CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

Addressing Opioid Use Disorder in Older Adults

Gaps, Challenges, and Solutions

Patience Moyo Dow & Francesca Beaudoin

Testimony of Patience Moyo Dow and Francesca Beaudoin submitted to the United States Senate Special Committee on Aging on opioid use disorder in older adults on March 5, 2025

The opinions expressed herein are their own and do not necessarily reflect the views or positions of Brown University or their funders.

Addressing Opioid Use Disorder in Older Adults: Gaps, Challenges, and Solutions

Testimony of Patience Moyo Dow and Francesca Beaduoin
Center for Advancing Health Policy through Research (CAHPR)
Brown University School of Public Health

Submitted to the Special Committee on Aging
United States Senate
March 5, 2025

When it comes to addiction related to opioids, American seniors are facing a one-two punch – an increasing burden of this chronic disease and multiple barriers to obtaining optimal treatment. Recent years have seen a multi-pronged effort to address the overdose crisis and surge of fentanyl at both the state and federal level, but these strategies have not focused on a particularly vulnerable part of our population. Opioid use disorder (OUD) affects approximately 1 million of U.S. adults ages 65 and older, hereafter referred to as older adults.[1] Although rates of OUD are generally lower among older adults than among younger people, the past decade has seen a steady rise in the number of older adults affected. The rate of OUD among older adults tripled from 4.6 to 15.7 cases per 1,000 Medicare fee-for-service beneficiaries between 2013 and 2018,[2] whereas drug overdose mortality rates quadrupled from 3.0 to 12.0 per 100,000 population from 2002 to 2021 among all U.S. older adults.[3] Several factors have contributed to increases in OUD rates among older adults. These

[1] Konakanchi, J. S., & Sethi, R. (2023). The Growing Epidemic of Opioid Use Disorder in the Elderly and Its Treatment: A Review of the Literature. *The Primary Care Companion for CNS Disorders*, *25*(1), 44998. https://doi.org/10.4088/PCC.21r03223

[2] Shoff, C., Yang, T. C., & Shaw, B. A. (2021). Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013-2018. *American Journal of Preventive Medicine*, *60*(6), 850–855. https://doi.org/10.1016/j.amepre.2021.01.010

[3] Humphreys, K., & Shover, C. L. (2023). Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US. *JAMA Psychiatry*, *80*(5), 518–520. https://doi.org/10.1001/jamapsychiatry.2022.5159

include the aging of the "baby boomer generation" - born between 1946 and 1964 - which has historically high rates of substance use than previous generations of older adults,[4,5] high burden of chronic pain and increased likelihood of being prescribed opioids,[6,7] and greater attention to screening and diagnosing OUD in older adults which was previously overlooked.[8,9] Limited access to Food and Drug Administration (FDA)-approved medications to treat OUD (MOUD) in Medicare is another potential contributor to rising OUD-related morbidity and mortality among older adults.[10] To help inform the committee about challenges and potential solutions for addressing OUD in older adults, we are offering insights from relevant research and clinical experience.

Our comments reflect our collective expertise in addiction health services and policy research, epidemiology, and clinical practice. We share clinical vignettes to highlight particular problems and we draw on research studies that employed various methods including (1) evidence synthesis of the literature on preventing, diagnosing, and managing OUD in older adults, (2) claims-based analyses of Medicare data to quantify OUD-related acute and post-acute care use,[11,12] and (3) qualitative inquiry to understand barriers and facilitators to admission and access to MOUD in skilled nursing facilities (SNFs).[13,14] We make three main points:

---

[4] Gfroerer, J., Penne, M., Pemberton, M., & Folsom, R. (2003). Substance abuse treatment need among older adults in 2020: the impact of the aging baby-boom cohort. *Drug and Alcohol Dependence*, *69*(2), 127–135. https://doi.org/10.1016/s0376-8716(02)00307-1

[5] Lehmann, S. W., & Fingerhood, M. (2018). Substance-Use Disorders in Later Life. *New England Journal of Medicine*, *379*(24), 2351–2360. https://doi.org/10.1056/nejmra1805981

[6] Nawai A. (2019). Chronic Pain Management Among Older Adults: A Scoping Review. *SAGE Open Nursing*, *5*, 2377960819874259. https://doi.org/10.1177/2377960819874259

