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Smarter—Not Bigger—Government Can Optimize Substance Use Disorder Treatment Access

By Stacey McKenna

Improving access requires smarter policy, not bigger government. Easing unnecessary regulatory burdens on evidence-based care while strengthening the oversight of OTPs could expand provider participation, reduce fraud, and improve patient choice, experience, and access.

Executive Summary

Substance use disorders (SUDs) affect tens of millions of Americans each year, yet most people struggling with an SUD do not access treatment. This gap is driven by a variety of factors, including the overregulation of medications for opioid use disorder (MOUD) and an insurance landscape that unintentionally disincentivizes comprehensive care. Recognizing the need to address this issue, the U.S. government has invested considerable funding and infrastructure in SUD treatment interventions. Unfortunately, recent policy shifts have significantly reduced that support.

In this policy paper, we outline the elements of an optimal SUD treatment landscape and assess how the U.S. government currently supports

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or hinders those efforts. Our analysis reveals that although access to comprehensive SUD treatment modalities would benefit individuals and society as a whole, some current policies impede this framework. Therefore, to optimize treatment access, we suggest several key policy recommendations:

1. Reduce regulatory barriers that constrain access to gold-standard care,
2. Address policies that limit workforce capacity, and
3. Modernize public-insurance rules to align coverage with clinical evidence, offer a more diverse set of treatment options, and better support patient–provider decision making.

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Introduction

More than 1 million Americans have died of an overdose since 2000, and nearly 30 million reported struggling with an SUD involving illicit or prescription drugs like heroin, cocaine, fentanyl, and opioids in 2023.[1] Despite these sobering numbers, research suggests that only 13 to 25 percent of those who need SUD treatment receive it.[2] Given the substantial individual, social, and economic costs of untreated SUD—including higher rates of overdose, co-occurring mental health challenges, and avoidable health-system and criminal-justice expenditures—it is essential that policies facilitate, rather than discourage, access to appropriate care.[3]

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Even so, in 2025, President Donald J. Trump's administration ended nearly $2 billion in grants for state health departments, cut SUD treatment and overdose prevention funding by $350 million, and dismantled important federal health agencies that support these efforts.[4] These numbers are likely to worsen in the coming years if the administration continues to cut federal treatment resources and expand the regulation of evidence-based care. Such policy choices would only deepen access challenges and the rippling negative effects of SUDs on individuals and communities. One model suggests that the Medicaid cuts in the One Big Beautiful Bill Act alone would likely cut off 156,000

1. "Drug Abuse Statistics," National Center for Drug Abuse Statistics, last accessed Nov. 17, 2025. https://drugabusestatistics.org; Substance Abuse and Mental Health Services Administration, "Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health," Department of Health and Human Services, July 2024. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report.
2. Ibid.; Ethan Sahker et al., "Evaluating the substance use disorder treatment gap in the United States, 2016-2019: A population health observational study," *The American Journal on Addictions* 33:1 (Aug. 15, 2023), pp. 36- 47. https://onlinelibrary.wiley.com/doi/abs/10.1111/ajad.13465; Cynthia Reilly and Samantha Arsenault, "Insurance Coverage for Substance Use Disorder Treatment Impedes Care," Pew, March 29, 2017. https://www.pew.org/en/research-and-analysis/articles/2017/03/29/insurance-coverage-for-substance-use-disorder-treatment-impedes-care; Jeffrey A. Singer, "Still Out of Reach: Why Effective Opioid Treatment Isn't Getting to Patients," CATO Institute, April 15, 2025. https://www.cato.org/blog/still-out-reach-why-effective-opioid-treatment-isnt-getting-patients.
3. National Institute on Drug Abuse, "Drugs, Brains, and Behavior: The Science of Addiction," Department of Health and Human Services, July 2020. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health; "Opioid Use Disorder," Cleveland Clinic, July 22, 2025. https://my.clevelandclinic.org/health/diseases/24257-opioid-use-disorder-oud; Stacey McKenna and Chelsea Boyd, "Why Quitting Cold Turkey May Not Be the Best Answer to Addiction," *Discourse*, May 31, 2023. https://www.discoursemagazine.com/p/why-quitting-cold-turkey-may-not-be-the-best-answer-to-addiction; Cora Peterson et al., "Assessment of Annual Cost of Substance Use Disorder in US Hospitals," *JAMA Network Open* 4:3 (March 5, 2021), p. 5. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777032; "The High Cost of Drug Addiction," Gateway Foundation, Oct. 19, 2025. https://www.gatewayfoundation.org/blog/cost-of-drug-addiction; Curtis Florence et al., "The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017," *Drug and Alcohol Dependence* 218 (Jan. 1, 2021). https://pubmed.ncbi.nlm.nih.gov/33121867.
4. O. Rose Broderick and Lev Facher, "Trump cuts have decimated the federal addiction and mental health agency," *STAT News*, Oct. 30, 2025. https://www.statnews.com/2025/10/30/samhsa-grant-cuts-staff-reductions-impact-analyzed.

people's access to opioid use disorder (OUD) treatment, resulting in an additional 1,000 overdose deaths annually.[5]

The Trump administration has stated that it intends to improve Americans' health and stop drug deaths while saving taxpayers money.[6] To accomplish this, it is imperative that federal support for SUD treatment get smarter, not smaller. In this policy paper, we outline a path forward with these goals in mind. We describe the core elements of effective, evidence-based SUD treatment and examine how current federal policy shapes access to those services. With this understanding, we offer targeted policy recommendations to improve access to optimal SUD treatment and strengthen the foundation for more effective and expanded pathways to recovery.

Key Elements of an Effective SUD Treatment Framework

Because people experience SUDs in diverse and dynamic ways, a well-functioning SUD care landscape must offer flexible, accessible, evidence-based treatment options that meet people where they are.[7] The American Society of Addiction Medicine recommends providing access to a full continuum of treatment resources, including a spectrum of options ranging from high-intensity inpatient or residential programs to outpatient treatment modalities for those who are stable but need continued support.[8] Importantly, because SUD recovery is rarely linear and treatment needs may shift over time, flexibility in moving between levels and types of care is paramount. The sections that follow outline core components of optimal, patient-centered SUD treatment, noting persistent gaps that may hinder access, where relevant.

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Behavioral Therapies

Several behavioral therapies have been applied to the treatment of SUD with modest benefit. Because SUD often co-occurs with mental health disorders and a wide range of social, medical, and economic challenges, behavioral approaches are most effective when tailored to the individual.[9]

Behavioral approaches are most effective when tailored to the individual.

5. Benjamin Linas et al., Letter to U.S. Congress, July 2, 2025. https://d197nivf0nbma8.cloudfront.net/uploads/2025/07/MOUD-Loss-and-Overdose-Letter-7.2.25.pdf.
6. "Establishing the President's Make America Healthy Again Commission," The White House, Feb. 13, 2025. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission; Brian Mann, "As drug deaths hit a 5-year low, Trump continues to cite fentanyl as a major threat," NPR, Aug. 30, 2025. https://www.npr.org/2025/08/30/nx-s1-5522046/drugs-deaths-trump-fentanyl.
7. Chelsea Boyd, "Drug Use 101: Substance Use Disorders," R Street Institute, Oct. 24, 2024. https://www.rstreet.org/research/drug-use-101-substance-use-disorders; Kimberly Johnson et al., "Receiving addiction treatment in the US: Do patient demographics, drug of choice, or substance use disorder severity matter?," *International Journal of Drug Policy* 75 (January 2020). https://www.sciencedirect.com/science/article/abs/pii/S095539591930283X; Nora D. Volkow and Carlos Blanco, "Substance use disorders: a comprehensive update of classification, epidemiology, neurobiology, clinical aspects, treatment and prevention," *World Psychiatry* 22:2 (June 2023), pp. 203-229. https://onlinelibrary.wiley.com/doi/full/10.1002/wps.21073.
8. "The ASAM Criteria," American Society of Addiction Medicine, 2025. https://www.asam.org/asam-criteria/about-the-asam-criteria.
9. Angela L. Stotts and Thomas F. Northrup, "The promise of third-wave behavioral therapies in the treatment of substance use disorders," *Current Opinion in Psychology* 2 (April 2015), pp. 75-81. https://www.sciencedirect.com/science/article/abs/pii/S2352250X14000463.

