

Saving Lives From Overdose During a Pandemic

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Summary of Recommendations

Data & Surveillance

1. Congress should provide funding to support robust data on the overdose crisis in the pandemic. This funding should support additional resources for the Centers for Disease Control and Prevention, additional epidemiologists in state and local health departments, and support for ethnographic field research.
 - The federal government and states should track changes in treatment utilization related to COVID-19.
 - The federal government and states should track changes in access to harm reduction service programs in the pandemic.
 - The federal government and states should track health by race in the dual overdose and viral epidemics.
 - The federal government and states should track COVID-19 among individuals with substance use disorders in the detention system.
2. The National Institutes of Health should increase support research on the overdose epidemic in the pandemic, with a focus on health disparities.

Harm Reduction

3. States and local jurisdictions should declare syringe services programs essential services in the pandemic.
4. States and local jurisdictions should issue emergency orders enabling distribution of harm reduction supplies, including syringes, based on the needs of people who use drugs.
5. Congress should lift the ban that would allow syringe service programs to use federal funding to purchase sterile syringes to promote evidence-based practice.
6. States and local health departments should provide harm reduction programs, including syringe service programs, with sufficient personal protective equipment.
7. States should expand distribution of free naloxone at community sites, including harm reduction programs, treatment facilities, and pharmacies.

Treatment

8. Congress should provide additional funding to support The Substance Abuse and Mental Health Services Administration and states, specifically for substance use disorder, with flexibility to support COVID-19 services for patients.
9. The Drug Enforcement Administration and SAMHSA should allow for telehealth initiation of methadone.

10. States should eliminate regulations on telehealth, and methadone and buprenorphine regulation that are more restrictive than federal guidelines.
11. All public and private payers should allow providers to bill for telephonic visits.
12. All public and private payers should eliminate cost sharing and unnecessary utilization management for buprenorphine and methadone for treatment of opioid use disorder.
13. The DEA should allow community pharmacies to dispense methadone for the treatment of opioid use disorder.
14. SAMHSA should fund mobile treatment services to reach vulnerable patient populations who are unable to engage in telehealth.
15. State and local health authorities should acquire and distribute personal protective equipment to opioid treatment programs, residential treatment centers, and other programs that must continue in-person visits.

Special Considerations

16. State and local health authorities should work with community-based treatment and outreach programs for vaccine distribution to individuals at high risk of COVID-19.
17. States should release and avoid detaining people in jails and prisons who were arrested for low-level, nonviolent drug offenses.
18. States and local jurisdictions should rapidly fund reentry support for detention facilities.
19. States should enable immediate Medicaid coverage upon release.
20. States and local authorities should prioritize the use of emergency funds to establish emergency housing.

Introduction

The COVID-19 pandemic — responsible already for more than 16 million infections and 300,000 deaths in the United States¹—arrives at a time that the nation is still battling another crisis: the rising rates of fatal overdose from opioids and other drugs. Drug-related deaths have skyrocketed in the past few decades to levels that are four times greater than in the 1990s.² Unintentional injuries—which include overdose deaths—are now the third leading cause of death in the country.³

The COVID-19 pandemic has the potential to make the overdose crisis worse. Even before the pandemic began, only a minority of people with opioid use disorder (OUD) received evidence-based treatment with medications,⁴ and many people who use drugs struggled to get access to lifesaving harm reduction services like syringe service programs.⁵ Early reports show that states are already cutting budgets for these critical substance use services as attention is turned to combatting the COVID-19 pandemic.⁶ However, with the recent economic downturn, even more people may be in need of harm reduction, treatment, and other substance use resources than before. Historically high unemployment rates and preventative physical distancing measures have also exacerbated social isolation and despair, known risk factors for substance use disorders.⁷ Many models indicate that COVID-19 will cause increases in suicides, substance use, and overdose deaths.^{8,9,10}

