

## FINANCING STRATEGIES FOR SUBSTANCE USE DISORDER TREATMENT

# Expanding Access to Harm Reduction Services for People with Substance Use Disorder: A Checklist for States

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**M**ore and more states recognize the valuable role that **harm reduction services** can play in a comprehensive approach to preventing death, overdose, and infectious disease (e.g., human immunodeficiency virus (HIV), hepatitis C) among people with substance use disorder (SUD). In addition to saving lives, evidence shows that harm reduction services, such as needle-exchange, support reductions in drug use and increase entry into substance use treatment programs.<sup>1</sup>

Harm reduction services are a critical component of a comprehensive, evidence-based state strategy to address the urgent health needs of groups that have been marginalized. A recent study on overdose mortality data shows that — while overdose deaths increased for nearly all subgroups examined — American Indian or Alaska Native men (aged 15 to 34 years) and Black and American Indian or Alaska Native men (aged 35 to 64 years) had the highest overdose death rates; for women, the highest rates were among American Indian or Alaska Native individuals.<sup>2</sup> Targeted harm reduction interventions offer an opportunity to address health inequities by reaching these and other populations disproportionately affected by SUD, such as people who identify as lesbian, gay, or bisexual.<sup>3</sup>

Drawing from [\*State Principles for Financing Substance Use Care, Treatment, and Support Services\*](#), this checklist identifies four areas for states to explore as they consider expanding harm reduction services:



1. **Assess the status of publicly financed harm reduction services;**



3. **Ramp up emerging and innovative, evidence-informed harm reduction programs; and**



2. **Assess the policy landscape for expanding harm reduction services;**



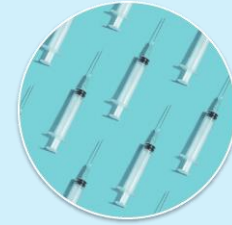
4. **Use public health data to address disparities through harm reduction.**

## PRINCIPLES-IN-ACTION SERIES: Financing Strategies for Substance Use Disorder Treatment

This checklist is part of a series detailing practical steps to guide state policy development aimed at strengthening substance use disorder (SUD) treatment systems, with a focus on sustainability and equity. It draws from the report *State Principles for Financing Substance Use Care, Treatment, and Support Services*. The report and series were developed by the Center for Health Care Strategies through a partnership with The Pew Charitable Trusts and support from Bloomberg Philanthropies. [VIEW THE SERIES »](#) | [READ THE FULL REPORT »](#)

### Why expand access to harm reduction services?

Harm reduction is an array of strategies designed to meet people who use drugs “where they are at” in a non-judgmental manner. This approach aims to reduce the negative consequences associated with drug use.<sup>4</sup> Some harm reduction strategies involve distributing supplies for safer drug use, such as sterile syringes and injection equipment, drug checking equipment (e.g., fentanyl test strips), and naloxone. Other strategies involve a comprehensive set of services, such as linkage to behavioral health or medical care, education on prevention of overdose or HIV/sexually transmitted infections/viral hepatitis, wound care, and vaccinations. Medications for opioid use disorder (MOUD) are also considered a form of harm reduction, though MOUD is technically a form of treatment (see CHCS resource, “[Expanding Access to MOUD: A Checklist for States](#)”).



**Overcoming stigma.** People who use drugs may feel mistrustful or uncomfortable seeking care in traditional health care settings for reasons related to stigma among health care providers,<sup>5</sup> historical racism, discrimination, fear of punishment, etc. Harm reduction approaches offer a means to compassionately connect with people who use drugs, regardless of whether these individuals are ready to change their drug use. That connection serves as a foundation for delivering care that has been documented to save lives, prevent overdose, and reduce the spread of infectious disease.

**Demonstrated evidence.** Growing evidence shows that harm reduction can:

- **Decrease opioid overdose deaths.**<sup>6,7</sup>
- **Increase engagement with drug treatment programs.**<sup>8,9</sup>
- **Increase likelihood of stopping drug use.**<sup>10,11</sup>
- **Reduce the transmission of infectious diseases,** such as HIV and hepatitis C, including when combined with MOUD.<sup>12,13</sup>

## Adopt a Comprehensive Approach to Increasing Access to SUD Services

A multi-pronged approach is necessary to confront the substance use and overdose crisis in the United States. No single SUD treatment service alone can address the breadth of the crisis. As a first step, states should **establish an interagency workgroup** to assess the needs and strengths of their SUD systems, and harm reduction can be a part of that overall planning. As many different agencies oversee and fund services that are relevant to the care of people with SUD, key stakeholders to consider include representatives from the governor’s office, Medicaid, substance use, mental health, public health, corrections, children and families, education, and housing departments. People with lived experience and subject matter experts knowledgeable about harm reduction should also be part of the interagency workgroup and part of decision-making process.