Cognitive behavioral therapy (CBT) is an established approach that helps people change their thinking patterns and behaviors.[10] Research indicates that it can be an effective tool in addressing SUD, especially early in recovery, but benefits may lessen over time.[11] The mechanisms by which CBT is effective for SUD are not yet well understood, so funding for more research to elucidate specifics and fine-tune approaches is needed.[12]

Two newer, "third-wave" behavioral therapies—acceptance and commitment therapy and dialectical behavior therapy—also show promise, especially for complex SUD presentations. These approaches emphasize the context and function of distressing psychological experiences and thoughts instead of their content.[13] Both have performed well in clinical trials, though further research is needed here as well.[14]

MOUD

Three medications are approved by the U.S. Food and Drug Administration (FDA) for the treatment of OUD: buprenorphine, methadone, and naltrexone.[15] All three work by binding to opioid receptors in the brain, preventing other opioids from attaching.[16] Because naltrexone is an opioid antagonist (meaning it binds to receptors without producing any effects of its own), it has no potential for misuse or diversion. This makes it a popular choice in jails and prisons and subjects it to fewer prescribing restrictions.[17] However, compared to buprenorphine and methadone—both of which activate opioid receptors without producing the significant euphoric effects of heroin or fentanyl—naltrexone is more difficult to initiate, has lower treatment retention, and does not provide any protection against overdose.[18] Therefore, buprenorphine and methadone are considered gold-standard treatments for most people with OUD.[19] They are associated with greatly improved treatment retention, lower rates of relapse, and as much

Buprenorphine, methadone, and naltrexone are approved treatments for OUD; however, buprenorphine and methadone are associated with greatly improved treatment retention and lower rates of relapse.

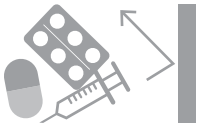
10. "What is Cognitive Behavioral Therapy?," American Psychological Association, 2017. https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.
11. Cassandra L. Boness et al., "An evaluation of cognitive behavioral therapy for substance use disorders: A systematic review and application of the society of clinical criteria for empirically supported treatments," *Clinical Psychology: Science and Practice* 30:2 (2023), pp. 129-142. https://psycnet.apa.org/record/2023-49918-001.
12. Molly Magill et al., "The search for mechanisms of cognitive behavioral therapy for alcohol or other drug use disorders: A systematic review," *Behaviour Research and Therapy* 131 (August 2020). https://www.sciencedirect.com/science/article/pii/S0005796720300991.
13. Stotts and Northrup. https://www.sciencedirect.com/science/article/abs/pii/S2352250X14000463.
14. Ibid.
15. "Information about Medications for Opioid Use Disorder (MOUD)," U.S. Food and Drug Administration, Dec. 26, 2024. https://www.fda.gov/drugs/information-drug-class/information-about-medications-opioid-use-disorder-moud.
16. "Information about Medications for Opioid Use Disorder (MOUD)." https://www.fda.gov/drugs/information-drug-class/information-about-medications-opioid-use-disorder-moud.
17. Justin Berk et al., "Medication for opioid use disorder service delivery in carceral facilities: update and summary report," *Health & Justice* 13:8 (2025). https://link.springer.com/article/10.1186/s40352-025-00317-9#.
18. Ibid.; Andrew J. Saxon et al., "Medication-assisted treatment for opioid addiction: Methadone and buprenorphine," *Journal of Food and Drug Analysis* 21:4 (December 2013), pp. S69-S72. https://www.sciencedirect.com/science/article/pii/S1021949813001014.
19. Saxon et al. https://www.sciencedirect.com/science/article/pii/S1021949813001014; Jennifer J. Carroll, "Medication-Assisted Treatment ('MAT') for Opioid Use Disorder," National Association of Counties Strategy Brief, July 25, 2022. https://www.naco.org/resource/osc-mat; Richard P. Mattick et al., "Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence," *Cochrane Database Systematic Reviews* 2014:2 (Feb. 6, 2024). https://pubmed.ncbi.nlm.nih.gov/24500948; Richard P. Mattick et al., "Methadone Maintenance therapy versus no opioid replacement therapy for opioid dependence," *Cochrane Database of Systematic Reviews* 2003:2 (July 8, 2009). https://pubmed.ncbi.nlm.nih.gov/12804430.

as an 80 percent reduction in overdose risk compared to non-medication treatment.[20] Moreover, improvements extend beyond clinical outcomes. Individuals taking MOUD are better able to work, less likely to commit crimes, and more likely to participate in healthy family and social lives.[21]

Yet even with these demonstrated benefits, significant disparities limit access to MOUD. These include racial, geographic, and age-related gaps that leave many individuals without viable treatment options. Consider the following statistics, which highlight the issue:

- Only 25 percent of individuals with OUD report taking a MOUD in the past year; this number falls to about 13 percent among adults 50 years of age or older.[22]
- As of August 2020, fewer than 50 percent of facilities providing treatment for OUD offered MOUD at all, and only 4 percent offered all three FDA-approved options.[23]
- Buprenorphine prescribers are predominantly located in majority-white areas.[24]
- Opioid treatment programs (OTPs)—the only facilities that offer methadone for OUD in the United States—disproportionately serve Black, Hispanic, and urban communities.[25]
- American Indian/Alaska Native–majority and rural communities face significant gaps in MOUD access across medications.[26]

Because different medications and treatment programs suit different individuals, disparities such as these dramatically reduce patient choice, which in turn can undermine treatment satisfaction and retention.[27]



Despite demonstrated benefits, significant disparities limit access to MOUD. These include racial, geographic, and age-related gaps that leave many individuals without viable treatment options.

20. Sarah E. Wakeman et al., "Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder," *JAMA Network Open* 3:2 (Feb. 5, 2020). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032; Robin E. Clark et al., "Risk Factors for Relapse and Higher Costs Among Medicaid Members with Opioid Dependence or Abuse: Opioid Agonists, Comorbidities, and Treatment History," *Journal of Substance Use & Addiction Treatment* 57 (October 2015), pp. 75-80. https://www.jsatjournal.com/article/S0740-5472(15)00106-3/fulltext; Mallory Locklear, "Treating opioid disorder without meds more harmful than no treatment at all," YaleNews, Dec. 19, 2023. https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all; Robert Heimer et al., "Receipt of opioid use disorder treatments prior to fatal overdoses comparison to no treatment in Connecticut, 2016-17," *Drug and Alcohol Dependence* 254 (Jan. 1, 2024). https://www.sciencedirect.com/science/article/pii/S0376871623012784; Arthur Robin Williams, "MOUD saves lives, especially after 60 days, and the longer the better," *Addiction* 117:12 (Sept. 13, 2022), pp. 3089-3090. https://pmc.ncbi.nlm.nih.gov/articles/PMC9633431; Darius A. Rastegar, "Medication for Opioid Use Disorder Reduces the Risk of Overdose More Than Treatment Without Medication," Alcohol, Other Drugs, and Health: Current Evidence, last accessed Nov. 17, 2025. https://www.bu.edu/aodhealth/2021/03/09/medication-for-opioid-use-disorder-reduces-the-risk-of-overdose-more-than-treatment-without-medication.

