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Opioid use disorder treatment and the role of New Jersey Medicaid policy changes: Perspectives of office-based buprenorphine providers

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Abstract

Background: In the US, seventy percent of drug-related deaths are attributed to opioids. In response to the ongoing opioid crisis, New Jersey's Medicaid program implemented the MATrx model to increase treatment access for Medicaid participants with opioid use disorder (OUD). The model's goals include increasing the number of office-based treatment providers, enhancing Medicaid reimbursement for certain treatment services, and elimination of prior authorizations for OUD medications.

Objectives: To explore office-based addiction treatment providers' experiences delivering care in the context of statewide policy changes and their perspectives on treatment access changes and remaining barriers.

Methods: This qualitative study used purposive sampling to recruit office-based New Jersey medications for opioid use disorder (MOUD) providers (1). Twenty-two providers (11 female, 11 male) discussed treatment experiences since the policy changes in 2019, including evaluations of the current state of OUD care in New Jersey and perceived outcomes of the MATrx model policy changes.

Results: Providers reported the MOUD climate in NJ improved as Medicaid implemented policies intended to reduce barriers to care and increase treatment access. Elimination of prior authorizations was noted as important, as it reduced provider burden and allowed greater focus on care delivery. However, barriers remained, including stigma, pharmacy supply issues, and difficulty obtaining injectable or non-generic medication formulations.

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The authors report no conflicts of interest.

Conclusion: NJ policies may have improved access to care for Medicaid beneficiaries by reducing barriers to care and supporting providers in prescribing MOUD. Yet, stigma and lack of psychosocial supports still need to be addressed to further improve access and care quality.

Keywords

substance use; MOUD; addiction treatment; state policy; primary care; opioid use disorder; Medicaid

Introduction

The 1990s overprescription of opioid medications in the United States contributed to a rise in opioid use disorder (OUD) and increasing rates of overdose and death, first with prescription opioids then transitioning to heroin and later fentanyl (2). Medications for OUD (MOUD) are the first line of treatment for OUD and are available as methadone in strictly-regulated opioid treatment programs (OTPs) that provide methadone maintenance treatment, and by prescription as buprenorphine and naltrexone. Oral buprenorphine formulations (e.g., Suboxone, Subutex) are most often used, but use of extended-release injectable (e.g., Sublocade) products is growing. Vivitrol, a monthly extended-release injection, is the most common formulation of naltrexone; oral naltrexone is rarely used for OUD due to low retention and effectiveness (3).

Access to MOUD remains a challenge, particularly for Medicaid beneficiaries and those seeking treatment in general health care settings, although rates of MOUD delivery in primary care settings are increasing (4). Although the long-standing requirement to obtain a DATA-2000 waiver to prescribe buprenorphine was removed in 2023, additional barriers to prescribing remain. Barriers commonly reported by prescribers include prior authorization (PA) requirements for MOUD; low reimbursement rates for MOUD services; a lack of knowledge among the PCP community; limited resources for providers to address patient psychosocial barriers; stigma toward people who use drugs and MOUD as a form of treatment; and concerns over diversion and increased monitoring by regulatory agencies (5-9).

In response to the opioid crisis, the state of New Jersey enacted a series of policies to increase treatment availability (10). As part of these reforms, New Jersey's Division of Medical Assistance and Health Services (DMAHS), the state Medicaid agency, developed the MATrx Model (The Model) to increase access and utilization of non-methadone MOUD services. The program was implemented in 2019 and targeted primary care providers (PCP) and other practitioners in office-based settings, who at the time did not prescribe MOUD in large numbers. The Model was designed to address barriers to prescribing MOUD in office-based settings by removing PA requirements for MOUD in NJ's Medicaid program; establishing the Office-Based Addiction Treatment (OBAT) program, which increased reimbursement rates for participating office-based providers delivering MAT services who offer patient navigation services; creating reimbursement codes for patient navigators in office-based settings; offering clinical guidance and support for participating providers, in the form of technical assistance from two DMAHS-funded Centers of Excellence

(COEs); and creating a network of "Premier Providers," or integrated care settings such as federally qualified health centers (FQHCs) and opioid treatment programs (OTPs) that provide MOUD treatment. A study on the outcomes of New Jersey's MATrx Model found buprenorphine utilization and prescribing increased following implementation (11), and other research has shown that similar initiatives can increase MOUD uptake. For example, eliminating PA requirements likely increases buprenorphine prescribing (12,13), and support for providers, provided by the COEs, has been shown to increase MOUD uptake and reduce stigma toward drug users (14-16). Increasing reimbursement and providing additional supports to providers to address patient psychosocial needs was also shown to expand treatment availability and utilization among Virginia Medicaid enrollees (17).

Given the ongoing opioid crisis and the many alternative policy responses, there is a need to understand provider perspectives on policies expanding access to evidence-based treatment and identify service gaps and barriers to care. To date, little work has examined provider perceptions of MOUD in a rapidly changing service and policy environment, and the potential successes and limitations of state-level initiatives designed to improve access. This study seeks to fill this gap by: exploring New Jersey office-based providers' perceptions of MOUD treatment and access in the context of policy developments and changes in the treatment landscape; identifying remaining barriers to MOUD treatment that have been insufficiently addressed; and recommending additional policy and structural changes to improve MOUD access.

Methods

Recruitment and eligibility

This study utilized purposive sampling to recruit prescribers, office managers, and patient navigators from NJ office-based practices that prescribe MOUD to Medicaid beneficiaries. A sampling frame was developed by using state 2019-2020 Medicaid claims data to identify prescribers in practices registered as Medicaid OBATs (identified using OBAT-specific billing codes and provider setting documented on claims) as well as those in non-OBAT office-based practices, to capture perspectives of providers in both practice types. Eligible providers could have prescribed before or after MATrx implementation, or during both time periods. We also included in the sampling frame buprenorphine prescribers listed in a directory of NJ's largest Medicaid managed care organization and a directory of NJ Sublocade prescribers (18,19). We purposively selected providers who varied according to patient volume (number of Medicaid patients prescribed buprenorphine), specialty, and geographic location (urban, suburban), determined using Medicaid claims and NPI registry data. Providers were added to the sampling frame to reflect diverse characteristics and ensure that those with specific characteristics were not overrepresented (e.g., including prescribers in small office-based practices and those in large, urban medical centers). Using information collected through web searches, we contacted eligible individuals by phone and email. Study eligibility criteria, verified in the initial contact, included current employment as an MOUD prescriber, patient navigator, or office manager in a New Jersey office-based practice that accepts Medicaid; and knowledge regarding MOUD practice and policies in the state. Study recruitment continued until thematic saturation was achieved

(20). From the sampling frame of 218 providers, a total of 22 interviews were conducted. Of the remaining individuals, 190 could not be reached and 6 declined to participate. Participants provided informed consent and all study procedures were approved by the Rutgers University Institutional Review Board (IRB).