Indeed, preliminary data show increases in both fatal and nonfatal overdoses in many cities and states.^{11,12,13} There was an increase of 35% in opioid-related overdose in Arizona in March 2020 compared to March 2019.¹⁴ North Carolina is estimating a 15% increase in overdose-related emergency department visits since the beginning of the pandemic.¹⁵ Without additional attention to the preexisting overdose crisis, the loss of life of COVID-19 and its impact on vulnerable populations of people who use drugs will be immense.^{16,17,18}

The COVID-19 and overdose crises both reflect the crucial importance of addressing structural determinants of health. Both crises have had a disproportionate impact on racial and ethnic minority populations due to factors like racism and poverty. Integrating equity in our public health responses to these epidemics will not only have immediate benefits amidst our national crisis but also will transform health outcomes for years to come.

The intersecting COVID-19 and overdose crises demand urgent public health action. This paper offers a series of recommendations to policymakers for immediate action in the areas of funding, data and surveillance, harm reduction, and treatment, and for special populations to ensure equitable response to the overdose epidemic in an era of COVID-19.

Data and Surveillance

To respond to COVID-19, many health departments reassigned staff and tools to track the new threat, leaving gaps in their ability to create a complete picture of the consequences of COVID-19 and the overdose epidemic. While various tracking systems exist for the COVID-19 epidemic, the existing public health data infrastructure is lacking, and robust dual surveillance is necessary to understand the impact of COVID-19 outcomes with other key health issues. Specifically, in the overdose crisis, morbidity and mortality are poorly reported, and data can take months to years to be fully analyzed. To build capacity to monitor the dual crises of COVID-19 and the overdose epidemic:

- 1. Congress should provide funding to support robust data on the overdose crisis in the pandemic. This funding should support additional resources for the Centers for Disease Control and Prevention, additional epidemiologists in state and local health departments, and support for ethnographic field research.**

Despite the long-standing opioid crisis, many state epidemiologic departments remain understaffed,¹⁹ especially in the fields of mental health and substance use. Having insufficient personnel with the expertise and time to closely monitor trends results in a lag in data analysis and the potential for poorly informed interventions. This is especially important as the public health community has yet to fully understand the intersections of the COVID-19 pandemic with mental health and substance use. States should prioritize the creation of data management systems to automate the assembly of drug-related data to provide timely analysis and sharing.

Specifically:

The federal government and states should track changes in treatment utilization related to COVID-19.

The COVID-19 pandemic has motivated important federal policy changes designed to increase access to medications for opioid use disorder. For example, emergency regulations for telemedicine initiation of buprenorphine may have reduced barriers to access. States should use claims and other administrative data to examine how these improvements influenced the use of services at all levels of care, with a particular focus on medications and telemedicine. These data can show direct outcomes of policy changes and should be shared with the federal government and the public. Utilizing evidence from these data can inform regulation to sustain positive impacts and address disparities in access.

The federal government and states should track changes in access to harm reduction service programs in the pandemic.

Changing regulations to comply with physical distancing orders have increased the risk of fatal overdose for many due to disruptions to syringe service programs' capacity to provide services, access to safe drug supply chains, and typical harm-reducing practices (e.g., not using alone). To understand new risks and challenges introduced by COVID-19, governmental agencies can partner with public health researchers to gather information from people who use drugs through harm reduction service providers, street-based outreach, and mail-order naloxone programs. Tracking these data assists in identifying key evidence-based practices needed to save lives.

The federal government and states should track health by race in the dual overdose and viral epidemics.

Several risks collide and are amplified during the COVID-19 pandemic for people of color. People of color are already inequitably impacted by racist and systemic injustices and now face additional risk as racial disparities in the mortality rates for COVID-19 emerge.²⁰ States commonly examine outcomes by age and gender, but often neglect race/ethnicity as an important demographic exacerbating structural inequities that have contributed to disproportionate rates of overdose deaths, lack of access to substance use treatment, and, now, increased risk of contracting, being hospitalized, and dying of COVID-19 within communities of color.²¹ Monitoring data by race allows public officials to identify gaps and assumptions in access, and ensure that the needs of all of their constituents are met and resources are equitably distributed.