[7] Potru, S., & Tang, Y. L. (2021). Chronic Pain, Opioid Use Disorder, and Clinical Management Among Older Adults. *Focus (American Psychiatric Publishing)*, *19*(3), 294–302. https://doi.org/10.1176/appi.focus.20210002

[8] Zullo AR, Danko KJ, Moyo P, Adam GP, Riester M, Kimmel HJ, Panagiotou OA, Beaudoin FL, Carr D, Balk EM. (2020). Prevention, Diagnosis, and Management of Opioids, Opioid Misuse, and Opioid Use Disorder in Older Adults. Technical Brief No. 37. (Prepared by the Brown Evidence-based Practice Center under Contract No. 290-2015-00002-I.) AHRQ Publication No. 21-EHC005. Rockville, MD: Agency for Healthcare Research and Quality. Posted final reports are located on the Effective Health Care Program search page. DOI: 10.23970/AHRQEPCTB37

[9] Duggirala, R., Khushalani, S., Palmer, T., Brandt, N., & Desai, A. (2022). Screening for and Management of Opioid Use Disorder in Older Adults in Primary Care. *Clinics in Geriatric Medicine*, *38*(1), 23–38. https://doi.org/10.1016/j.cger.2021.07.001

[10] Kuo, Y.-F., Westra, J., Harvey, E. P., & Raji, M. A. (2025). Use of Medications for Opioid Use Disorder in Older Adults. *American Journal of Preventive Medicine*. https://doi.org/10.1016/j.amepre.2025.01.019

[11] Moyo, P., Choudry, E., George, M., Zullo, A. R., Ritter, A. Z., & Rahman, M. (2024). Disparities in Access to Highly Rated Skilled Nursing Facilities among Medicare Beneficiaries with Opioid Use Disorder. *Journal of the American Medical Directors Association*, *25*(10), 105190. https://doi.org/10.1016/j.jamda.2024.105190

[12] Moyo, P., Eliot, M., Shah, A., Goodyear, K., Jutkowitz, E., Thomas, K., & Zullo, A. R. (2022). Discharge locations after hospitalizations involving opioid use disorder among medicare beneficiaries. *Addiction Science & Clinical Practice*, *17*(1), 57. https://doi.org/10.1186/s13722-022-00338-x

[13] Moyo, P., Nishar, S., Merrick, C., Streltzov, N., Asiedu, E., Roma, C., Vanjani, R., & Soske, J. (2024). Perspectives on Admissions and Care for Residents With Opioid Use Disorder in Skilled Nursing Facilities. *JAMA Network Open*, *7*(2), e2354746. https://doi.org/10.1001/jamanetworkopen.2023.54746

[14] Nishar, S., Soske, J., Vanjani, R., Kimmel, S. D., Roma, C., & Dow, P. M. (2024). Access and care for people with opioid use disorder in U.S. skilled nursing facilities: A policy commentary. *The International Journal on Drug Policy*, *133*, 104607. https://doi.org/10.1016/j.drugpo.2024.104607

1. Opioid use disorder, opioid-related acute care use, and drug overdose deaths are increasing among U.S. adults ages 65 and over.
2. There is a critical need to address gaps in access to medications for opioid use disorder for older adults including in post-acute and long-term care facilities.
3. There are several opportunities for Congress and the federal government to consider to improve the care and health of older adults with opioid use disorder.

Opioid use disorder, opioid-related acute care use, and drug overdose deaths are increasing among U.S. adults ages 65 and over.

As a practicing emergency physician who now also works in outpatient addiction medicine, I have seen the full impacts of the opioid and overdose epidemic in older adults – from taking care of overdoses in the emergency department (ED) to now helping people access life-saving medical treatment at opioid treatment programs ('methadone clinic'). Older adults with OUD end up coming to the ED for help, not just because they are in crisis, but because they are slipping through the cracks. I remember taking care of a man in his mid-70s in the ED after the family had called 911 after finding him on the floor of his home. The family and EMS had thought they had a stroke, but it turned out that it was actually an opioid overdose and the person regained consciousness and returned to normal after receiving naloxone (the antidote). Not all stories end with a full recovery and when we think of it as a 'young person' problem, we may miss diagnosing and treating a significant number of people. Even when the diagnosis of OUD is made in older adults, there are numerous and unique barriers to accessing care (e.g., location, mobility, whether the methadone clinic accepts Medicare). There is nothing more disheartening than having a patient who is motivated to seek help for their addiction only to have them not be able to get into treatment. (Francesca L. Beaudoin, MD, PhD)