Data collection

This study utilized a pragmatic qualitative inquiry framework (1). Questionnaire development was based on a review of MOUD service delivery and related policies in NJ. Items related to implementation were informed by the Consolidated Framework for Intervention Research (CFIR), which explores implementation outcomes from the perspective of individuals with influence (21). CFIR domains reflected in the questionnaire included Inner Setting and Outer Setting (e.g., questions pertaining to internal or external contextual factors impacting implementation) and Implementation Process (e.g., questions eliciting information on success of implementation) (21). The interview guide explored the following areas: impact of NJ Medicaid policies on MOUD practice; perceptions of MOUD access and service delivery; and remaining policy and practice barriers to uptake and utilization of MOUD (see interview guide in Supplementary Material) (22,23). Four trained graduate-level interviewers conducted interviews by phone or videoconference from August 2021 through February 2022. Interviews averaged one hour in length. All interviews were audio-recorded and transcribed verbatim. Participants provided informed consent and shared demographic and other characteristics via an online form. Study procedures were approved by the Rutgers Institutional Review Board.

Analysis

Qualitative data were analyzed by three graduate-level researchers with training and experience in qualitative methods. An initial codebook was developed deductively based on concepts reflected in the study questionnaire. Additional inductive codes that emerged from the data were discussed by the research team, added to the codebook, and retroactively applied to previously coded transcripts. The first four interviews were coded by all analysts and reviewed for consistency in coding styles and applications. Thereafter, two analysts separately coded each transcript and met to discuss and resolve discrepancies. Analysts then conducted a cross-case analysis, in which similarities and differences across cases are examined to deepen understanding and explanation, and to enhance transferability to other contexts (24). Pattern coding was used to group codes into a smaller number of themes. Analytic memos were used throughout the process to document reflections and preliminary interpretations, and descriptors were attached to transcripts to facilitate analysis by provider characteristics (e.g., type, setting) (24). Dedoose software was used to manage and code data.

Results

Participant characteristics are provided in Table 1. The sample was 50% female, 55% non-Hispanic White, 14% non-Hispanic Black, and 9% Hispanic. 41% were physicians (MD/DO) and 41% were advanced practitioners (nurse practitioners, physician assistants). Among prescribers, the most common practice specialty was primary care (47%). Results

of qualitative analyses are presented by theme. Theme summaries and additional illustrative quotes are shown in Table 2. Participant descriptors (sex: F = female, M = male; provider type: prescriber, administrator, navigator) are attached to quotations.

NJ MOUD climate improved

Providers reflected on the MOUD climate in NJ in recent years. As the policy landscape changed, providers experienced fewer barriers and saw improved attitudes toward addiction care among policymakers, insurers, other providers, and the community.

> I'd say that in terms of writing a prescription for Suboxone, doing an induction in my office and writing prescription and getting it filled at a retail pharmacy, it's really easy. It's day and night from when I was started.
>
> (929, Prescriber, M)

Interviewees described how New Jersey's improvements in MOUD acceptability shifted service delivery toward evidence-based practices, including dosage guidelines and decisions around continuing or tapering medication. Whereas low doses and shorter treatment duration were favored in the past, higher doses and longer treatment duration based on patients' needs and wishes have become more commonplace.

> We typically start them at 16 milligrams as a routine starting point… But I always tell the patients, "You are going to tell me when you're ready to come down." This is a very fragile moment in their lives and it has to be done with great delicacy.
>
> (967, Prescriber/Administrator, M)

Providers highlighted a key shift to improving MOUD care in New Jersey was elimination of PA requirements for generic formulations of buprenorphine and naltrexone in 2019, allowing faster access to treatment and reducing providers' burdens:

> In the beginning, forget it, [prescribing MOUD] was a headache. You try to get the prior authorization and they're going to cover the strips and not the tablets, and then the tablets and not the strips, and then the generic and not the generic. But then when the full restriction was removed, then it was just great.
>
> (361, Prescriber, M)

A few respondents added that removal of PA allowed for greater focus on delivering high quality care:

> When we had prior auths for almost everything, we had almost like a full-time nurse that was just doing that all the time. So now that nurse is able to spend time with patients and be a nurse instead of managing PAs all day.
>
> (828, Prescriber, F))

In addition to the PA changes, interview participants highlighted how technical assistance from state-funded organizations were pivotal in attracting new MOUD providers and supporting practices:

> The model of having the Center of Excellence has definitely benefited us. I think we have a pretty good relationship with [COE staff member] and a lot of our providers have gone through the [training] program.
>
> (828, Prescriber, F)

Respondents who joined Medicaid's OBAT program reported the payment structure, enhanced reimbursement for prescribers and reimbursement for navigation, helped them establish or expand MOUD programs:

> When [colleague] said there is this OBAT program, there is reimbursement, it gave us something to latch onto. Now we could make a program, an OBAT program and having the billing aspect was definitely the bait to it.
>
> (684, Navigator, M)

A few respondents further spoke to the added value of offering patient navigation services in the OBAT program, which helped address patients' psychosocial needs:

> When they are able to get a certain resource… they always come back and thank me, and we still continue to add different resources.
>
> (167, Navigator, F)

MOUD barriers persisted despite policy efforts

PA changes improved medication access, but approval barriers remained— Despite the overall improvement in MOUD access, prescribers continued to experience barriers with specific formulations or brands: *"I mean the Vivitrol is more complicated because it's much more expensive*." (174, Prescriber, F). One provider, corroborated by another who highlighted barriers with newer formulations, gave Sublocade as an example: "*We are able to do Sublocade, but it's become so cumbersome that we've had no more than two patients in a year."* (328, Prescriber, M).