21. Jessica Shortall, "When they give me positive doors to walk through, I'm going to keep choosing those doors': An Interview with Gordon Perry," Safer From Harm, June 25, 2024. https://www.saferfromharm.org/blog/when-they-give-me-positive-doors-to-walk-through-im-going-to-keep-choosing-those-doors-an-interview-with-gordon-perry; Megan K. Reed et al., "Sorting through life: evaluating patient-important measures of success in a medication for opioid use disorder (MOUD) treatment program," *Substance Abuse Treatment, Prevention, and Policy* 18:4 (2023). https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-022-00510-1.

22. Deborah Dowell et al., "Treatment for Opioid Use Disorder: Population Estimates – United States, 2022," *Morbidity and Mortality Weekly Report* 73:25 (June 27, 2024), pp. 567-574. https://www.cdc.gov/mmwr/volumes/73/wr/mm7325a1.htm; Pia M. Mauro et al., "Use of Medication for Opioid Use Disorder Among US Adolescents and Adults With Need for Opioid Treatment, 2019," *JAMA Network Open* 5:3 (March 1, 2022). https://pubmed.ncbi.nlm.nih.gov/35319762.

23. "Medications for Opioid Use Disorder Improve Patient Outcomes," Pew, Dec. 17, 2020. https://www.pew.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes.

24. William C. Goedel et al., "Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States," *JAMA Network Open* 3:4 (2020). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663.

25. Ibid.; Chelsea Boyd, "Why Opioid Treatment Program Locations Matter," R Street Institute, Oct. 14, 2025. https://www.rstreet.org/research/why-opioid-treatment-program-locations-matter.

26. Solmaz Amiri et al., "Disparities in access to opioid treatment programs and buprenorphine providers by race and ethnicity in the contiguous U.S.," *Journal of Substance Use and Addiction Treatment* 156 (January 2024). https://www.sciencedirect.com/science/article/abs/pii/S2949875923002448.

27. Caty Simon et al., "The Methadone Manifesto: Treatment Experiences and Policy Recommendations From Methadone Patient Activists," *American Journal of Public Health* 112:S2 (April 2022), pp. S117-S122. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306665.

The Importance of Treatment Retention

Research consistently demonstrates that when people complete or remain engaged in SUD treatment long-term, they are much more likely to have positive recovery outcomes, including a lower risk of mortality, increased substance abstinence, and better social and economic well-being.[28] However, about 30 percent of those engaged in SUD treatment do not complete their programs.[29] This attrition is partly driven by limited access and overly restrictive treatment programs (e.g., requirements for daily in-person medication dosing or fixed counseling schedules instead of patient-centered care).[30] It can also stem from motivation issues, survival challenges, or a lack of "recovery capital" (i.e., the "resources that help people envision and achieve change: community, housing, transportation, food, financial security").[31] Therefore, an important part of the SUD care continuum is access to resources or programs that keep people engaged in treatment. Some evidence-based approaches that support engagement include contingency management, recovery housing, and peer support.

Contingency Management (CM)

CM is an approach that provides positive financial reinforcement or incentives to individuals in SUD treatment for engaging in specific treatment-related behaviors.[32] Some programs focus on providing incentives for abstinence, whereas others emphasize attending therapy appointments or meeting health goals co-defined by the patient and provider.[33] CM has been used to treat alcohol use disorder for at least 60 years and has more recently been shown to be an effective tool for improving treatment retention and outcomes for other SUDs.[34] A recent meta-analysis found that CM was associated with increased abstinence from stimulants, polysubstance use, illicit opioids, and cigarettes.[35] It also improved treatment attendance and medication adherence.[36] In addition, even attendance-focused (versus abstinence-focused) CM programs have been shown to modestly improve abstinence outcomes.[37] Given its demonstrated efficacy, CM is currently the

CM has been used to treat alcohol use disorder for at least 60 years and has more recently been shown to be an effective tool for improving treatment retention and outcomes for other SUDs.

28. Yih-Ing Hser et al., "Relationship between drug treatment services, retention, and outcomes," *Psychiatric Services* 55:7 (July 2004), pp. 767-774. https://pubmed.ncbi.nlm.nih.gov/15232015; Wakeman et al. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032; Clark et al. https://www.jsatjournal.com/article/S0740-5472(15)00106-3/fulltext; Locklear. https://news.yale.edu/2023/12/19/treating-opioid-disorder-without-meds-more-harmful-no-treatment-all; Heimer et al. https://www.sciencedirect.com/science/article/pii/S0376871623012784; Williams. https://pmc.ncbi.nlm.nih.gov/articles/PMC9633431; Rastegar. https://www.bu.edu/aodhealth/2021/03/09/medication-for-opioid-use-disorder-reduces-the-risk-of-overdose-more-than-treatment-without-medication.
29. Sara N. Lappan et al., "Dropout rates of in-person psychosocial substance use disorder treatments: a systematic review and meta-analysis," *Addiction* 115:2 (February 2020), pp. 201-217. https://pubmed.ncbi.nlm.nih.gov/31454123.
30. David Frank et al., "'It's like 'liquid handcuffs':' The effects of take-home dosing policies on Methadone Maintenance Treatment (MMT) patients' lives," *Harm Reduction Journal* 18:88 (Aug. 14, 2021). https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-021-00535-y.
31. "Identifying and Unlocking Resources to Support Recovery," School of Social Work, University at Buffalo, last accessed Nov. 18, 2025. https://socialwork.buffalo.edu/resources/multidimensional-inventory-recovery-capital.html; Alexis Madrigal, "Shoshana Walter's 'Rehab' Finds Corruption, Profiteering and Dismal Rates of Recovery in America's Drug Treatment System," KQED, Aug. 8, 2025. https://www.kqed.org/forum/2010101910854/shoshana-walters-rehab-finds-corruption-profiteering-and-dismal-rates-of-recovery-in-americas-drug-treatment-system.
32. Nancy M. Petry, "Contingency management: what it is and why psychiatrists should want to use it," *Psychiatrist* 35:5 (May 2011), pp. 161-163. https://pmc.ncbi.nlm.nih.gov/articles/PMC3083448.
33. "Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention," Office of the Assistant Secretary for Planning and Evaluation, Nov. 7, 2024. https://www.ncbi.nlm.nih.gov/books/NBK606623.
34. "Contingency Management," Legislative Analysis and Public Policy Association, October 2023. https://legislativeanalysis.org/wp-content/uploads/2023/10/Contingency-Management-Fact-Sheet-FINAL.pdf; Hypatia A. Bolivar et al., "Contingency Management for Patients Receiving Medication for Opioid Use Disorder," *JAMA Psychiatry* 78:10 (Oct. 1, 2021), pp. 1092-1102. https://pubmed.ncbi.nlm.nih.gov/34347030.
35. Bolivar et al. https://pubmed.ncbi.nlm.nih.gov/34347030.
36. Ibid.
37. Rory A. Pfund et al., "Contingency management for treatment attendance: A meta-analysis," *Journal of Substance Abuse Treatment* 133 (February 2022). https://www.sciencedirect.com/science/article/pii/S0740547221002828.

preferred treatment modality for people with stimulant use disorders, which are often resistant to alternative options.[38]