Harm reduction services may already be supported in many states through a variety of public funding streams. Since Medicaid does not currently cover important harm

reduction services such as sterile syringe distribution or overdose prevention counseling, it is critical that the interagency group consider optimizing other flexible funds to expand certain harm reduction services.

States can use the following checklist to determine approaches for expanding harm reduction services.

## 1. Assess the status of publicly financed harm reduction services.



### ❑ How is the state currently funding harm reduction services?

The interagency workgroup could begin by conducting a [fiscal mapping process](#) to inventory existing funds that support the array of harm reduction services. Information should include the specific service, source, amount, limitations on funding, and number of people the funding is serving. Since harm reduction services have historically been underfunded due to stigma and misperceptions regarding their impact on communities, it is critical for states to assess both governmental and non-governmental funding sources supporting harm reduction as many have relied on patchwork funding for years, partially made up of smaller, philanthropic grants.

### ❑ Which public funds (state and federal) can support harm reduction services?

Federal and state funding for harm reduction is lacking in comparison to funding for treatment and recovery services, stemming from the long-standing stigma around harm reduction services. Since certain harm reduction services are not allowable under all public funding streams, the interagency workgroup should inventory all available state and federal funding sources for harm reduction services to determine how to maximize these funds for future investments in harm reduction. The inventory should include traditional sources of public funding for harm reduction (e.g., CDC, state departments of health budgets) as well as more recent federal funding opportunities, such as the unprecedented \$30 million for harm reduction allocated to the Substance Abuse and Mental Health Services Administration (SAMHSA) through the American Rescue Plan,<sup>14</sup> opioid settlement funding, and broader public health funding that may be used to support harm reduction services (if they include certain infectious disease prevention and treatment activities, such as COVID testing or vaccination).<sup>15</sup>

### ❑ Are there opportunities to expand Medicaid coverage for certain harm reduction services not yet authorized under the state plan or through waiver opportunities?

The interagency workgroup should consider opportunities to expand Medicaid coverage of harm reduction services provided in both traditional health care

settings as well as community-based harm reduction programs. Medicaid currently covers common harm reduction services like naloxone distribution and infectious disease testing.<sup>16,17</sup> However, it does not cover sterile syringe distribution,<sup>18</sup> fentanyl test strips, or overdose prevention education — all of which are critical to providing an effective and comprehensive harm reduction suite of services. States should consider opportunities to amend state plans and/or pursue federal 1115 waiver opportunities aimed at expanding access to all coverable harm reduction services. In addition to the clear evidence base for improved patient outcomes via harm reduction services, states should consider making the cost-savings case to managed care plans to encourage the inclusion of harm reduction services in managed care benefit offerings.

**□ Are existing harm reduction programs equipped to bill Medicaid for allowable services?**

Harm reduction services across the country are commonly provided through community-based organizations outside of health systems, relating to legal barriers, logistical challenges, differing perspectives between the harm reduction model and the established medical model, etc.<sup>19</sup> These community-based providers have operated in the shadows for decades, with little funding, and in the face of significant stigmatization. Therefore, opportunities to build infrastructure have been scarce and few harm reduction provider organizations are approved Medicaid providers with adequate billing capacity. States can consider providing support to community-based harm reduction providers to develop the infrastructure necessary to bill Medicaid for allowable services, including providing technical assistance (TA) and guidance to programs that may have concerns regarding patient data collection requirements. States can assess opportunities to relax data collection requirements where possible and work closely with harm reduction partners to develop data collection processes that are informed by people who utilize these services.

**2. Assess the policy landscape for expanding harm reduction services.**

**□ Are any existing state laws or regulations creating barriers to expanding harm reduction services?**

There is demonstrated evidence to support investment in lifesaving harm reduction services.<sup>20,21,22</sup> Despite this, some state laws and regulations can impede the development and uptake of these services. For example, although fentanyl test strips have been shown to positively change the behavior of people who use drugs, as of August 2022, it was considered a crime to possess



this drug-checking equipment in 21 states.<sup>23</sup> Further, due to the stigma around harm reduction and people who use drugs, certain state laws and regulations place highly restrictive requirements on the entities interested in developing and/or expanding harm reduction services and where those service are allowed to operate. States should review laws and regulations that directly control syringe services, which in some states have not been revisited for over 30 years.<sup>24</sup> States should also assess zoning and land use laws as they have been used to significantly limit where harm reduction services can operate — often restricting programs to locations that are not accessible to people in need of services. Once states establish clarity on the policy and regulatory landscape, they can identify opportunities to create a more favorable regulatory environment for promoting access to harm reduction programs, in partnership with harm reduction advocates and people with lived experience who can play a critical role in policy reform efforts.