Stigma associated with SUDs and MOUD persisted—Despite the increased prevalence of programs and policies supporting MOUD administration, prescribers described OUD/SUD stigma in primary care settings as barriers for patients and providers.

> Although stigma is decreased, there is still a bit of stigma attached to the diagnosis of an addictive disorder, and that limits the uptake for treatment.
>
> (767, Prescriber, M)

Some providers suggested MOUD access could improve if more medical professionals were to receive education related to addiction, an area the Centers of Excellence were meant to address.

> I think a lot of the reason is there's just not enough education surrounding addiction and as bad as it is in medicine, there just is still a stigma.
>
> (125, Navigator, F)

Attitudes towards MOUD's role in recovery affected MOUD prescribing practices—Contextual factors that may have inhibited an even more positive effect of

state-wide policies were provider willingness to give MOUD for long-term maintenance, or whether they prescribed it as a short-term solution to support an ultimate goal of total abstinence. Defined as intervention stigma (i.e., stigma associated with engagement in a medical intervention) (25), MOUD decisions may vary according to providers' concerns about diversion or perception of MOUD as "just another drug" (9). Even with the enhanced professional development available through the Model, a few providers held conservative beliefs regarding MOUD and explicitly stated that their goal was to taper patients off medications:

> I think we do a pretty good job of weaning them down and we kind of tell them from the very beginning, "You're not going to stay on this dose, you're going to wean down and I'm going to wean you and this is how we're going to do it."
>
> (270, Prescriber, M)

Other providers recognized that returning to substance use was common among people with SUDs and were willing to prescribe ongoing:

> We wouldn't just terminate them from the program… We just do our best to try to help, but we don't terminate, we don't refuse services.
>
> (463, Navigator, F)

Beyond provider-level differences in medication administration there were broader questions as to the role of MOUD in SUD treatment:

> There's so much of a move towards harm reduction only. Meaning, let's give them Suboxone, nothing else, but at least we prevent overdoses and we prevent the vagaries of serious opioid addiction. But we don't treat any other aspects of their addiction… So we're reducing harm, but we've given up the emphasis of treating an addiction, which I do not think can be done without psychosocial interventions.
>
> (328, Prescriber, M))

Recommendations to improve MOUD treatment

Increase support for addressing psychosocial challenges—Interview participants highlighted the ongoing psychosocial challenges associated with drug use. Navigators help bridge patients to community resources, yet siloed systems of care exacerbate barriers:

> One of the things that I see is people are not as committed to taking their medications as they were, because they have other concerns that they are trying to address. Like their housing, like their food, like they have relatives that passed away from COVID.
>
> (482, Prescriber, F)

Although NJ Medicaid covers medical transportation provided by a contractor, a few interviewees reported transportation services as unreliable and a critical area of improvement. One respondent said medical transportation should be *"deemed a medical necessity" (463, Navigator, F)* in the context of the opioid crisis. Providers indicated a further need for safe and supportive housing for people on MOUD, who often have limited options:

> I think the biggest thing that I see the problem is housing… If they're interested in sober communities or on Oxford houses or any type of supportive housing, those houses often don't allow people on buprenorphine…So even if they say they're Suboxone friendly, they often won't let people move in with Suboxone because there's so much stigma.
>
> (828, Prescriber, F)

Psychiatric services were also said by some to be lacking for Medicaid enrollees:

> There needs to be readily available, more mental health. There seems to be a lack of mental health. And addiction and mental health are hand in hand.
>
> (847, Prescriber, F)

Respondents also reported limited options when it came to referring patients to counseling, community-based wrap-around services, or other non-pharmacological supports:

> I think the outpatient IOP social work type of thing would be really important. To follow these folks. I think it's not always accessible or known where that support system is.
>
> (270, Prescriber, M)

Medication approval and pharmacy-level improvements—While providers highlighted that elimination of PA requirements for generic MOUD improved medication access, the fact that some formulations were still subject to PA remained a challenge. One provider recommended that Medicaid *"expand that mandate that all medications for MOUD not require prior authorization" (767, Prescriber, M)* beyond generic formulations, while others suggested simplifying the process for obtaining extended-release injectable medications.

Interview participants highlighted pharmacies as instrumental partners in MOUD access, but shared that some pharmacies did not routinely stock adequate buprenorphine supplies or held stigmatizing beliefs:

> Some pharmacies still give [patients] a hard time because it's an opiate… Some pharmacies don't carry a lot of it [buprenorphine] because of the cost, whether it's, "We only have the strips," or, "We have the tablets, we got two milligrams, not the eights," and that sort of thing.
>
> (361, Prescriber, M)

Expanding MOUD into other settings—Many providers suggested expanding buprenorphine availability in non-traditional settings. A few providers highlighted how emergency department (ED) based buprenorphine prescribing could be helpful given the high prevalence of OUD among ED visits:

> Another approach that we've seen in Pennsylvania is their Medicaid office provided incentives to hospitals to implement these different pathways to ED treatment, including buprenorphine induction and a couple other options, and a large incentive to hospitals to make that work.

(929, Prescriber. M)

Interviewees also spoke to improving access for key populations, including pregnant people:

> I don't know of any OB-GYN that prescribes Suboxone… Most OBs don't understand it, but it's a huge problem… These OB providers are just afraid to get somebody … to even take a patient with Suboxone.

(366, Prescriber, M)

Another prescriber suggested improving transitions of care for people recently released from correctional facilities, who often fail to continue treatment initiated during incarceration due to structural barriers:

> A third of all [people with SUDs] in New Jersey are rolling out of prisons and jails. We're just not using that platform efficiently to get any of them into the community. That would be a great place to focus.