As with MOUD, CM remains substantially underused. A recent Veterans Affairs (VA) study found that fewer than 1 percent of individuals with a stimulant use disorder had tried CM despite its widespread appeal among this group.[39] Access to the modality may be somewhat better beyond the VA healthcare system, but a 2023 legislative analysis reported that fewer than 10 percent of SUD treatment providers use CM on a regular basis, suggesting that there is still much room to broaden adoption.[40]

Recovery Housing

Recovery housing provides people in recovery from an SUD with an abstinence-based living environment connected to treatment services.[41] Such housing is typically organized into four levels, ranging from programs with on-site, paid staff to those rooted in a peer-community mindset.[42] Research on these programs is generally positive. The more comprehensive programs are associated with increases in abstinence, income, and employment and decreases in criminal charges and incarceration.[43] Data on housing that provides coordinator and safe-space roles (vs. those that provide resources only) is limited but promising.[44] Recovery housing is thought to improve treatment retention and satisfaction by providing stable, low-cost housing and helping individuals build recovery capital across multiple domains, including social and financial supports.[45]

Despite its potential benefits, access to recovery housing remains challenging for many people with SUD. These barriers often stem from program-level constraints. For example, many recovery housing programs do not admit people taking MOUD or are unable to accommodate families despite the fact that a majority of women seeking addiction treatment have children.[46]

Research on recovery housing programs is generally positive, but access remains challenging for many people with SUD. These barriers often stem from program-level constraints.

38. Franco De Crescenzo et al., "Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis," *PLOS Medicine* (Dec. 26, 2018). https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002715; "The ASAM/AAAP Clinical Guideline on the Management of Stimulant Use Disorder," American Society of Addiction Medicine and American Academy of Addiction Psychiatry, last accessed Nov. 18, 2025. https://eguideline.guidelinecentral.com/i/1519511-stimulant-use-disorder/0.
39. Samuel Acuff, "Who Receives Contingency Management for Stimulant Use Disorder?," Recovery Research Institute, August 2025. https://www.recoveryanswers.org/research-post/who-receives-contingency-management-for-stimulant-use-disorder; Tyler G. Erath et al., "Interest in contingency management and reducing stimulant use among syringe service program participants," *Journal of Substance Use and Addiction Treatment* 177 (July 31, 2025). https://pmc.ncbi.nlm.nih.gov/articles/PMC12358049.
40. "Contingency Management." https://legislativeanalysis.org/wp-content/uploads/2023/10/Contingency-Management-Fact-Sheet-FINAL.pdf.
41. Amy A. Mericle et al., "The role of recovery housing during outpatient substance use treatment," *Journal of Substance Abuse and Treatment* 133 (February 2022). https://pubmed.ncbi.nlm.nih.gov/34657785; "Recovery Housing: Best Practices and Suggested Guidelines," Substance Abuse and Mental Health Services Administration. (2019). https://mhacbo.org/media/filer_public/e4/b4/e4b474ff-0c70-4b31-bb34-3596f7591232/housing-best-practices-100819.pdf.
42. "The NARR Standard," National Alliance of Recovery Residences, last accessed Nov. 18, 2025. https://narronline.org/standards.
43. Corrie L. Vilsaint et al., "Recovery housing for substance use disorder: a systematic review," *Frontiers in Public Health* 13 (March 5, 2025). https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1506412/full.
44. Mericle et al. https://pubmed.ncbi.nlm.nih.gov/34657785.
45. Ibid.
46. Kathryn R. Gallardo et al., "Development and implementation of recovery housing policies and practices to support people taking medications for opioid use disorder," *Journal of Substance Use and Addiction Treatment* 180 (January 2026). https://www.sciencedirect.com/science/article/pii/S2949875925001961; Billy Kobin, "Maine lacks housing for parents trying to overcome addiction," *Bangor Daily News,* June 13, 2023. https://www.bangordailynews.com/2023/06/13/news/augusta/maine-lacks-help-for-parents-overcoming-addiction-joam40zk0w; Madison Ashworth, "Barriers and facilitators to recovery support interventions in US Rural Recovery Houses: Implementing the SMART life skills program," *Evaluation and Program Planning* 114 (February 2026). https://www.sciencedirect.com/science/article/pii/S0149718925001843; "Women in Recovery," Recovery Research Institute, last accessed Dec. 1, 2025. https://www.recoveryanswers.org/resource/women-in-recovery.

Recovery housing is also expensive to operate. Although it does offer long-term cost-savings potential, it is generally not covered by Medicaid or other insurers, so affordability is an issue for many potential candidates.[47] In addition, complicated zoning laws can make it difficult to open and operate recovery houses, keeping availability low and limited to certain areas.[48]

Mutual-Support Programs

Commonly referred to as 12-step programs, these groups have been proven highly effective among people with alcohol use disorder.[49] This success has led some to promote them for other SUDs, though the evidence supporting their effectiveness beyond alcohol use disorder is more mixed.[50] Furthermore, some programs tailored to SUD, like Narcotics Anonymous, have historically had a complete abstinence (i.e., anti-MOUD) philosophy, which can deter individuals from engaging with effective medical treatment.[51] Nonetheless, some may find the approach and sense of community to be useful complements to other treatments.[52]

Commonly referred to as 12-step programs, some may find the approach and sense of community to be useful complements to other treatments.

Peer Recovery-Support Services

These services, which are staffed by individuals who have had an SUD and who are in recovery (referred to as peer-support specialists), are designed to help people in treatment navigate their own journey.[53] The research on these programs is mixed, but growing evidence suggests that they can reduce the costs associated with treatment by as much as $2,000 per patient.[54]

Peer recovery-support services are designed to help people in treatment navigate their own journey.

Nonabstinence Approaches

Nonabstinence approaches are rooted in the philosophy that any positive change is good, and people with SUD should actively participate in their treatment and recovery goal-setting.[55] Although nonabstinence may seem

Nonabstinence is a promising alternative that can help keep individuals engaged in care and build recovery capital.

47. Ashworth. https://www.sciencedirect.com/science/article/pii/S0149718925001843; Peggy Bailey, "Medicaid and Federal Grant Funding Can Improve Treatment and Housing Options for People With Substance Use Disorders," Center on Budget and Policy Priorities, Aug. 2, 2018. https://www.cbpp.org/research/health/medicaid-and-federal-grant-funding-can-improve-treatment-and-housing-options-for.
48. Rachel L. Andersen, "Litigation Landmines: Exclusionary Zoning and Sober Living Homes," *Benefits & Social Welfare Law Review* 25:2 (2024). https://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=1110&context=benefits.
49. John F. Kelly et al., "Alcoholics Anonymous and 12-Step Facilitation Treatments for Alcohol Use Disorder: A Distillation of a 2020 Cochrane Review for Clinicians and Policy Makers," *Alcohol and Alcoholism* 55:6 (November 2020), pp. 641-651. https://academic.oup.com/alcalc/article/55/6/641/5867689.
50. Catherine E. Paquette et al., "Expanding the continuum of substance use disorder treatment: Nonabstinence approaches," *Clinical Psychology Review* 91 (February 2022). https://pmc.ncbi.nlm.nih.gov/articles/PMC8815796; James Gamble and Henry O'Lawrence, "An Overview of the Efficacy of the 12-Step Group Therapy for Substance Abuse Treatment," *Journal of Health and Human Services Administration* 39:1 (2016), pp. 141-159. https://journals.sagepub.com/doi/abs/10.1177/107937391603900108; Martin Bøg et al., "12-step programs for reducing illicit drug use," Social Welfare Coordinating Group, February 2017. https://onlinelibrary.wiley.com/doi/pdf/10.4073/csr.2017.2.
51. Laura B. Monico et al., "Buprenorphine treatment and 12-step meeting attendance: Conflicts, compatibilities, and patient outcomes," Journal of Substance Abuse Treatment 57 (May 12, 2015), pp. 89-95. https://pmc.ncbi.nlm.nih.gov/articles/PMC4560966; Elizabeth Brico, " By shunning medication-assisted therapy, 12-step meetings are making the opioid crisis worse," STAT10, Oct. 4, 2017. https://www.statnews.com/2017/10/04/medication-assisted-therapy-12-step.
52. Keith Humphreys et al., "Impact of 12 Steps Mutual Help Groups on Drug Use Disorder Patients across Six Clinical Trials," *Drug and Alcohol Dependence* 215 (Oct. 1, 2020). https://pmc.ncbi.nlm.nih.gov/articles/PMC7502458/pdf/nihms-1618868.pdf; Annette Mendola and Richard L. Gibson, "Addiction, 12-Step Programs, and Evidentiary Standards for Ethically and Clinically Sound Treatment Recommendations: What Should Clinicians Do?," *AMA Journal of Ethics* (June 2016). https://journalofethics.ama-assn.org/article/addiction-12-step-programs-and-evidentiary-standards-ethically-and-clinically-sound-treatment/2016-06.
53. David Eddie et al., "Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching," *Frontiers in Psychology*, 10 (June 12, 2019). https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2019.01052/full.
54. Ibid.; Lynn Videka et al., "National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement," University of Michigan Behavioral Health Workforce Research Center, August 2019. https://www.healthworkforceta.org/wp-content/uploads/2023/07/BHWRC_National-Analysis-of-Peer-Support_Policy-Brief.pdf.
55. Paquette et al. https://pmc.ncbi.nlm.nih.gov/articles/PMC8815796.