### 3. Ramp up emerging and innovative, evidence-informed harm reduction programs.

- ❑ **Are flexible funds being directed toward harm reduction services that show promising evidence, but are not yet fully authorized under Medicaid or being provided at scale?**



Given the scope of the overdose crisis, there is an urgent need to accelerate the scaling of innovative harm reduction services since evidence is growing in real-time. Certain flexible funds, present opportunities to make immediate investment in these services, such as federal grant programs (including SAMHSA’s State Opioid Response (SOR) grant), which allow for the purchase of rapid fentanyl test strips.<sup>25</sup> Opioid settlement funds also present opportunities for investments in harm reduction. For example, **Rhode Island** is allocating a nearly \$2 million investment from opioid settlement funds, along with other grant funds, to operate harm reduction centers, specifically overdose prevention centers (sometimes called safe/supervised-consumption sites), scheduled to open in 2024.<sup>26,27</sup> The sites will provide staff trained in monitoring drug consumption, responding to overdose, distribution of safer drug supplies, counseling and linkages to wrap-around supports in the community.<sup>28</sup> While only a small number of these sites exist in the U.S., due to issues of legality, promising evidence is emerging from countries like Canada and Australia indicating these sites can significantly reduce overdose and increase access to SUD treatment programs without increasing crime or drug-related public nuisance.<sup>29</sup>

**□ Is the state partnering with people with lived experience with SUD and investing in community coalitions?**

The harm reduction movement in the United States has been a grassroots effort, inextricably linked to the HIV/AIDS epidemic.<sup>30</sup> One of the core tenets of the harm reduction philosophy is the autonomy of people who use drugs. Harm reduction prioritizes the genuine engagement of people with lived experience in decisions on services and funding. Therefore, it is critical that states engage and partner with people with lived experience in their harm reduction expansion efforts. Given the severity of the overdose crisis, community harm reduction coalitions have emerged in many states. Bringing people with lived experience to the table in harm reduction expansion efforts ensures that state leaders hear first-hand the issues experienced by, and serve the needs of, people who use drugs. This approach has the potential to increase the likelihood of success for harm reduction expansion efforts and may serve as a key driver of increased health equity. Partnering with community coalitions is often an effective strategy to increase community buy-in, decrease stigma, and develop a broader coalition to address policy barriers to expansion.

For example, the [Coalition for Overdose Prevention & Education](#) is made up of diverse public and private community partners in El Dorado County, **California**, including health systems, health centers, law enforcement, the local health department, the high school district, community-based organizations, etc. They meet quarterly with the shared goal of reducing opioid addiction and overdose deaths and their collaborative efforts have led to a decline in opioid prescriptions and increases in the availability of MOUD and naloxone in the county.<sup>31</sup>

**4. Use public health data to address disparities through harm reduction.**

**□ Is the state using public health data to identify disparities and target resources appropriately?**

Due to the consistently worsening overdose epidemic, as well as the COVID-19 pandemic, states have strengthened their public health data collection systems and have begun to better identify disparities and tailor interventions appropriately. The interagency workgroup could consider conducting a harm reduction needs assessment, including relevant gap analysis, to determine how many additional harm reduction programs are needed in their state to provide adequate geographical coverage.

State and local public health departments are increasingly tracking overdose “hot spots” where most overdoses typically occur and are increasing the provision of



community-based harm reduction services in those areas. Some communities, like Baltimore, **Maryland**, are partnering with their local health department to identify unexpected drug-related overdose spikes in specific areas and sending targeted SMS/text alerts (“Bad Batch Alerts”). These texts provide recipients with timely information, allowing for opportunities to take additional measures to prevent overdose, such as obtaining naloxone or drug checking equipment.<sup>32</sup>

Further, through data analysis states have identified racial and ethnic groups disproportionately impacted by the overdose crisis and have tailored harm reduction services to address disparities and increase health equity. For example, **New Jersey** recently analyzed crisis system data to strengthen access to harm reduction services for Black residents of the state, who experience the highest overdose mortality rate of any racial/ethnic group in the state.<sup>33</sup> The data examined instances where emergency medical service providers or law enforcement administered naloxone to a person with a suspected opioid overdose.<sup>34</sup> Looking at a two-year period, they found 30 specific locations where over nine of these incidents occurred and determined four key location types: transportation hubs, correctional facilities, hotels/motels, and apartment complexes.<sup>35</sup> The New Jersey Health Department is deploying resources, including outreach workers, to frequent overdose locations, with an emphasis on areas with the highest overdose rate and highest disparities among Black residents.<sup>36</sup>

## Conclusion

This checklist serves as an initial resource and encourages states to explore four key areas related to harm reduction expansion efforts including: (1) assessing public financing for harm reduction services; (2) assessing the policy landscape for expanding harm reduction services; (3) ramping up emerging evidence-informed harm reduction programs; and (4) using public health data to address disparities through harm reduction. By leveraging a multifaceted approach and maximizing available funding sources, states can not only effectively increase access to harm reduction, but also aim for sustainability and equity in building more a more comprehensive SUD treatment system. Additional policy actions and state examples can be found in the [\*State Principles for Financing Substance Use Care, Treatment, and Support Services\*](#) report.



### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit [www.chcs.org](http://www.chcs.org).

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## ENDNOTES

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