(967, Prescriber/Administrator, M)

Discussion

Interviews with NJ office-based MOUD providers highlight policy and payer strategies that may reduce barriers to buprenorphine prescribing, as well as opportunities for addressing remaining barriers. From providers' perspectives, statewide policy changes, including those implemented by Medicaid under the MATrx model, resulted in greater MOUD access for NJ Medicaid enrollees and an overall improved MOUD climate. Providers found that elimination of PAs decreased administrative burden, enabled providers to spend more time with patients, and resulted in higher quality care. Providers stated that MAT Centers of Excellence were a useful resource, and that OBAT programs, via new reimbursement codes for use in office-based settings, increased access to MOUD and psychosocial support in those settings. Although the study design precludes making causal inferences regarding policy effects, our interviews support the effectiveness of MOUD access policies like those implemented by NJ Medicaid.

PA requirements have historically been noted as a major barrier to OUD treatment (26-28), and although nearly all state Medicaid programs now cover MOUD (29), most still require PAs (30). Participants in our study unanimously agreed that eliminating PA requirements was tremendously beneficial, a finding that is backed by studies showing that removal of PAs increases the availability of buprenorphine among Medicare beneficiaries (13) and is associated with higher likelihood that addiction treatment facilities offer MOUD to Medicaid patients (12). Despite these improvements, providers still experienced barriers to medication approvals when changing dosages and formulations, especially for name brand and extended-release injectable formulations (i.e., Vivitrol, Sublocade). These challenges could be addressed by simplifying processes for obtaining medications or strengthening referral networks so patients can be referred from office-based practices to organizations with established protocols and resources for obtaining these medications. Study participants reported pharmacy-level barriers too, including lack of supply, consistent with a recent audit study of 11 states that found New Jersey pharmacies had the second-lowest availability of

buprenorphine (31). These barriers, which may be due to pharmacist stigma and supply caps imposed by pharmaceutical distributors in response to DEA regulations (31,32), could be mitigated through pharmacist education on OUD, greater transparency in algorithms used by pharmaceutical distributors in determining when caps are reached, and excluding buprenorphine from monitoring approaches intended to reduce opioid diversion (33,34).

A consistent concern among providers was availability of psychosocial supports for patients, understood both as psychotherapeutic treatment and resources to meet basic needs. Respondents consistently highlighted psychological services as a crucial element of addiction treatment, despite mixed empirical evidence on effectiveness of psychotherapies for OUD and polysubstance disorders (35,36), or their potential to improve outcomes beyond MOUD alone (36-38). Material needs were also regarded as critical necessities that could derail recovery if not addressed. These barriers are consistently highlighted in other studies as well (39), and often named by treatment recipients as integral to their recovery (40,41). Housing was identified as a specific challenge for MOUD. Although recovery housing is available in many communities, some programs prohibit residents from using MOUD, while others have administrators or residents who hold negative attitudes towards MOUD, limiting options for individuals on MOUD (42,43). Transportation is a key factor in healthcare access and retention (44). The burden of lack of transportation may be exacerbated by cost and geographic location for individuals with OUD (45), and care management can be challenging even in places with limited public transportation due to schedules and distance (46).

Consistent with prior research (27,28), study participants cited limited social or community supports as a barrier to MOUD. Medicaid's OBAT program, a component of the MATrx model, sought to mitigate these concerns by establishing reimbursement codes for patient navigation in office-based settings (47). Alongside this, NJ used State Opioid Response grant funding to implement multiple statewide recovery support programs for people with SUDs, including peer support services and community recovery centers located throughout the state (48). Despite these supports being in place, no study participants identified them as resources, which may suggest a lack of coordination among treatment and recovery support services. Fragmented care is common for patients receiving SUD treatment, and care quality and effectiveness could be improved through better integration (49).

Evidence-based care for OUD emphasizes the importance of MOUD treatment (50), connecting patients to comprehensive services that specifically address their needs (41), and engaging in collaborative shared decision making with their patients (51). Some providers held conservative treatment views, preferring temporary MOUD use with an intention of tapering patients off medications to achieve sobriety. Such views have been identified as a barrier to MOUD care (18, 56) and are in tension with the emerging literature suggesting MOUD treatment alone, regardless of continued illicit opioid use or psychosocial intervention, is effective at maintaining individuals in treatment as well as preventing overdose (52-54). Common among such MOUD perspectives was mandating participation in comprehensive services, like counseling, but these requirements often lead to decreased retention due to financial strain and other burdens (55). Among Medicaid recipients in North Carolina, high retention in buprenorphine treatment was associated with

higher starting doses, individualized treatment plans, and greater leniency (56). These results indicate the influence and necessity of evidence based MOUD practice, centering individual needs and utilizing a flexible approach to care.

Although New Jersey providers reported improvement in addiction care, their heterogenous views of addiction treatment may reflect the ongoing problem of shared stigmas around OUD. Stigma is a well-studied disruptor to the substance use care continuum (9,57). As such, individuals with OUD may encounter singular or compounding forms of stigma (e.g., structural, public, self or MOUD related stigma)(58).

Patients consistently identify experiencing stigma in accessing SUD treatment (59), and stigma is consistently linked to worse self-described health (60). Providers perceived stigma as a barrier to increased system-level physician participation in addiction services (61), and a reason why providers won't prescribe MOUD and patients won't access it (27). Providers in our study suggested that further capacity building and education across the healthcare continuum may reduce stigma and ultimately improve access to MOUD (26). Moreover, providers should explore the effects of structural racism as a contributing factor to stigma (55,56). A study capturing the experiences of Virginia office-based addiction programs found political engagement and informative workshops may decrease community stigma (62). The Respectful, Equitable Access to Compassionate Healthcare (REACH) practice model, implemented in New York, offered a patient-centered, harm reduction approach to MOUD care (63). Implementation of similar programs may challenge long held stigmatizing perceptions of individuals with OUD, while concurrently building patient/provider relationships and addressing workforce concerns. These goals are reached through the harm reduction's principal feature of centering patients' needs, including treatment readiness and psychosocial care (63).

Policy recommendations suggested by providers included expanding MOUD programs to address the needs of people who are incarcerated, pregnant people, or patients being treated in EDs. Although MOUD is being expanded in correctional facilities, and is available throughout NJ state prisons, nationally most facilities do not offer MOUD at all, offer only 1-2 medications, or restrict who can access medications (e.g., pregnant people, individuals already on MOUD prior to incarceration) (64-66). Among people who are pregnant, MOUD has been shown to reduce adverse pregnancy outcomes as well as maintain people on MOUD afterwards (67). Buprenorphine initiation in the ED is linked with longer treatment retention after discharge (68), and highlighted by patients as another opportunity to be offered MOUD as one of many treatment options (69).