The federal government and states should track COVID-19 among individuals with substance use disorders in the detention system.

More than half of all incarcerated individuals are estimated to have a substance use disorder.²² As long as drug use is criminalized, our jails and prisons will house many of those most impacted by the overdose crisis. Jails and prisons are an especially high-risk setting for the rapid transmission of COVID-19 within an already medically vulnerable population, so it is imperative that these facilities have rigorous procedures to surveil COVID-19.^{23,24} Federal, state, and local health departments should require frequent testing and transparent reporting on COVID-19 cases among staff and incarcerated persons from all detention facilities. They should establish independent oversight of these procedures within facilities,²⁵ and all data should be made available to the public. The U.S. Department of

Health and Human Services should consider providing additional grants to jails and prisons to enable and support testing and reporting.

2. The National Institutes of Health should increase support research on the overdose epidemic in the pandemic, with a focus on health disparities.

Given the novelty and the historical importance of the current time, the skills of researchers are particularly needed to bring light to the uncertainty of the future. The pandemic continues to expose structural inequities that perpetuate health disparities. Communities of color historically experience health inequities and that continues to be true with COVID-19. Funding to support academic partnerships with governmental agencies, with a requirement to examine racial disparities, can illuminate the causes of health disparities and, therefore, inform equitable and culturally aware solutions to the current overdose crisis.

Harm Reduction

Harm reduction organizations are often the first point of contact for difficult-to-reach populations of people who use drugs by building rapport and providing lifesaving services, including naloxone distribution, access to sterile injection and other drug use equipment, and drug treatment referrals. People providing harm reduction services are also often trusted community members who would be well-suited to provide information to people who use drugs about COVID-19.

Early data already shows that existing harm reduction organizations are facing decreased staff capacity and an inability to ensure staff safety due to personal protective equipment (PPE) shortages.²⁶ Many have closed or suspended service when they are unable to address these challenges. During the pandemic, states and localities should ensure that these lifesaving services continue and are delivered in a way that protects both service providers and clients.

3. States and local jurisdictions should declare syringe service programs essential services in the pandemic.

Syringe service programs are an evidence-based, lifesaving service for people who inject drugs. As of 2019, syringe exchange programs were illegal in 12 states, and another 9 states have local restrictions prohibiting the operation of syringe service programs.²⁷ The CDC considers syringe service programs essential public health services and has recommended that state and local jurisdictions support syringe service programs to continue operations during COVID-19.²⁸ States should align policy with the CDC and ensure that syringe service programs are able to operate in all of their local jurisdictions. This may require eliminating legal obstacles at the state and local level.

4. States and local jurisdictions should issue emergency orders enabling distribution of harm reduction supplies, including syringes, based on the needs of people who use drugs.

To reduce the risk of COVID-19 exposure for both staff and clients, many syringe service programs are decreasing the frequency of outreach and reducing the amount of time spent during individual client visits. To maintain a sufficient supply of harm reduction materials in the community, it is essential to increase the number of supplies distributed during a single visit,²⁹ a best practice that many organizations are already implementing.³⁰ Unfortunately, other organizations are limited by statutes and regulations that restrict the numbers of supplies distributed. For example, some localities have implicit or explicit “one-to-one” syringe exchange rules that require clients to produce one used syringe to exchange for

each sterile one. In the context of less frequent service provision, this restriction poses excessive risk to this vulnerable community. Organizations should also make naloxone available or encourage the use of mail-order naloxone services.

States and local jurisdictions should also enable harm reduction programs to follow other best practices for syringe service programs, such as eliminating unnecessary data collection and anonymizing data.³¹

5. Congress should lift the ban that would allow syringe service programs to use federal funding to purchase sterile syringes to promote evidence-based practice.

The Consolidated Appropriations Act of 2018 allows the use of funds from the Department of Health and Human Services to support the operation of syringe service programs. However, federal funds for these programs is limited and cannot be used to purchase syringes. Given this policy, many harm reduction programs must find alternate funding sources in order to purchase syringes. Many rely on philanthropic donations to replenish supplies, which may not be a sustainable source of funding given the current economic climate. Without additional funding, harm reduction programs may soon be faced with dwindling supplies and additional financial resources are needed to ensure program sustainability.