A growing share of older Americans have substance use disorders (SUD) and specifically an OUD and the vast majority of those diagnosed with SUD/OUD are enrolled in Medicare.[2,15] Opioid-related hospitalizations and ED visits and drug overdose mortality are also rising among older adults.[16,17] In our state of Rhode Island, in 2014, 17% of opioid overdose fatalities occurred in people over the age of 55 – by 2024, 36% of all overdose deaths occurred in those over 55.[18]

---

[15] Yarnell, S., Li, L., MacGrory, B., Trevisan, L., & Kirwin, P. (2020). Substance Use Disorders in Later Life: A Review and Synthesis of the Literature of an Emerging Public Health Concern. *The American Journal of Geriatric Psychiatry : Official Journal of the American Association for Geriatric Psychiatry*, *28*(2), 226–236. https://doi.org/10.1016/j.jagp.2019.06.005

[16] Acevedo, A., Rodriguez Borja, I., Alarcon Falconi, T. M., Carzo, N., & Naumova, E. (2022). Hospitalizations for Alcohol and Opioid Use Disorders in Older Adults: Trends, Comorbidities, and Differences by Gender, Race, and Ethnicity. *Substance Abuse : Research and Treatment*, *16*, 11782218221116733. https://doi.org/10.1177/11782218221116733

[17] Carter, M. W., Yang, B. K., Davenport, M., & Kabel, A. (2019). Increasing Rates of Opioid Misuse Among Older Adults Visiting Emergency Departments. *Innovation in Aging*, *3*(1), igz002. https://doi.org/10.1093/geroni/igz002

[18] Rhode Island Department of Health. (2021). *Statewide Count and Percentage: All Drug Involved Fatal Overdose by Age Category and Year*. ArcGIS Hub; Rhode Island Department of Health.

National trends mirror this alarming statistic, drug overdose mortality rates among older adults quadrupled over the past two decades with Non-Hispanic Black men being disproportionately impacted.[3,19] Older adults also have higher rates of chronic pain and other comorbidities (such as COPD) which make living with an OUD, as well as treating an OUD, much more complicated. There is an urgent and unmet need to identify and treat older adults with OUD through new clinical practice and policy interventions, including strategies in SNFs and expanded access to MOUD.

There is a critical need to address gaps in access to medications for opioid use disorder for older adults including in post-acute and long-term care facilities.

SNFs which provide post-acute medical services following hospitalization report receiving more referrals of patients with OUD than any time in the past.[20] Yet, there remain substantial barriers to SNF placement and access to evidence-based OUD treatment in SNFs.[11,13,14] The confluence of the rising demand for post-acute and long-term care services with older age and increasing rates of OUD in older adults underscores the importance of an age-friendly healthcare system that integrates evidence-based geriatric models of care with OUD treatment and recovery support across diverse settings.[21]

Age-friendly health systems are characterized by providing older adults with safe, effective, reliable, and patient-centered care across the care continuum. Such systems are designed to help overcome the unique challenges experienced by older adults in their ability to access and engage with health services. The existing addiction treatment system, influenced by structural ageism and often fragmented from primary care, impedes the ability of older adults to access MOUD.[22] For instance, lack of transportation and mobility limitations related to multiple and complex health conditions could be barriers to seeking and receiving OUD treatment, particularly from opioid treatment programs (OTPs) which often require daily in-person medication dosing. Social isolation which is a risk factor for substance use and related harms

---

https://ridoh-drug-overdose-surveillance-fatalities-rihealth.hub.arcgis.com/datasets/rihealth::statewide-count-and-percentage-all-drug-involved-fatal-overdose-by-age-category-and-year/explore

[19] Kramarow, E. A., & Tejada-Vera, B. (2022). Drug Overdose Deaths in Adults Aged 65 and Over: United States, 2000-2020. *NCHS data brief*, (455), 1–8.