counterintuitive in a treatment landscape long shaped by abstinence-based models, research suggests that such programs fill an important gap.[56] Indeed, many people with SUD either do not want to quit, do not think they need to quit, or are not yet ready to fully abstain from substances, and their resistance to complete abstinence is often cited as a barrier to engaging with treatment.[57] Thus, nonabstinence approaches provide individuals with an opportunity to engage with the other services associated with recovery environments—building healthier relationships, engaging in therapy, and more—without the pressure to abstain from substances. The approach is well established and has been shown to be effective for individuals with alcohol use disorder, though it is less studied with illicit substances, where the illegal nature of the drugs makes all consumption risky and renders moderation difficult to define or safely pursue.[58] Still, nonabstinence is a promising alternative that can help keep individuals engaged in care while they build recovery capital.

Nonabstinence approaches provide individuals with an opportunity to engage with the other services associated with recovery environments without the pressure to abstain from substances.

Effective SUD Care as a Pathway to Justice-System Savings

U.S. federal and state governments spend an estimated $10 billion each year to incarcerate roughly 450,000 people for drug offenses.[59] Accordingly, facilitating access to evidence-based SUD care not only has the potential to benefit individuals and society as a whole—it could also lower the U.S.'s disproportionately high drug-related justice-system costs. Although surprisingly little research exists on this topic, available data suggests that expanded SUD treatment could help reduce criminal recidivism and justice system involvement.[60] It also has the potential to generate cost savings.[61] In a recent study, researchers modeled the cost of 26 different MOUD treatment scenarios—including medication alone; medication paired with add-on interventions like psychotherapy, overdose education with naloxone distribution [OEND], or CM; and OEND alone—relative to the costs associated with quality of life lost, overdose and fatality, and justice system involvement.[62] They found per-person lifetime cost savings ranging from $25,000 to $105,000, with the greatest savings coming from combining methadone and CM.[63]

Researchers found per-person lifetime cost savings ranging from $25,000 to $105,000, with the greatest savings coming from combining methadone and CM.

Government Drivers of SUD Treatment Access and Barriers

Although multiple drivers contribute to gaps in SUD treatment access, government policy remains one of the most consequential. This section explores a number of policy domains that most directly affect treatment accessibility and affordability: the regulation of MOUD, anti-kickback laws,

56. Ibid.
57. Center for Behavioral Health Statistics and Quality, "Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration. (2018). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf.
58. Paquette et al. https://pmc.ncbi.nlm.nih.gov/articles/PMC8815796.
59. "The High Cost of Drug Addiction." https://www.gatewayfoundation.org/blog/cost-of-drug-addiction; "Costs and Benefits? The Impact of Drug Imprisonment in New Jersey," Open Society Foundations, last accessed Nov. 17, 2025. https://www.opensocietyfoundations.org/publications/costs-and-benefits-impact-drug-imprisonment-new-jersey.
60. Ibid.; Erminia Fardone et al., "Economic benefits of substance use disorder treatment: A systematic literature review of economic evaluation studies from 2003 to 2021," *Journal of Substance Use and Addiction Treatment* 152 (September 2023). https://www.sciencedirect.com/science/article/pii/S2949875923001352.
61. Michael Fairley et al., "Cost-effectiveness of Treatments for Opioid Use Disorder," *JAMA Psychiatry* 78:7 (2021), pp. 767-777. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2778020.
62. Ibid.
63. Ibid.

Medicaid/Medicare coverage and reimbursement, federal and state grant/settlement funding, and licensing and credentialing rules that shape the SUD workforce pipeline.

Regulation of MOUD and Other Evidence-Based Interventions

The United States imposes stringent regulations on both gold-standard MOUD options—methadone and buprenorphine—which impacts access.[64] Methadone, specifically, is the most heavily regulated medication in the country. Federal law prohibits clinicians from prescribing it for OUD outside of certified OTPs (also known as methadone clinics), where it must be dispensed or administered on site.[65] Additionally, OTPs are restricted by federal and state regulations that make them difficult to open and operate and that make patient access logistically difficult and even dehumanizing.[66] For example, federal and state laws restrict take-home doses, especially for patients early in their recovery process, forcing clients to travel to the clinic almost daily to receive their methadone dose in person and under supervision.[67] Given the limited number of OTPs, this often involves an hour or more of travel as well as on-site waiting time.[68] Patients report that it interferes with work and family obligations, especially for those in rural areas or with unreliable transportation.[69] Table 1 outlines a number of key OTP regulations that restrict access to care.

The United States imposes stringent regulations on both gold-standard MOUD options—methadone and buprenorphine—which impacts access. Methadone, specifically, is the most heavily regulated medication in the country.

Table 1: Regulations that Limit OTP Access

Barriers to Opening New OTPs	• Methadone storage restrictions • Requirement for on-site pharmacist or pharmacy licensing • Geographic/zoning restrictions—e.g., cannot be near another treatment facility; certain areas can have only one OTP
Factors Impeding Patient Participation	• Take-home dose restrictions • Some states require and/or OTPs impose urine-screening requirements that exceed federal minimums • Some states require OTPs to encourage clients to eventually taper off MOUD, even when long-term treatment may be beneficial • Some states and/or OTPs mandate rigid counseling schedules (rather than taking a patient-centered approach to scheduling)

64. Stacey McKenna, "How Red Tape Limits Access to Medications for Opioid Use Disorder," R Street Institute, Nov. 7, 2023. https://www.rstreet.org/research/how-red-tape-limits-access-to-medications-for-opioid-use-disorder.
65. Anna Conway et al., "Typology of laws restricting access to methadone treatment in the United States: A latent class analysis," *International Journal of Drug Policy 119* (Aug. 2, 2023). https://pmc.ncbi.nlm.nih.gov/articles/PMC11790254; Federal opioid treatment standards, 42 CFR 8.12 (2002). 1. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8/subpart-C/section-8.12.
66. Stacey McKenna, "Barriers to Opening an OTP," R Street Institute, Sept. 3, 2025. https://www.rstreet.org/research/barriers-to-opening-an-otp; Frank et al. https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-021-00535-y.
67. Ibid.
68. Robert A. Kleinman, "Comparison of Driving Times to Opioid Treatment Programs and Pharmacies in the US," *JAMA Psychiatry* 77:11 (July 15, 2020), pp. 1-9. https://pmc.ncbi.nlm.nih.gov/articles/PMC7364344; Boyd, "Why Opioid Treatment Program Locations Matter." https://www.rstreet.org/research/why-opioid-treatment-program-locations-matter; Giliane Joseph et al., "Reimagining patient-centered care in opioid treatment programs: Lessons from the Bronx during COVID-19," *Journal of Substance Abuse Treatment* 122 (March 2021). https://www.sciencedirect.com/science/article/pii/S0740547220304761.
69. Frank et al. https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-021-00535-y.

