in the previous sections can be acquired through a process familiar to many who have filled a prescription at their local pharmacy. Prescriptions are sent to the pharmacy to be filled and may be retrieved when filled or when refills are available. In this case reimbursement occurs as a normal process of the business operations.

While more akin to the "average" experience with prescription medications, workgroup members noted that pharmacies may have organizational policies that may be uniquely applied to MOUD, posing barriers to access. While this pathway resembles a norm for many, it is important to note that those experiencing OUD and other use disorders may experience challenges beyond what the "average" Oregonian does when receiving a prescription from their doctor such as limited transportation or other mobility concerns, which may cause delays in access, resulting in less desirable outcomes.

[45] Denials that occur when an individual received a serviced within the "grace period" of insurance coverage where eligibility concerns have occurred (e.g. individual is unable to pay insurance premiums and may lose coverage if payments do not resume) and ultimately loses coverage. This loss of coverage results in a "retroactive denial" where costs are required to be repaid. Workgroup members identified that this type of denial might be more prevalent with those who experience OUD as less stable employment is a common occurrence for those experiencing SUD.