[20] Han, B. H., Tuazon, E., Kunins, H. V., & Paone, D. (2020). Trends in inpatient discharges with drug or alcohol admission diagnoses to a skilled nursing facility among older adults, New York City 2008-2014. *Harm Reduction Journal*, *17*(1), 99. https://doi.org/10.1186/s12954-020-00450-8

[21] Jones, K. F., Beiting, K. J., Ari, M., Lau-Ng, R., Landi, A. J., Kelly, L., Pravodelov, V., & Han, B. H. (2023). Age-friendly care for older adults with substance use disorder. *The Lancet. Healthy longevity*, *4*(10), e531–e532. https://doi.org/10.1016/S2666-7568(23)00174-5

[22] Han, B. H., Moore, A. A., & Levander, X. A. (2022). To Care For Older Adults With Substance Use Disorder, Create Age-Friendly Health Systems. *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20220505.917481

among older adults could also impede treatment engagement.[23,24,25] The lack of data specific to MOUD use and safety in older adults also may contribute to low clinician self-efficacy to initiate and manage MOUD in this population, which could result in older adults having difficulty accessing MOUD prescribers.[26] It is evident that the aging of adults with OUD poses new challenges in medicine and public health and calls for evidence-informed policymaking and practice to address OUD in older adults.

Methadone, buprenorphine, and naltrexone are FDA-approved to treat OUD. While MOUD is effective in treating OUD,[27] historically fewer than 1 in 5 Medicare enrollees with OUD received these medications[28] lagging the rates of MOUD use observed in both private insurance and Medicaid.[29] Methadone and buprenorphine are effective in reducing opioid withdrawal, all-cause mortality, and overdose death,[30,31] and taking these medications at sufficient doses can support treatment retention.[32] However, MOUD receipt is low with one study estimating that 15% of Medicare beneficiaries with OUD received these medications in 2022.[10,19] Treatment retention is often poor after MOUD initiation with 26% of methadone recipients and 54% of buprenorphine recipients discontinuing treatment within 6 months.[33] However, this research was conducted in younger adults and there could be missed opportunities to optimize

---

[23] Han, B. H., Orozco, M. A., Miyoshi, M., Doland, H., Moore, A. A., & Jones, K. F. (2024). Experiences of Aging with Opioid Use Disorder and Comorbidity in Opioid Treatment Programs: A Qualitative Analysis. *Journal of General Internal Medicine*, *39*(9), 1673–1680. https://doi.org/10.1007/s11606-024-08676-z

[24] Farmer, A. Y., Wang, Y., Peterson, N. A., Borys, S., & Hallcom, D. K. (2022). Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *77*(5), 919–929. https://doi.org/10.1093/geronb/gbab078

[25] Thandi, M. K. G., & Browne, A. J. (2019). The social context of substance use among older adults: Implications for nursing practice. *Nursing Open*, *6*(4), 1299–1306. https://doi.org/10.1002/nop2.339

[26] Parish, W. J., Mark, T. L., Weber, E. M., & Steinberg, D. G. (2022). Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers. *American Journal of Preventive Medicine*, *63*(2), 225–232. https://doi.org/10.1016/j.amepre.2022.01.021

[27] National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for opioid use disorder save lives*. The National Academies Press. https://doi.org/10.17226/25310

[28] Connery, H. S. (2015). Medication-Assisted Treatment of Opioid Use Disorder. *Harvard Review of Psychiatry*, *23*(2), 63–75. https://doi.org/10.1097/hrp.0000000000000075

[29] Mauro, P. M., Gutkind, S., Annunziato, E. M., & Samples, H. (2022). Use of Medication for Opioid Use Disorder Among US Adolescents and Adults With Need for Opioid Treatment, 2019. *JAMA Network Open*, *5*(3), e223821. https://doi.org/10.1001/jamanetworkopen.2022.3821

[30] Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ (Clinical Research ed.)*, *357*, j1550. https://doi.org/10.1136/bmj.j1550

[31] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, *3*(2), e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622

[32] Chambers, L. C., Hallowell, B. D., Zullo, A. R., Paiva, T. J., Berk, J., Gaither, R., Hampson, A. J., Beaudoin, F. L., & Wightman, R. S. (2023). Buprenorphine Dose and Time to Discontinuation Among Patients With Opioid Use Disorder in the Era of Fentanyl. *JAMA Network Open*, *6*(9), e2334540. https://doi.org/10.1001/jamanetworkopen.2023.34540

[33] Timko, C., Schultz, N. R., Cucciare, M. A., Vittorio, L., & Garrison-Diehn, C. (2016). Retention in medication-assisted treatment for opiate dependence: A systematic review. *Journal of Addictive Diseases*, *35*(1), 22–35. https://doi.org/10.1080/10550887.2016.1100960