Findings of this study should be interpreted with several limitations in mind. First, the sample was limited to New Jersey office-based providers servicing Medicaid beneficiaries, and results may not reflect the experiences of other provider types, those treating patients covered by other payers, or providers practicing in other states. Although saturation was achieved after 22 interviews, the sample size did not allow for subgroup analyses by provider characteristics. All information contained in this study was self-reported and may be impacted by social desirability bias, as respondents may have shared information that reflects standards of care rather than their own practices. This study only captured provider

perspectives on MOUD treatment in the context of state policy changes; additional research is needed to understand patient perspectives.

Conclusion

Providers highlighted improvements in the MOUD climate in NJ, attributed by them in part to Medicaid policies that aimed to reduce barriers and increase access to care. Elimination of PAs for MOUD was consistently described as a critical change that simplified MOUD prescribing and allowed providers to focus more on delivering high-quality care. Despite these improvements, respondents identified multiple ongoing barriers, including difficulty obtaining injectable and non-generic MOUD formulations, pharmacy-level supply issues, and stigma. To further address policy and practice barriers, respondents recommended increasing support for addressing psychosocial challenges, expanding MOUD access in non-traditional settings, and ensuring that pharmacies stock adequate MOUD supply.

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References

1. Patton M Qualitative Research & Evaluation Methods [Internet]. SAGE Publications Inc. 2020 [cited 2020 Aug 11]. Available from: https://us.sagepub.com/en-us/nam/qualitative-research-evaluation-methods/book232962
2. US Centers for Disease Control & Prevention. Opioid Data Analysis and Resources [Internet]. 2021 [cited 2022 May 12]. Available from: https://www.cdc.gov/opioids/data/analysis-resources.html
3. Sofuoglu M, DeVito EE, Carroll KM. Pharmacological and Behavioral Treatment of Opioid Use Disorder. Psychiatric Research and Clinical Practice. 2019 Apr;1(1):4–15.
4. Olfson M, Zhang V, Schoenbaum M, King M. Buprenorphine Treatment By Primary Care Providers, Psychiatrists, Addiction Specialists, And Others: Trends in buprenorphine treatment by prescriber specialty - primary care providers, psychiatrists, and addiction medicine specialists. Health Affairs. 2020 Jun 1;39(6):984–92. [PubMed: 32479224]
5. Chang ET, Oberman RS, Cohen AN, Taylor SL, Gumm E, Mardian AS, et al. Increasing Access to Medications for Opioid Use Disorder and Complementary and Integrative Health Services in Primary Care. J GEN INTERN MED. 2020 Dec 1;35(3):918–26.
6. Oros SM, Christon LM, Barth KS, Berini CR, Padgett BL, Diaz VA. Facilitators and barriers to utilization of medications for opioid use disorder in primary care in South Carolina. Int J Psychiatry Med. 2021 Jan 1;56(1):14–39. [PubMed: 32726568]
7. Russell HA, Sanders M, Meyer JKV, Loomis E, Mullaney T, Fiscella K. Increasing Access to Medications for Opioid Use Disorder in Primary Care: Removing the Training Requirement May Not Be Enough. J Am Board Fam Med. 2021 Nov 1;34(6):1212–5. [PubMed: 34772776]
8. Andrilla CHA, Moore TE, Patterson DG. Overcoming Barriers to Prescribing Buprenorphine for the Treatment of Opioid Use Disorder: Recommendations from Rural Physicians. The Journal of Rural Health. 2019;35(1):113–21. [PubMed: 30339720]
9. Dickson-Gomez J, Spector A, Weeks M, Galletly C, McDonald M, Green Montaque HD. "You're Not Supposed to be on it Forever": Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids. Subst Abuse. 2022 Jan;16:117822182211038.
10. Vitale JPL 2017 c.28. 2017