6. States and local health departments should provide harm reduction programs, including syringe service programs, with sufficient personal protective equipment.

According to a recent national survey of syringe service programs, at least 25% of syringe service programs reported closing sites and almost double reported decreased availability of services.³² The inability of syringe service programs to provide PPE to their staff is a key factor driving decreases in service provision—unlike larger medical and public health institutions, community-based syringe service programs may not have the resources to acquire PPE on their own. Since syringe service programs provide essential, lifesaving services to people who use drugs, including linkage to treatment, state and local health departments should direct PPE to these organizations.³³ These efforts should include both syringe service programs that receive explicit support from public health departments and those that are independent so that they can continue to provide services during the pandemic.

7. States should expand distribution of free naloxone at community sites, including harm reduction programs, treatment facilities, and pharmacies.

Increasing mental health distress because of social isolation and economic insecurity, a potential lack of predictability in drug supply, and increased allowances for take-home methadone may increase the risk of overdose during the COVID crisis. Many jurisdictions are already reporting increases in overdose deaths during COVID-19.³⁴ Naloxone is an opioid antagonist that can reverse overdose and save lives, but its rising³⁵ price over the past few years is a barrier to patients with OUD. To eliminate this barrier, all states should purchase naloxone and distribute it to community sites, including treatment facilities and harm reduction programs. All states authorities should follow the example led by the state of Michigan, and their partnership with nationwide programs, like NEXT Naloxone,³⁶ to promote free mail-order naloxone programs. Pharmaceutical companies should also take action to reduce naloxone prices. Finally, the FDA and companies should complete the process of making naloxone an over-the-counter medication.

Treatment

During the pandemic, it is critical to maintain and expand access to lifesaving substance use treatments including opioid agonist medication treatment for opioid use disorder. Economic strain compounded by the pandemic's impact on unemployment and loss of insurance may also limit the ability of people with OUD to access lifesaving treatment. The anchors of effective treatment are medications, especially the opioid agonists methadone and buprenorphine.³⁷ People are at higher risk of relapse and death without the access to these medications.³⁸

People in treatment for opioid use disorder are likely to be at high risk for serious illness from COVID-19, as a result of other chronic illnesses including diabetes and lung disease. For many vulnerable patients, substance use treatment services may be the only point of access to care, making it even more important that these organizations act as a critical access point to educational resources, and testing and vaccination for COVID-19.

The federal government has taken several actions to enhance access to substance use treatment on an urgent basis. These include regulatory changes issued by the DEA and SAMHSA allowing for telehealth initiation of buprenorphine and flexibility with methadone dispensation, including permitting non-healthcare workers to deliver methadone to patients at home in lockboxes. However, with overdoses on the rise, more can be done.

8. Congress should provide additional funding to support The Substance Abuse and Mental Health Services Administration and states, specifically for substance use disorder, with flexibility to support COVID-19 services for patients.

In 2016, Congress authorized \$181 million each year for states and localities to address the opioid crisis in the CARRA Act. These funds were largely used for prevention and education efforts and treatment expansions. The COVID-19 crisis has placed these gains in jeopardy as physical distancing regulations may decrease providers' ability to maintain services or meet the increased demand for services.

The Coronavirus Aid, Relief and Economic Security Act, or CARES Act (H.R. 748), allocated \$425 million to SAMHSA for mental health and substance use disorder assistance in the pandemic. Specifically, \$250 million has been assigned to address access to mental health services and \$100 million of emergency grants will act as flexible funding to provide support for those suffering from mental health conditions, substance use disorders, and homelessness. Without additional and continued congressional support, many substance

use treatment organizations are at risk of closing due to COVID-19, thus jeopardizing their ability to provide lifesaving care to individuals in their communities. When negotiating stimulus money and 2021 fiscal year budgets, Congress should maintain, and ideally increase, additional funding to SAMHSA and states to effectively respond to COVID-19 and allocate additional funds to account for the increased need for substance use services during this time. These funds should also be available to support critical COVID-19 services, such as testing and vaccination, as appropriate at treatment sites.