MOUD initiation and retention in ways that take into account the unique medical, functional, and social factors affecting older adults.[8]

Beyond individual-level factors, older adults also face structural barriers to MOUD access. Importantly, Medicare coverage for methadone MOUD only began in 2020 and there is variable uptake as some OTPs do not accept Medicare insurance as payment.[34] In 2022, of the 1854 OTPs in the U.S., 1115 (60%) billed Medicare, with substantial state-to-state variability of 13% to 100%.[35] Concerningly, Wyoming has no OTPs and South Dakota and Tennessee lack OTPs that bill fee-for-service Medicare. Therefore, older adults with OUD face significant geographic and Medicare insurance related challenges that impede methadone access given that to date, methadone can only be dispensed in certified OTPs - or within hospitals per recent changes to 42 CFR Part 8 that designate hospitals exempt from certification as an OTP to dispense methadone. Furthermore, despite the elimination of the previously DEA-required buprenorphine X-waiver in December 2022,[36] barriers to buprenorphine access persist with the volume of clinicians prescribing buprenorphine remaining low and growing problems around filling buprenorphine prescriptions at pharmacies.[37] In one study, among 5283 pharmacies contacted, 3058 (58%) reported buprenorphine-naloxone stock in 2022.[38]

In our work we have also found that logistical barriers posed by stringent federal regulations that specifically apply to methadone are often cited as reasons for denying SNF admission for individuals, including older adults, with OUD.[13] Currently, SNFs require special procedures to make methadone available to their residents as they are disallowed from directly dispensing methadone.[39] Therefore, SNFs need to coordinate with an OTP to provide methadone either by transporting a resident to the OTP or transporting methadone to the SNF under take home flexibilities or medical exceptions granted by OTPs.[14] However, SNF administrators have reported that persist staff shortages at SNFs often hamper the capacity to navigate the logistics of coordinating methadone access and disincentivize admissions of individuals with OUD. Although people with OUD are referred to SNFs for skilled care needs rather than OUD treatment, SNFs must be equipped to continue existing OUD care and provide MOUD as part of their overall care offerings. Developing the capacity for SNFs and facilities providing long-term

---

[34] Harris, S. J., Yarbrough, C. R., & Abraham, A. J. (2023). Changes In County-Level Access To Medications For Opioid Use Disorder After Medicare Coverage Of Methadone Treatment Began. *Health Affairs (Project Hope)*, *42*(7), 991–996. https://doi.org/10.1377/hlthaff.2023.00148

[35] Nakamoto, C. H., Huskamp, H. A., Donohue, J. M., Barnett, M. L., Gordon, A. J., & Mehrotra, A. (2024). Medicare Payment for Opioid Treatment Programs. *JAMA Health Forum*, *5*(7), e241907. https://doi.org/10.1001/jamahealthforum.2024.1907

[36] LeFevre, N., St Louis, J., Worringer, E., Younkin, M., Stahl, N., & Sorcinelli, M. (2023). The End of the X-waiver: Excitement, Apprehension, and Opportunity. *Journal of the American Board of Family Medicine : JABFM*, *36*(5), 867–872. https://doi.org/10.3122/jabfm.2023.230048R1

[37] Winstanley, E. L., Gray, A., & Thornton, D. (2024). Addressing the Escalating Problems That Patients Encounter When Filling Buprenorphine Prescriptions. *JAMA Psychiatry*, *81*(12), 1167–1168. https://doi.org/10.1001/jamapsychiatry.2024.3076

[38] Weiner, S. G., Qato, D. M., Faust, J. S., & Clear, B. (2023). Pharmacy Availability of Buprenorphine for Opioid Use Disorder Treatment in the US. *JAMA Network Open*, *6*(5), e2316089. https://doi.org/10.1001/jamanetworkopen.2023.16089