11. Treitler P, Nowels M, Samples H, Crystal S. Buprenorphine Utilization and Prescribing Among New Jersey Medicaid Beneficiaries After Adoption of Initiatives Designed to Improve Treatment Access. JAMA Network Open. 2023 May 5;6(5):e2312030. [PubMed: 37145594]
12. Andrews CM, Abraham AJ, Grogan CM, Westlake MA, Pollack HA, Friedmann PD. Impact of Medicaid Restrictions on Availability of Buprenorphine in Addiction Treatment Programs. Am J Public Health. 2019 Mar;109(3):434–6. [PubMed: 30676789]
13. Mark TL, Parish WJ, Zarkin GA. Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. JAMA Network Open. 2020 Apr 20;3(4):e203132. [PubMed: 32310285]
14. Puckett HM, Bossaller JS, Sheets LR. The impact of project ECHO on physician preparedness to treat opioid use disorder: a systematic review. Addiction Science & Clinical Practice. 2021 Jan 22;16(1):6. [PubMed: 33482906]
15. Kaplan-Dobbs M, Kattan JA, Tuazon E, Jimenez C, Saleh S, Kunins HV. Increasing Access to Buprenorphine in Safety-Net Primary Care Clinics: The New York City Buprenorphine Nurse Care Manager Initiative. Am J Public Health. 2021 Feb;111(2):215–8. [PubMed: 33351661]
16. Madden EF, Prevedel S, Light T, Sulzer SH. Intervention Stigma toward Medications for Opioid Use Disorder: A Systematic Review. Substance Use & Misuse. 2021 Dec 6;56(14):2181–201. [PubMed: 34538213]
17. Cunningham P, Pierre-Louis S, Britton E, Farzana Urmi A, Barnes A. Addiction and Recovery Treatment Services: Evaluation Report for State Fiscal Years 2019 and 2020 [Internet]. Virginia Commonwealth University, School of Medicine; 2022. Available from: https://hbp.vcu.edu/policy-briefs/arts-policy-briefs/
18. Horizon NJ Health. Find Horizon NJ Health Doctors [Internet]. Horizon NJ Health. 2022 [cited 2022 May 19]. Available from: https://www.horizonnjhealth.com/findadoctor
19. SUBLOCADE. Find a Buprenorphine Treatment Provider [Internet]. [cited 2022 May 19]. Available from: https://www.sublocade.com/buprenorphine-treatment-provider
20. Hennink M, Kaiser BN. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Social Science & Medicine. 2022;292:114523. [PubMed: 34785096]
21. Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. Implementation Science. 2022 Oct 29;17(1):75. [PubMed: 36309746]
22. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009 Aug 7;4:50. [PubMed: 19664226]
23. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. 1999 Sep;89(9):1322–7. [PubMed: 10474547]
24. Miles MB, Huberman AM, Saldaña J. Qualitative data analysis: A methods sourcebook. 3rd. 2014;
25. Madden EF. Intervention stigma: How medication-assisted treatment marginalizes patients and providers. Social Science & Medicine. 2019 Jul 1;232:324–31. [PubMed: 31125801]
26. Haffajee RL, Andraka-Christou B, Attermann J, Cupito A, Buche J, Beck AJ. A mixed-method comparison of physician-reported beliefs about and barriers to treatment with medications for opioid use disorder. Substance Abuse Treatment, Prevention, and Policy. 2020 Sep 14;15(1):69. [PubMed: 32928272]
27. Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. J GEN INTERN MED. 2020 Dec 1;35(3):954–63. [PubMed: 33145687]
28. Lanham HJ, Papac J, Olmos DI, Heydemann EL, Simonetti N, Schmidt S, et al. Survey of Barriers and Facilitators to Prescribing Buprenorphine and Clinician Perceptions on the Drug Addiction Treatment Act of 2000 Waiver. JAMA Network Open. 2022 May 12;5(5):e2212419. [PubMed: 35552721]
29. Burns RM, Pacula RL, Bauhoff S, Gordon AJ, Hendrikson H, Leslie DL, et al. Policies related to opioid agonist therapy for opioid use disorders: The evolution of state policies from 2004 to 2013. Substance Abuse. 2016 Jan 2;37(1):63–9. [PubMed: 26566761]

30. Weber E, Gupta A. State Medicaid Programs Should Follow the “Medicare Model” Remove Prior Authorization Requirements for Buprenorphine and Other Medications to Treat Opioid Use Disorders [Internet]. Legal Action Center; 2019 Jul [cited 2022 May 27]. Available from: https://www.lac.org/resource/state-medicaid-programs-should-follow-the-medicare-model-remove-prior-authorization-requirements-for-buprenorphine-and-other-medications-to-treat-opioid-use-disorders

31. Hill LG, Loera LJ, Evoy KE, Renfro ML, Torrez SB, Zagorski CM, et al. Availability of buprenorphine/naloxone films and naloxone nasal spray in community pharmacies in Texas, USA. Addiction. 2021;116(6):1505–11. [PubMed: 33140519]

32. Ostrach B, Carpenter D, Cote LP. DEA Disconnect Leads to Buprenorphine Bottlenecks. Journal of addiction medicine. 2021 Jul;15(4):272–5. [PubMed: 33181577]

33. Kazerouni NJ, Irwin AN, Levander XA, Geddes J, Johnston K, Gostanian CJ, et al. Pharmacy-related Buprenorphine Access Barriers: An Audit of Pharmacies in Counties with a High Opioid Overdose Burden. Drug and Alcohol Dependence. 2021 Apr;108729. [PubMed: 33932744]

34. Cooper HL, Cloud DH, Freeman PR, Fadanelli M, Green T, Van Meter C, et al. Buprenorphine dispensing in an epicenter of the U.S. opioid epidemic: A case study of the rural risk environment in Appalachian Kentucky. International Journal of Drug Policy. 2020 Nov;85:102701. [PubMed: 32223985]

35. Dutra L, Stathopoulou G, Basden SL, Leyro TM, Powers MB, Otto MW. A Meta-Analytic Review of Psychosocial Interventions for Substance Use Disorders. AJP. 2008 Feb;165(2):179–87.

36. Dugosh K, Abraham A, Seymour B, McLoyd K, Chalk M, Festinger D. A Systematic Review on the Use of Psychosocial Interventions in Conjunction with Medications for the Treatment of Opioid Addiction. Journal of Addiction Medicine. 2016;10(2):93–103. [PubMed: 26808307]

37. Rice D, Corace K, Wolfe D, Esmaeilisaraji L, Michaud A, Grima A, et al. Evaluating comparative effectiveness of psychosocial interventions adjunctive to opioid agonist therapy for opioid use disorder: A systematic review with network meta-analyses. PLOS ONE. 2020 Dec 28;15(12):e0244401. [PubMed: 33370393]

38. Schwartz RP. When Added to Opioid Agonist Treatment, Psychosocial Interventions do not Further Reduce the Use of Illicit Opioids: A Comment on Dugosh et al. Journal of addiction medicine. 2016;10(4):283–5. [PubMed: 27471920]

39. Hooker SA, Sherman MD, Lonergan-Cullum M, Sattler A, Liese BS, Justesen K, et al. Mental Health and Psychosocial Needs of Patients Being Treated for Opioid Use Disorder in a Primary Care Residency Clinic. J Prim Care Community Health. 2020 Jan 1;11:2150132720932017. [PubMed: 32507067]

40. Andraka-Christou B, Randall-Kosich O, Totaram R. Designing an “Ideal” Substance Use Disorder Treatment Center: Perspectives of People Who Have Utilized Medications for Opioid Use Disorder. Qual Health Res. 2021 Feb 1;31(3):512–22. [PubMed: 33213261]

41. Friedmann PD, Hendrickson JC, Gerstein DR, Zhang Z. The effect of matching comprehensive services to patients’ needs on drug use improvement in addiction treatment. Addiction. 2004 Aug;99(8):962–72. [PubMed: 15265093]

42. Majer JM, Beasley C, Stecker E, Bobak TJ, Norris J, Nguyen HM, et al. Oxford House Residents’ Attitudes Toward Medication Assisted Treatment Use in Fellow Residents. Community Ment Health J. 2018 Jul 1;54(5):571–7. [PubMed: 29302767]