9. The Drug Enforcement Administration and SAMHSA should allow for telehealth initiation of methadone.

Currently, accessing methadone treatment requires patients to receive a screening assessment and diagnosis confirmation via an in-person visit with a provider. However, these in-person visits increase many patients' possible exposure to COVID-19 when entering treatment facilities and spending time in waiting rooms. This is an unnecessary risk to patients when alternative options are available through telehealth. Federal agencies have taken important steps in allowing telehealth initiation of buprenorphine, and they should further expand access by allowing telehealth initiation of methadone. Methadone is a safe and effective treatment for OUD and is available in outpatient settings in many countries.³⁹ Physician leaders across the country are already calling for this change.⁴⁰ The Drug Enforcement Administration and SAMHSA should allow for telehealth initiation of methadone.

10. States should eliminate regulations on telehealth and on methadone and buprenorphine that are more restrictive than federal guidelines.

Even where federal rules now permit flexibility in telehealth treatment of opioid use disorders, state-level restrictions may still be in place. States should eliminate restrictive requirements, specifically those that limit access to or billing for telemedicine, limit telehealth initiation of buprenorphine or methadone, or impose challenging constraints on medication provision, such as behavioral health counseling.⁴¹ States should also promote and facilitate telehealth access. When federal regulations were relaxed, Tennessee began permitting telephonic visits in lieu of office visits for weekly, biweekly, and monthly office visits with a physician, case manager, or counselor.

11. All public and private payers should allow providers to bill for telephonic visits.

Currently, many payers, including Medicare via the 1135 waiver, require telehealth visits to incorporate video for reimbursement, especially for new patients initiating treatment. However, low-income patients often do not have smartphones with data plans, thus limiting their ability to utilize audiovisual technology required to access telemedicine. All payers should instead allow providers to bill for telephonic health visits for new and established patients. Additionally, reimbursement rates should be adequate so as to encourage this modality of delivering services.

12. All public and private payers should eliminate cost sharing and unnecessary utilization management for buprenorphine and methadone for treatment of opioid use disorder.

Ensuring the affordability of medications for opioid use disorder is critical. Even before the pandemic, only a minority of patients who might benefit from medications had access to them—now, the rising unemployment rate and economic security in the context of the pandemic threaten the ability for people who were already on medications to continue them. Payers should eliminate cost sharing to lower thresholds to accessing this lifesaving medication. Additionally, payers should eliminate utilization management techniques that unnecessarily delay access to medications, such as prior authorization.

13. The DEA should allow community pharmacies to dispense methadone for the treatment of opioid use disorder.

Due to OTP regulations under 42 C.F.R. § 8.12(h)(1), methadone can only be dispensed at "opioid treatment programs." Recent regulatory changes related to COVID-19 have allowed Opioid Treatment Programs to engage non-health care personnel, including staff members, National Guard personnel, or law enforcement officers to deliver methadone to lockboxes in patients' homes. However, Opioid Treatment Programs may lack the resources to facilitate these deliveries: the time to establish a chain of custody, the staff to make deliveries, and funds used to purchase lockboxes for patients may be meaningfully spent elsewhere. Additional regulation change allowing pharmacy dispensation of methadone, as is done in many other countries,⁴² would permit treatment facilities and health departments to refocus important energies elsewhere. Making methadone more accessible has the potential to have a long-lasting impact even after the pandemic passes.

14. SAMHSA should fund mobile treatment services to reach vulnerable patient populations who are unable to engage in telehealth.

Although telehealth has been used to expand access to services during the pandemic, many vulnerable patients—such as those living in poverty or experiencing homelessness—lack the resources to engage in telemedicine. It is crucial to quickly establish and fund flexible models of patient outreach, including mobile access to treatment, to reach these patients. SAMHSA should allocate funds to assist providers in expanding to mobile services. Some Opioid Treatment Programs and harm reduction providers have already purchased mobile units to provide acute medical services and provide prescriptions for buprenorphine, and many are awaiting approval to begin operations for mobile methadone. To support these efforts, the DEA should also quickly approve proposed guidance on mobile methadone programs.