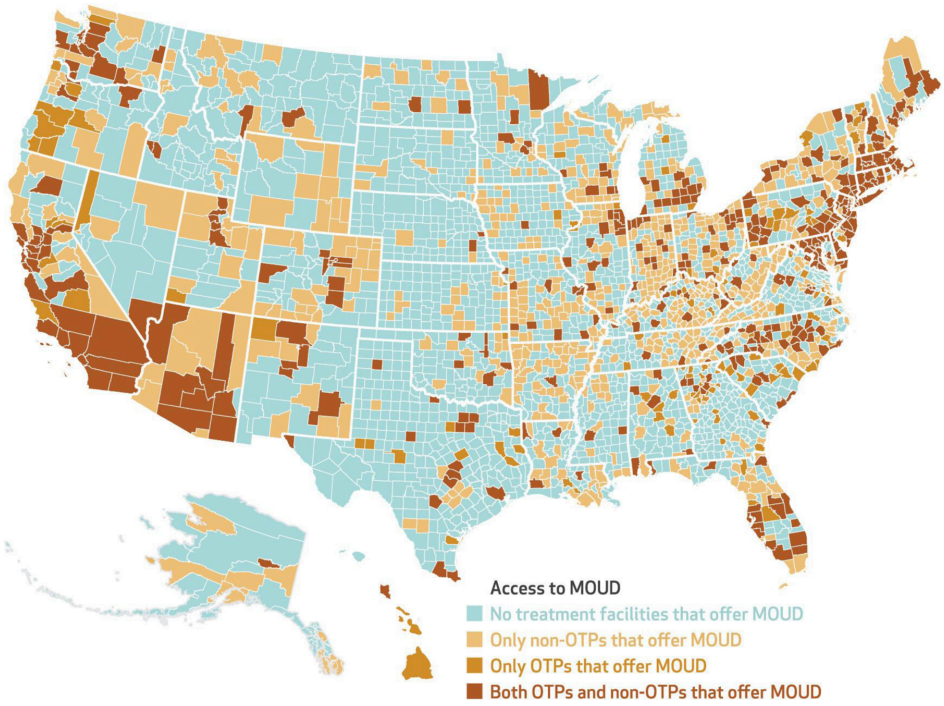
[39] Pytell, J. D., Sharfstein, J. M., & Olsen, Y. (2020). Facilitating Methadone Use in Hospitals and Skilled Nursing Facilities. *JAMA Internal Medicine*, *180*(1), 7–8. https://doi.org/10.1001/jamainternmed.2019.5731

care to serve as touchpoints for OUD treatment is a critical step toward addressing OUD in older adults.

There are several opportunities for Congress and the federal government to consider to improve the care and health of older adults with opioid use disorder.

In the fall of 2021, I began working at an OTP. After 15 years working in the ED and more than a decade of substance use research, I wanted to better understand the people and the problems that I had spent a majority of my career trying to help. The most staggering thing about the OTP system that most people do not realize is just how tightly regulated it is. If we were to ask anyone with any other chronic health condition to come to the same place every day, usually in the early morning, to receive their life saving medications – it would seem a herculean lift. Then we ask our most fragile, our most vulnerable to do this. Now, add in chronic pain, mobility problems (not to mention the problems with Medicare coverage) – we are basically building a brick wall in front of medication treatment for older adults with OUD. The first time I learned that not all OTPs accepted Medicare I was shocked and the patient I tried to help navigate treatment was overwhelmed and eventually lost to care. I still do not know what happened to her. (Francesca L. Beaudoin, MD, PhD)

In 2018, almost 2% of older adult Medicare fee-for-service beneficiaries were diagnosed with an OUD,[2] – this underscores the need to maximize access treatment, particularly to MOUD, via Medicare coverage policies. There have been recent major regulatory (e.g., removal of the buprenorphine X-waiver requirement, expanded methadone take-home flexibilities) and Medicare coverage policy changes that promise to improve access to OUD treatment and health outcomes in older adults. However, continued efforts are still needed to help turn the tide of rising OUD and related consequences among older adults. Patients need to be able to have access to both types of MOUD (buprenorphine and methadone) given that some medications work better for some people, no different than high blood pressure or diabetes medicines. Methadone in particular is highly regulated and many OTPs still do not accept Medicare,[34] despite the fact that Medicare began reimbursing for OTP services in 2020. Rural older adult Medicare beneficiaries have the least access (see figure below, light blue areas), with greatest access in the Northeast and Southwest.



County-level access to medications for opioid use disorder (MOUD) for Medicare beneficiaries in opioid treatment programs (OTPs) and non-OTP specialty substance use treatment facilities in the US, 2021 (Health Aff (Millwood). 2023 Jul;42(7):991–996. doi: 10.1377/hlthaff.2023.00148)

Expanding methadone access should directly result in improved access to treatment for older and younger adults alike. The following are steps that could be taken to optimize the care and health of older adults with OUD:

Allow methadone to be prescribed by addiction specialist physicians and dispensed outside OTPs in community pharmacies.