Interestingly, although methadone access and delivery are subject to extensive regulation, OTPs themselves may not receive sufficient financial and compliance oversight. A recent report found that Medicaid could have saved more than $300 million if OTPs were more transparent about the services they provided.[70] Similarly, a 2023 report found that Medicare also overpaid OTPs for bundled services.[71] More concerning, an entire network of OTP providers recently faced fraud charges, raising concerns about oversight for OTPs that could more broadly affect program funding and care quality.[72] All of these issues are attributable to and exacerbated by the virtual monopoly OTPs hold on methadone access in the United States.[73]

Although methadone faces the bulk of MOUD regulation in the United States, there are regulatory barriers to accessing buprenorphine as well. DEA scrutiny deters distributors and pharmacies from supplying the drug for fear that they will be flagged for investigation.

Although methadone faces the bulk of MOUD regulation in the United States, there are regulatory barriers to accessing buprenorphine as well. Buprenorphine is like most other prescription medications in that it can be prescribed by primary care providers who are licensed to prescribe controlled medications and picked up from a pharmacy.[74] However, Drug Enforcement Administration (DEA) scrutiny deters distributors and pharmacies from supplying the drug for fear that they will be flagged for investigation.[75] As a result, fewer than 21,000 of the nation's 52,528 pharmacies dispensed the medication on a regular basis as of 2023.[76] Long-acting buprenorphine formulations are even more difficult to access, with strict storage, dispensing, and administration regulations requiring careful (and potentially logistically unfeasible) coordination between patient, provider, and pharmacist.[77] In fact, in 2019, doctors issued only about 7,000 prescriptions for the injectable and implantable versions of the medication, compared with more than 700,000 prescriptions for the oral forms.[78]

Another category of regulatory barriers limits access to other evidence-based services like CM because of anti-kickback laws and anti-inducement rules.[79] Anti-kickback laws, which exist at both the state and federal levels, "prohibit healthcare providers from paying patients to seek treatment."[80]

70. Office of Inspector General, "Medicare Could Have Saved $301.5 Million if Bundled Payment Rates for Opioid Use Disorder Treatment Services Had Reflected Services Provided to Enrollees," Department of Health and Human Services, October 2025. https://oig.hhs.gov/documents/audit/11237/A-09-23-03002.pdf.
71. Office of Inspector General, "Medicare Made $17.8 Million in Potentially Improper Payments for Opioid-Use-Disorder Treatment Services Furnished by Opioid Treatment Programs," Department of Health and Human Services, August 2023. https://oig.hhs.gov/reports/all/2023/medicare-made-178-million-in-potentially-improper-payments-for-opioid-use-disorder-treatment-services-furnished-by-opioid-treatment-programs.
72. Katie Thomas and Jessica Silver-Greenberg, "Fraud and Fakery at the Country's Largest Chain of Methadone Clinics," *The New York Times*, Dec. 7, 2024. https://www.nytimes.com/2024/12/07/health/acadia-methadone-clinics-fraud.html.
73. Lev Facher, "The methadone clinic monopoly: Opioid treatment chains backed by private equity are fighting calls for reform," *STAT News*, March 19, 2024. https://www.statnews.com/2024/03/19/methadone-clinics-opioid-addiction-private-equity.
74. "Primary Care Providers Can Prescribe with Confidence," U.S. Food and Drug Administration, last accessed Nov. 18, 2025. https://www.fda.gov/drugs/prescribe-confidence/primary-care-providers-can-prescribe-confidence.
75. USC Schaeffer Center, "Despite Relaxed Prescribing Rules, Opioid Addiction Treatment Still Hard to Find at Pharmacies," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, Sept. 2, 2025. https://schaeffer.usc.edu/research/opioid-treatment-buprenorphine-access-pharmacies.
76. Jenny S. Guadamuz et al., "Trends In The Availability of Buprenorphine At US Retail Pharmacies, 2017-23," *Health Affairs* 44:9 (September 2025), pp. 1157-1163. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00349.
77. James Cosgrove et al., "Opioid Use Disorder: Treatment with Injectable and Implantable Buprenorphine," U.S. Government Accountability Office, Aug. 4, 2020. https://www.gao.gov/products/gao-20-617; McKenna, "How Red Tape Limits Access to Medications for Opioid Use Disorder." https://www.rstreet.org/research/how-red-tape-limits-access-to-medications-for-opioid-use-disorder.
78. Ibid.
79. "Contingency Management." https://legislativeanalysis.org/wp-content/uploads/2023/10/Contingency-Management-Fact-Sheet-FINAL.pdf.
80. Ibid., p. 2.

Similarly, the "Beneficiary Inducements CMP," section 1128A(a)(5) of the Social Security Act, penalizes individuals for providing monetary incentives that might influence healthcare decisions of Medicare and state health program beneficiaries.[81] In recent years, as support for CM has grown, federal agencies have provided clarity on these policies, indicating that CM would not be automatically prohibited and instead would be addressed on a case-by-case basis.[82] The primary tool states have used to improve CM access is a Medicaid Section 1115 waiver, which provides exceptions to the general rules, explicitly allowing the program's "motivational incentives" in a specific scope.[83] At least five states have applied for and received this waiver since 2021.[84]

Medicaid and Medicare Coverage and Reimbursement

The way public insurance plans cover SUD treatment does not always facilitate access to optimal care.

As public insurers, Medicaid and Medicare are both funders of SUD treatment services. About 21 percent of Medicaid recipients and 8 percent of Medicare beneficiaries have SUD, compared to approximately 16 percent of individuals with commercial insurance.[85] As such, Medicaid is the largest payer of SUD services in the United States.[86] However, the way these public plans cover SUD treatment does not always facilitate access to optimal care. For example, some research has found that although state Medicaid expansion decreases the uninsured population, this does not necessarily translate into more people being engaged in treatment.[87]

Two primary factors help explain this gap. First, many treatment facilities do not accept Medicaid or Medicare. A 2021 estimate found that one out of every four SUD treatment facilities did not accept Medicaid, and fewer than one-half of SUD treatment providers accepted Medicare.[88] This insurance coverage shortfall translates directly into access barriers, placing many publicly insured Americans too far from an SUD provider who accepts their coverage.[89] This bears out in a notable and concerning finding from a 2020 analysis: Although 21 percent of Medicaid recipients qualified as having SUD, only 8 percent received SUD treatment.[90]