15. State and local health authorities should acquire and distribute personal protective equipment to opioid treatment programs, residential treatment centers, and other programs that must continue in-person visits.

It is essential that treatment providers who must continue in-person visits, like those working at Opioid Treatment Programs, have access to adequate PPE in order to protect themselves and minimize risk to their patient population. The treatment services offered by these providers are essential and lifesaving, and some institutions may not have the resources to obtain PPE on their own. Additionally, some facilities, such as residential treatment facilities, may require additional guidance from public health departments on ensuring adequate safety and isolation protocols for their long-term residents in order to adhere to basic public health guidelines.

Special Considerations

Vaccination of Critical Populations

The U.S. Food and Drug Administration approved the first COVID-19 vaccine which is now being administered to front line workers. The CDC emphasizes outreach to critical populations⁴³ as a core component of COVID-19 vaccination programs. Many of these critical populations, including people with underlying medical conditions, people who are incarcerated, people experiencing homelessness, and people with limited access to routine vaccinations,⁴⁴ often overlap with communities of people who use drugs. Public health leaders responsible for drafting and managing vaccine distribution programs should take into account the special needs of this population.

16. State and local health authorities should work with community-based treatment and outreach programs for vaccine distribution to individuals at high risk of COVID-19.

In previous research studies, people who use drugs report negative experiences at traditional health care settings due to feelings of stigmatization and fear of criminal justice involvement.⁴⁵ To access this critical population, vaccine distribution plans should not solely rely on traditional health care settings, but should include community-based treatment programs and outreach services, such as harm reduction programs and homeless service providers. States and localities should provide the necessary support to community organizations to store and administer the vaccine, and adhere to federal/central state tracking guidelines.

Public health departments should engage these providers and recipients of these services when planning distribution to local communities. For example, by including them in vaccine distribution planning committees to ensure that outreach efforts address the unique barriers for people who use drugs. Resources should be provided to increase capacity of these community-based programs to support all of their clients in returning for their second dose.

Community-based organizations and community-based health workers can play an important role in increasing public trust, particularly with vulnerable groups. Resources should be allocated to facilitate partnerships with trusted sources within communities. States should ensure that the vaccination be provided for at no cost to these populations. They should work with community-based organizations to reduce barriers that may prevent individuals from accessing the vaccine.

Criminal Justice

COVID-19 has begun to clearly expose how structural forces like racism and poverty impact vulnerability to poor health outcomes. Racism and poverty also impact outcomes for OUD. People with OUD—especially racial minorities—are disproportionately represented in the criminal justice system due to the criminalization of substance use disorders. Jails and prisons, with their close quarters and poor health care provision, present a high risk of COVID-19 transmission. Exposure to criminal justice settings also increases the risk of overdose.

As a result, decreasing the prison and jail population during COVID-19 not only will reduce the risk of outbreaks but it will also promote racial equity. Federal and state authorities should act urgently to reduce the number of people who are incarcerated and should ensure that those exiting detention have the support they need—such as insurance and other reentry services—to support a safe transition into the community.

17. States should release and avoid detaining people in jails and prisons who were arrested for low-level, nonviolent drug offenses.

Close quarters make transmission of a viral respiratory illness almost inevitable, and detention facilities are not adequately staffed to care for detainees with COVID-19—many of whom likely have comorbidities and will require more sophisticated care. To help this population that is medically vulnerable to the pandemic, states can decrease the number of people in detention by stopping the influx of those arrested for low-level, nonviolent drug-related offenses and facilitating the release of such individuals from jail and prisons.

Actions to reduce the number of people entering detention include, but are not limited to, the following: police immediately ceasing arrests for low-level, nonviolent drug offenses, prosecutors declining to prosecute and/or dismissing low-level, nonviolent drug offenses and eliminating requests for pre-trial detention in such cases, and vacating fines and fees so that people are not at risk of detention for nonpayment.