43. Majer JM, Jason LA, Norris J, Hickey P, Jeong H, Bobak TJ. Medications for Opioid Use Disorder Utilization Among Oxford House Residents. Community Ment Health J. 2020 Jul 1;56(5):925–32. [PubMed: 31993842]

44. Stewart RE, Shen L, Kwon N, Vigderman J, Kramer S, Mandell DS, et al. Transporting to treatment: Evaluating the effectiveness of a mobile engagement unit. Journal of Substance Abuse Treatment. 2021 Oct;129:108377. [PubMed: 34080548]

45. Stone R, Campbell JK, Kinney D, Rothman EF. “He Would Take My Shoes and All the Baby’s Warm Winter Gear so We Couldn’t Leave”: Barriers to Safety and Recovery Experienced by a Sample of Vermont Women With Partner Violence and Opioid Use Disorder Experiences. The Journal of Rural Health. 2021 Jan;37(1):35–44. [PubMed: 32929780]

46. Chatterjee A, Yu EJ, Tishberg L. Exploring opioid use disorder, its impact, and treatment among individuals experiencing homelessness as part of a family. Drug and Alcohol Dependence. 2018 Jul;188:161–8. [PubMed: 29778009]
47. Tunney S NJ MATrx Model. NJ Department of Human Services, Division of Medical Assistance and Health Services; 2019 Jan.
48. National Association of State Alcohol and Drug Abuse Directors. New Jersey Use of STR/SOR Grant Funds to Address the Opioid Crisis. 2019.
49. Hooker SA, Sherman MD, Lonergan-Cullum M, Nissly T, Levy R. What is success in treatment for opioid use disorder? Perspectives of physicians and patients in primary care settings. Journal of Substance Abuse Treatment. 2022 May;108804. [PubMed: 35643586]
50. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014 Feb 6; (2):CD002207. [PubMed: 24500948]
51. Friedrichs A, Spies M, Härter M, Buchholz A. Patient Preferences and Shared Decision Making in the Treatment of Substance Use Disorders: A Systematic Review of the Literature. PLoS One. 2016;11(1):e0145817. [PubMed: 26731679]
52. Sofuoglu M, DeVito EE, Carroll KM. Pharmacological and Behavioral Treatment of Opioid Use Disorder. Psychiatric Research and Clinical Practice. 2019;1(1):4–15.
53. Connery HS. Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions. Harvard Review of Psychiatry. 2015 Apr;23(2):63–75. [PubMed: 25747920]
54. Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017 Apr 26;357:j1550. [PubMed: 28446428]
55. Samples H, Williams AR, Olfson M, Crystal S. Risk factors for discontinuation of buprenorphine treatment for opioid use disorders in a multi-state sample of Medicaid enrollees. Journal of Substance Abuse Treatment. 2018 Dec;95:9–17. [PubMed: 30352671]
56. Gertner AK, Robertson AG, Powell BJ, Jones H, Silberman P, Domino ME. Primary Care Providers And Specialists Deliver Comparable Buprenorphine Treatment Quality: Study examines how buprenorphine treatment quality differed between primary care providers and specialists In North Carolina Medicaid. Health Affairs. 2020 Aug 1;39(8):1395–404. [PubMed: 32744950]
57. Burgess A, Bauer E, Gallagher S, Karstens B, Lavoie L, Ahrens K, et al. Experiences of stigma among individuals in recovery from opioid use disorder in a rural setting: A qualitative analysis. Journal of Substance Abuse Treatment. 2021 Nov;130:108488. [PubMed: 34118715]
58. Garett R, Young SD. The Role of Misinformation and Stigma in Opioid Use Disorder Treatment Uptake. Substance Use & Misuse. 2022 Jul 3;57(8):1332–6. [PubMed: 35611913]
59. Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug and Alcohol Dependence. 2007 May 11;88(2):188–96. [PubMed: 17118578]
60. Kulesza M, Larimer ME, Rao D. Substance Use Related Stigma: What we Know and the Way Forward. J Addict Behav Ther Rehabil [Internet]. 2013 May 27 [cited 2020 Oct 3];2(2). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4228689/
61. Cioe K, Biondi BE, Easly R, Simard A, Zheng X, Springer SA. A systematic review of patients' and providers' perspectives of medications for treatment of opioid use disorder. Journal of Substance Abuse Treatment. 2020 Dec;119:108146. [PubMed: 33138929]
62. Brooks EM, Tong S. Implementing Office-Based Opioid Treatment Models in Primary Care. J Am Board Fam Med. 2020 Jul;33(4):512–20. [PubMed: 32675262]
63. Kapadia SN, Griffin JL, Waldman J, Ziebarth NR, Schackman BR, Behrends CN. A Harm Reduction Approach to Treating Opioid Use Disorder in an Independent Primary Care Practice: a Qualitative Study. J GEN INTERN MED. 2021 Jul;36(7):1898–905. [PubMed: 33469774]
64. National Academy for State Health Policy. Medications for Opioid Use Disorder (MOUD) Provided in State Prisons [Internet]. 2021 [cited 2021 Sep 24]. Available from: https://www.nashp.org/nashp-chart-medications-for-opioid-use-disorder-provided-in-state-prisons-march-2021/

65. Sufrin C, Sutherland L, Beal L, Terplan M, Latkin C, Clarke JG. Opioid use disorder incidence and treatment among incarcerated pregnant women in the United States: results from a national surveillance study. Addiction. 2020 Nov;115(11):2057–65. [PubMed: 32141128]

66. Curtis M, Larney S, Higgs P, Cossar RD, Winter RJ, Stewart AC, et al. Initiation of Medications for Opioid Use Disorder Shortly Before Release From Prison to Promote Treatment Retention: Strong Evidence but Compromised Policy. Journal of Addiction Medicine [Internet]. 2021;15(6). Available from: https://journals.lww.com/journaladdictionmedicine/Fulltext/2021/12000/Initiation_of_Medications_for_Opioid_Use_Disorder.19.aspx

67. Krans EE, Kim JY, Chen Q, Rothenberger SD, James AE III, Kelley D, et al. Outcomes associated with the use of medications for opioid use disorder during pregnancy. Addiction. 2021;116(12):3504–14. [PubMed: 34033170]