81. Ibid.
82. Ibid.; "Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention." https://www.ncbi.nlm.nih.gov/books/NBK606623.
83. Amaya Diana et al., "Section 1115 Waiver Watch: A Look at the Use of Contingency Management to Address Stimulant Use Disorder," KFF, Jan. 9, 2025. https://www.kff.org/medicaid/section-1115-waiver-watch-a-look-at-the-use-of-contingency-management-to-address-stimulant-use-disorder.
84. Ibid.
85. Heather Saunders, "A Look at Substance Use Disorders (SUD) Among Medicaid Enrollees," KFF, Feb. 17, 2023. https://www.kff.org/mental-health/a-look-at-substance-use-disorders-sud-among-medicaid-enrollees; William J. Parish et al., "Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers," *American Journal of Preventive Medicine* 63:2 (August 2022), pp. 225-232. https://pubmed.ncbi.nlm.nih.gov/35331570.
86. Ibid.
87. Mark Olfson et al., "Impact Of Medicaid Expansion On Coverage And Treatment Of Low-Income Adults With Substance Use Disorders," *Health Affairs* 37:8 (August 2018), pp. 1208-1215. https://pmc.ncbi.nlm.nih.gov/articles/PMC6190698.
88. Jonathan H. Cantor et al., "Patterns in Geographic Distribution of Substance Use Disorder Treatment Facilities in the US and Accepted Forms of Payment From 2010 to 2021," *JAMA Network Open* 5:11 (Nov. 1, 2022). https://pubmed.ncbi.nlm.nih.gov/36367729.
89. Ibid.
90. "Federal and State Funding Sources for Substance Use Disorder Treatment," National Academy for State Health Policy, Feb. 19, 2025. https://nashp.org/funding-options-for-states.

Second, reimbursement challenges, such as low payment rates, high administrative burdens, and parity-law constraints, deter providers from participating in these public-insurance programs and limit patient access.[91] For example, the Affordable Care Act's parity requirements and recent updates to the Mental Health Parity and Addiction Equity Act inadvertently equate behavioral health services to physical health care, creating standards of care that do not reflect the realities of SUD care.[92] While this improves MOUD coverage, it can discourage programs from covering other non-medication components of care like counseling or urine screens (which are often mandatory to remain in treatment).[93] And because only OUD, nicotine use disorder, and alcohol use disorder have FDA-approved medications, this gap disproportionately affects people with other types of SUD who rely more heavily on behavioral and supportive services.[94]

Grant and Settlement Funding

In addition to funding SUD treatment through Medicaid and Medicare, federal and state governments allocate money to SUD treatment programs, which have been targeted for cuts by the current administration.[95] In 2024, the federal government distributed $2 billion in Substance Use Prevention, Treatment, and Recovery Services Block Grants to all 50 states.[96] These grants are administered by state agencies and fill gaps in coverage by providing funds for off-label treatments and covering uninsured individuals.[97] State Opioid Response Grants are another pool of funds—totaling $1.6 billion in 2024—that are federally funded and state managed. They are distributed to states based on need and are also intended to fill gaps in the system.[98] These federal funds are among those that the administration has threatened throughout 2025. As of October 2025, $1.7 billion in SUD-focused block grants and almost $350 million in additional SUD services funds had been cut.[99]

As of October 2025, $1.7 billion in SUD-focused block grants and almost $350 million in additional SUD services funds had been cut.

In addition to federal funds, many states have access to and distribute opioid settlement dollars. These funds—totaling more than $55 billion—must primarily be used for opioid-related spending.[100] However, states have

91. Julia Dickson-Gomez et al., "Insurance barriers to substance use disorder treatment after passage of mental health and addiction parity laws and the affordable care act: A qualitative analysis," *Drug and Alcohol Dependence Reports* 3 (March 31, 2022). https://pmc.ncbi.nlm.nih.gov/articles/PMC9948907; Chris Mazzolini, "Medicare reimbursement rates explained: Why they keep declining, and what the future holds," Medical Economics, Feb. 17, 2025. https://www.medicaleconomics.com/view/medicare-reimbursement-rates-explained-why-they-keep-declining-and-what-the-future-holds; "Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services," Medicaid and CHIP Payment and Access Commission, January 2025. https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf.
92. "2025 Updates to the Mental Health Parity and Addiction Equity Act (MHPAEA)," Impact Wellness Network, Aug. 15, 2025. https://impactwellnessnetwork.com/2025-updates-to-the-mental-health-parity-and-addiction-equity-act-mhpaea.
93. Ibid.
94. Ibid.
95. "Federal and State Funding Sources for Substance Use Disorder Treatment." https://nashp.org/funding-options-for-states.
96. Ibid.
97. Ibid.; "Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)," Substance Abuse and Mental Health Services Administration, April 24, 2023. https://www.samhsa.gov/grants/block-grants/subg.
98. "Federal and State Funding Sources for Substance Use Disorder Treatment." https://nashp.org/funding-options-for-states.
99. "Tracker: Federal Cuts to Overdose Prevention & Addiction Treatment," Drug Policy Alliance, Sept. 2, 2025. https://drugpolicy.org/resource/federal-cuts-threaten-overdose-prevention; Broderick and Facher. https://www.statnews.com/2025/10/30/samhsa-grant-cuts-staff-reductions-impact-analyzed.
100. "Federal and State Funding Sources for Substance Use Disorder Treatment." https://nashp.org/funding-options-for-states.

wide latitude in deciding what constitutes opioid-related spending. Despite expert recommendations against it, some states spend the funds on law enforcement or other tangential programs, which means that SUD treatment programs may not be prioritized.[101]

SUD Provider Licensing

The United States is in the midst of an SUD treatment provider workforce shortage at all levels of care, from peer-support workers to addiction specialists.[102] In fact, models predict that over the next 12 years, demand for behavioral health services will climb as the number of qualified professionals in the field continues to fall.[103] To illustrate the scope of these projected shortages, estimates indicate that by 2036, the United States will lack:[104]

Models predict that over the next 12 years, demand for behavioral health services will climb as the number of qualified professionals in the field continues to fall.

- 87,630 addiction counselors
- 69,610 mental health counselors
- 62,490 psychologists
- 42,130 psychiatrists

Experts cite a number of barriers to growing this workforce. Of particular note is the interaction between licensing/credentialing and insurance reimbursements.[105] Insurers often limit reimbursements to licensed SUD treatment professionals.[106] Done right, the licensing and credentialing of healthcare providers can help ensure quality of care.[107] However, current licensing regimes—including which positions are credentialed—differ from state to state, can be redundant and confusing, are often expensive and time-consuming to maintain, and sometimes fail to guarantee an appropriate standard of care.[108] In addition, in some states, barrier laws still prevent individuals with a prior drug conviction from working in the SUD treatment field.[109] Further exacerbating this issue, the federal government's recent efforts to de-professionalize many of the fields that serve as SUD-aligned professionals could affect student loan eligibility and repayment ability, disincentivizing people from entering these careers altogether.[110]