To expedite release for individuals who are currently detained, probation and parole boards should expand release opportunities for people incarcerated for low-level, nonviolent drug offenses and governors can grant immediate commutations to low-risk detainees, identified by the CDC as particularly vulnerable.⁴⁶ States and localities can also scale up diversion efforts to complement these changes.⁴⁷

18. States and local jurisdictions should rapidly fund reentry support for detention facilities.

People with OUD have a high risk of overdose and mortality in the time immediately after release. As many prisons and jails are releasing individuals due to COVID-19, decarceration should be paired with aggressive steps to ensure that people are rapidly linked to care to not only reduce the risk of overdose but also support individuals during a time of global crisis. Additionally, reentry support reduces the risk of reincarceration,⁴⁸ which, given the recent community exposures of those entering detention facilities, would reduce the effect of COVID-19 on those already in custody.

Reentry services provide those who have been recently released with assistance in accessing much-needed services like insurance coverage, housing, immediate access to naloxone upon release, and warm handoffs to providers who offer medication for OUD in the community to mitigate this risk and support a successful transition of those who began or were continuing MOUD while incarcerated.

It will be difficult for jails and prisons to independently link recently released individuals to all of these services. Therefore, state and local health departments should engage with local reentry coalitions, organizations, and medical vendors to provide funding support for the hiring and training of more reentry counselors and deploy them to correctional facilities in order to support people who have been recently released as they transition to the community.

19. States should enable immediate Medicaid coverage upon release.

Access to insurance increases health care utilization, including substance use treatment,⁴⁹ and the Centers for Medicare and Medicaid Services recommends that states not terminate coverage while someone is incarcerated. However, many states have not expanded Medicaid to childless adults, and eight states still require Medicaid termination when a person enters detention.⁵⁰ To maximize access to treatment, remaining states should implement the Medicaid expansion, and states that terminate Medicaid upon incarceration should consider implementing Medicaid suspension and rapid reactivation instead.

States should review reactivation policies and data systems to ensure that they are streamlined and rapid. States that are already suspending Medicaid can consider implementing waiting periods before suspension so that people who are detained for very short periods of time experience no interruptions in coverage (Arizona waits 24 hours before

suspending and Connecticut waits 60 days). States should work with reentry counselors and other jail and prison staff to ensure that their policies and procedures enable assistance for those in filing for Medicaid coverage prior to release in order to support immediate coverage upon release. This is critically important to allow individuals immediate access to substance use treatment but also medical care due to the COVID-19 pandemic.

Housing

People who have recently been released from detention and people who use drugs are more likely to experience homelessness than the general population.⁵¹ Experiencing homelessness and poverty also increases risk of contracting COVID-19, as individuals may have underlying health conditions that increase vulnerability to contracting respiratory illnesses and they may not be able to afford sanitizing supplies or masks. Furthermore, traditional congregate housing provides little opportunity to properly social distance or self-quarantine to prevent spread. In attempts to comply with appropriate social distancing measures, shelters have had to reduce bed capacity, forcing many back out onto the streets, increasing the risks of both overdose and spread of COVID-19. Just as it is possible to increase these risks through inadequate housing, it is possible to address them both through expanded access to housing.

20. States and local authorities should prioritize the use of emergency funds to establish emergency housing.

Some states and local governments are already taking advantage of emergency funds to establish emergency COVID-19 shelters and house individuals in vacant hotel or motel rooms. However, some authorities have excluded people who use drugs from accessing these emergency housing services because they are actively using or have a criminal background. Being excluded from these emergency services leaves this population without a safe place to comply with shelter-in-place orders and other public health mandates. Emergency housing opportunities can also serve as a point of entry to provide people who use drugs access to harm reduction supplies, behavioral health services, access to treatment, and pathways to other support services. States and local authorities should include provisions to ensure that people who use drugs are not limited in access to emergency housing using a housing-first approach.

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