68. Reuter QR, Santos AD, McKinnon J, Gothard D, Jouriles N, Seaberg D. Long-term treatment retention of an emergency department initiated medication for opioid use disorder program. The American Journal of Emergency Medicine. 2022 May 1;55:98–102. [PubMed: 35304308]

69. Schoenfeld EM, Westafer LM, Beck SA, Potee BG, Vysetty S, Simon C, et al. “Just give them a choice”: Patients’ perspectives on starting medications for opioid use disorder in the ED. Academic Emergency Medicine [Internet]. [cited 2022 May 25];n/a(n/a). Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/acem.14507

Table 1:

Participant characteristics (N = 22)

	n	%
Sex		
Male	11	50%
Female	11	50%
Education		
MD/DO	9	41%
Advance practitioner (NP, PA)	9	41%
Other	4	18%
Race		
Non-Hispanic White	12	55%
Non-Hispanic Black/African American	3	14%
Hispanic	2	9%
Other	3	14%
Missing	2	9%
Role at Practice		
Prescriber	16	73%
Navigator and office manager	3	14%
Navigator only	2	9%
Office manager only	1	5%
Prescriber specialty (N = 16)		
Primary care	9	56%
Psychiatry	6	38%
Other	1	6%
Primary Practice Setting		
Solo private practice	7	32%
Group private practice - single specialty	8	36%
Group private practice - multiple specialty	2	9%
Certified Community Behavioral Health Clinic	2	9%
Hospital-based or affiliated mental health clinic	1	5%
Non-OTP specialty substance use treatment facility	2	9%

Note: Percentages may exceed 100% due to rounding. MD = Medical Doctor; DO = Doctor of Osteopathic Medicine; NP = Nurse Practitioner; PA = Physician Assistant; OTP = Opioid Treatment Program (i.e., methadone clinic).

Table 2:

Themes, subthemes, and supporting quotes

Theme	Subthemes	Theme summary	Supporting quotes
NJ MOUD climate improved	No subthemes in this category.	This theme captures providers' thoughts on addiction care and MOUD acceptability in New Jersey. Providers reported how perceptions of addiction have changed over time, with considerations on how perception affected treatment access.	*"I feel grateful to be practicing in New Jersey. I know via my other telehealth job, I interface with a lot of buprenorphine prescribers in other states around the country. And I feel like we have it so good here compared to so many of the other problems that I hear them facing. And I feel like there has been such a cultural shift in healthcare over the past few years of just New Jersey has so many resources and policies that strongly support MOUD. So I feel pretty happy overall. I mean, I know we still have improvements to make for sure, but it seems like … I'm definitely proud and happy to be in Jersey as an addiction treatment provider." (828)* *With regard to stigma and difficulties getting med access for patients: "…it's improved dramatically. So, New Jersey has a more open mind than in the past." (453)*
MOUD barriers persisted despite policy efforts	1. PA changes improved medication access overall, but approval barriers remained 2. Stigma associated with SUDs and MOUD persisted 3. Attitudes towards MOUD's role in recovery affected MOUD prescribing practices	Subcategories within this overall theme provides perceived outcomes to elimination of prior authorization policy and the role of stigma as ongoing barrier. Relatedly, stigma is considered as an factor in providers' prescription practices. Prediction practices vary, indicating diverse thoughts about harm reduction as recovery.	*"So the biggest hurdle that right now occurs with managed Medicaid, but not with straight Medicaid is dosing changes. So, if I go from two tablets to three, I usually have to do prior authorization.…And it got much better in 2020 because increasing the dose decreased a lot. So anytime I'd increased the dose, I would have a lot of prior auth, now it's no longer as much now it's sporadic. So those are the things that I've improved about. And when I do Zubsolv it used to always get denied. Now it's a lot easier." (463)* *"And a lot of times I've seen an improvement of the past couple of years with regards to Suboxone in New Jersey, I must say it's more available. When we first started, it was by pulley teeth, looking for prior authorization and all that. Now it's so much better, and the only difference is sometimes they don't have too much of a choice when it comes to preparation." (767)* *"With Vivitrol injection, I ran into that a lot. It was a month later and I still can't get this approved for somebody who's on Medicaid which I thought I didn't even have to do a prior auth for. It was just the craziest thing. And come to find that it was a couple pharmacies, I had to find the right pharmacy. I was just like, "If this is a specialty pharmacy and you would take other Medicaid patients, why not this one? What's the problem?" (749)* *"The only issue is pharmacies with stigma. I feel like it's better here than a lot of other places in the country, but there definitely are pharmacists that will treat patients poorly because they're on BUP or will say, "We don't carry that," or will just be rude. But I feel like we're world ahead of the rest of the country on that." (828)*
Recommendations to improve MOUD treatment	1. Increase support for addressing psychosocial challenges 2. Medication approval and pharmacy-level improvements 3. Expanding MOUD into other settings	Providers offered suggestions for future MOUD policy changes. Three key themes emerged from these interviews highlighting the impact of psychosocial services, opportunities for improved partnership with pharmacies, and expansion of MOUD treatment to other specialties.	*"So better reimbursement for therapists. That would be one because that's a problem my patients are coming across, is not being able to have substance abuse counselors." (453)* *"Now it is true that some of the formulations are not stocked regularly. Someone that put patients on four milligrams of buprenorphine. There have been some hiccups there because it's not regularly stocked. So I think, this is probably a small part of a pharmacy business. Boxes are bulky, but I think that would be something that we should look at policy wise in order to taper these patients, pharmacies have to carry or be able to quickly acquire all dosage strengths of buprenorphine." (967)* *"Another area that we work in is MAT in prisons and jails. I could definitely envision something like that happening in the EDS as well." (929)* *"…limiting the X waiver and providing better access through telemedicine and not requiring in-person, providing more funding. Things like that would definitely be helpful." (125)* *"They could do what Europe does and remove the restrictions of only certain doctors can prescribe it. And you know that they did do that for 24 hours. That was so funny. We were all excited about okay, now primary doctors can do it, we don't have to be the only ones." (328)*

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