101. Stacey McKenna and Jeffrey S. Smith, "What Opioid Settlement Recipients Can Learn from Tobacco Settlement Spending," R Street Institute, Jan. 11, 2024. https://www.rstreet.org/commentary/what-opioid-settlement-recipients-can-learn-from-tobacco-settlement-spending.
102. Melanie Whitter and Jose Silva, "The Substance Use Workforce Crisis: Drivers, Challenges, and Promising Strategies," National Association of State Alcohol and Drug Agency Directors, April 2025. https://nasadad.org/wp-content/uploads/2025/04/The-Substance-Use-Workforce-Crisis-Drivers-Challenges-and-Promising-Strategies_POST-2.pdf.
103. "Workforce Projections," HRSA Data Warehouse, last accessed Nov. 18, 2025. https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections.
104. Ibid.; Nilufer Isvan et al., "Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies and Practices Across the Nation," Office of Disability, Aging and Long-Term Care Policy, November 2019. https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf.
105. Isvan et al. https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf.
106. Ibid.
107. Olga Gershuni et al., "A Systematic Review on Professional Regulation and Credentialing of Public Health Workforce," *International Journal of Environmental Research and Public Health* 20:5 (2023). https://www.mdpi.com/1660-4601/20/5/4101.
108. Isvan et al. https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf.
109. "50-State Comparison: Limits on Use of Criminal Record in Employment, Licensing & Housing," Restoration of Rights Project, 2020. https://ccresourcecenter.org/state-restoration-profiles/50-state-comparisoncomparison-of-criminal-records-in-licensing-and-employment; Jakob Cordes, "Former drug addict turned addiction counselor fights laws barring him from providing counseling," ABC 8 News, Aug. 3, 2022. https://www.wric.com/news/virginia-news/former-drug-addict-turned-addiction-counselor-fights-law-keeping-him-from-working.
110. Corrinne Hess, "Nursing no longer considered a professional degree by Trump administration," Wisconsin Public Radio, Nov. 21, 2025. https://www.wpr.org/news/nursing-not-considered-professional-degree-trump-administration.

Policy Recommendations for Improving SUD Treatment

While different stakeholders debate whether it is the responsibility of the government to provide SUD treatment services or fund access, the right policies can improve program availability and help keep programs affordable and accessible for those who need them. This not only benefits individuals with SUD and their loved ones but also saves taxpayers money by reducing problematic substance use and the associated costs to society.[111]

We suggest the following smarter-not-bigger policies to help close the SUD treatment gap in the United States:

- **Medicaid and Medicare should cover a comprehensive range of evidence-based SUD treatments**, not based on "parity" with physical health but aligned with expert recommendations and evidence supporting a comprehensive and flexible continuum.[112] Improving public-program reimbursement rates and streamlining reporting and recordkeeping requirements would encourage providers to opt in to public insurers. Given the economic and social benefits associated with increasing treatment engagement, this would likely result in downstream cost savings even if upfront spending increased.[113]

Improved Medicaid and Medicare coverage for SUD treatment would likely result in downstream cost savings even if upfront spending increased.

- **Federal and state governments should reduce the regulation of methadone.** If states aligned their OTP rules with federal guidelines, patient-centered care would improve and more OTPs could open, increasing patient choice and providing competition that could drive up care quality. In addition, if the federal government were to allow specialists to prescribe methadone and pharmacists to dispense it—a strategy several countries have implemented with success—this would expand access, increase provider autonomy, and promote patient choice and competition among providers.[114]

Less-restrictive methadone regulations would improve patient-centered care and enable more OTPs to open.

- **OTP regulations should focus on holding programs accountable to evidence-based practices, fraud prevention, and transparent billing practices.** Such a focus would improve care and fiscal responsibility without diminishing patient access and treatment experience. In fact, if companies were held accountable to meet standards of care and prevented from engaging in abusive or wasteful economic practices, competition and patient options in the OUD treatment landscape could improve.

A shift in regulatory focus would improve care and fiscal responsibility without diminishing patient access.

- **Address DEA policies that flag pharmacies for stocking and dispensing buprenorphine.** Reducing concerns around this issue could have direct and indirect implications on medication access. First, it would reduce the

To reduce barriers to pharmacy-based buprenorphine prescribing and dispensing, DEA policies should be revisited.

111. Fardone et al. https://linkinghub.elsevier.com/retrieve/pii/S2949875923001352; Paquette et al. https://pmc.ncbi.nlm.nih.gov/articles/PMC8815796/ - R156.
112. Julia Dickson-Gomez et al., p. 6. http://linkinghub.elsevier.com/retrieve/pii/S2772724622000294.
113. Fardone et al. https://linkinghub.elsevier.com/retrieve/pii/S2949875923001352.
114. Stacey McKenna, "Unshackled from OTPs, Methadone Can Still Be Safe and Effective," R Street Institute, April 11, 2024. https://www.rstreet.org/research/unshackled-from-otps-methadone-can-still-be-safe-and-effective; Jeffrey A. Singer and Sofia Hamilton, "Expand Access to Methadone Treatment," Policy Analysis No. 960, CATO Institute, Sept. 7, 2023. https://www.cato.org/policy-analysis/expand-access-methadone-treatment.

direct fear of DEA scrutiny and potential associated penalties or disruptions to business.[115] Over time, it could have the indirect added benefit of reducing stigma related to MOUD and OUD, reducing another barrier to buprenorphine prescribing and dispensing.[116]

- **States should consider using the 1115 Waiver to enable the use of CM in SUD treatment programs.**[117] This would provide important quality-of-care and anti-fraud protections as well as legal clarity about what funded programs should look like. For example, 1115 Waiver approvals detail patient eligibility, program duration, and approved incentive amounts.[118]
- **States should examine their licensing regimes to confirm that they support high-quality care without placing undue burdens on practitioners.**[119] This would help optimize growing state and federal investments in behavioral health workforce training and development.

States should apply the 1115 Waiver to CM so it can be used more widely in SUD treatment programs.

State licensing practices should be assessed to optimize SUD workforce training and development.

Conclusion

SUD affects millions of Americans every year, yet most people who need treatment do not receive it. Although individual circumstances and choices influence treatment initiation and engagement, a substantial share of the treatment gap stems from policy barriers that can be removed or redesigned.

Improving access requires smarter policy, not bigger government. Easing unnecessary regulatory burdens on evidence-based care while strengthening the oversight of OTPs could expand provider participation, reduce fraud, and improve patient choice, experience, and access. Reassessing and adjusting parity rules to reflect evidence-based standards of care would also make it easier for providers and programs to accept Medicaid and Medicare, widening access to core recovery support systems.

Collectively, these types of policy changes would give patients more treatment options, increase competition, and ultimately drive improvements in care quality and affordability. Accordingly, aligning federal and state policy with the realities of effective SUD care is a necessary step to better support recovery and reduce preventable harm.

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About the Author

Stacey McKenna is a resident senior fellow in integrated harm reduction. Her research and writing focus on the ways that policy affects drug use, related risks, and the rights of people who use drugs to protect their health.

115. Jordan W. Kalil et al., "Addressing buprenorphine supply barriers: A guidance commentary," *Journal of the American Pharmacological Association* 64:2 (2024). https://pubmed.ncbi.nlm.nih.gov/38272311.
116. Winter Roth and David Dadiomov, "Community pharmacy attitudes and behaviors following a buprenorphine best practices dissemination," *The Mental Health Clinician* 15:2 (Apr. 4, 2025). https://pmc.ncbi.nlm.nih.gov/articles/PMC11993145.
117. Diana et al. https://www.kff.org/medicaid/section-1115-waiver-watch-a-look-at-the-use-of-contingency-management-to-address-stimulant-use-disorder.
118. Ibid.
119. Lisa de Saxe Zerden et al., "Findings from an opioid use disorders workforce expansion training program for MSW students," *Journal of Social Work Practice in the Addictions* 25:4 (2025). https://www.tandfonline.com/doi/full/10.1080/1533256X.2025.2503248?af=R; Rebekah Falkner, "Health Care Workforce Investment: How States Are Leading the Way," National Academy for State Health Policy, Sept. 29, 2023. https://nashp.org/health-care-workforce-investment-how-states-are-leading-the-way; "Supporting Workforce Pell Implementation: A Readiness Academy Open To All States and Territories," National Governors Association, Nov. 13, 2025. https://www.nga.org/projects/supporting-workforce-pell-implementation-a-readiness-academy-open-to-all-states-and-territories.