Allowing methadone to be prescribed by addiction specialist physicians and dispensed outside OTPs in community pharmacies could address structural barriers that currently impede access to methadone. The existing impediments are even more pronounced for older adults who experience functional limitations and complex medical conditions that are compounded by social isolation. Therefore, older adults stand to uniquely benefit from permanent reforms that eliminate regulatory barriers to methadone access both in community and institutional settings. While critics argue that extending the dispensing of methadone outside OTPs poses greater risk of methadone-related adverse events, evidence from other countries (e.g., Canada, England, Australia, France) supports that pharmacy-based methadone for OUD can be provided safely and

effectively [40,41] with adequate safeguards such as training and certification of pharmacists. For example, pharmacy-based dispensing of methadone in Canada has enabled harder-to-reach populations to engage in treatment resulting in rates of methadone receipt that are 3-4 times higher than in the U.S.[42] Leveraging community pharmacists, who are one of the most accessible healthcare professionals in the U.S., has the potential to extend the infrastructure for methadone treatment to better serve older adults with OUD.[43]

Consider further amending 42 CFR Part 8 regulations to clarify and extend the waiver for OTP certification to post-acute and long-term care facilities.

Considering that transitions to post-acute and long-term care become more common as people age, an important aspect of addressing OUD in older age is to ensure the consistent availability of MOUD across the care continuum. Although the final rule for changes to 42 CFR Part 8 ("Medications for the Treatment of Opioid Use Disorder") which became effective in April 2024 waived requirements for hospitals to be certified as OTPs to administer and dispense methadone, long-term care facilities were effectively not granted the same exemption as hospitals. The final rule states that certification as an OTP is not required for the initiation or continuation of MOUD for a patient who is admitted to a hospital, long-term care facility, or correctional facility that is registered with the Drug Enforcement Agency (DEA) as a hospital/clinic.[44] However, most long-term care facilities are not eligible for DEA licenses because they obtain medications from contracted outpatient pharmacies. Therefore, the full benefits of the recent revisions to 42 CFR Part 8 may not be realized without clear guidance that long-term care facilities could provide methadone directly for their residents as acute care hospitals currently do.

[40] Sheridan, J., Manning, V., Ridge, G., Mayet, S., & Strang, J. (2007). Community pharmacies and the provision of opioid substitution services for drug misusers: changes in activity and attitudes of community pharmacists across England 1995-2005. *Addiction (Abingdon, England)*, *102*(11), 1824–1830. https://doi.org/10.1111/j.1360-0443.2007.02016.x

[41] Cochran, G., Bruneau, J., Cox, N., & Gordon, A. J. (2020). Medication treatment for opioid use disorder and community pharmacy: Expanding care during a national epidemic and global pandemic. *Substance Abuse*, *41*(3), 269–274. https://doi.org/10.1080/08897077.2020.1787300

[42] Fischer, B., Kurdyak, P., Goldner, E., Tyndall, M., & Rehm, J. (2016). Treatment of prescription opioid disorders in Canada: looking at the "other epidemic"?. *Substance Abuse Treatment, Prevention, and Policy*, *11*(1). https://doi.org/10.1186/s13011-016-0055-4

[43] Jarrett, J. B., Bratberg, J., Burns, A. L., Cochran, G., DiPaula, B. A., Legreid Dopp, A., Elmes, A., Green, T. C., Hill, L. G., Homsted, F., Hsia, S. L., Matthews, M. L., Ghitza, U. E., Wu, L. T., & Bart, G. (2023). Research Priorities for Expansion of Opioid Use Disorder Treatment in the Community Pharmacy. *Substance Abuse*, *44*(4), 264–276. https://doi.org/10.1177/08897077231203849

[44] Medications for the Treatment of Opioid Use Disorder, 42 CFR Part 8 (2024). https://www.federalregister.gov/d/2024-01693

Require behavioral health parity in Medicare.

Federal parity rules, per the Mental Health Parity and Addiction Equity Act of 2008, apply to most public and private health insurance but not Medicare, either fee-for-service or Medicare Advantage.[45] Closing this treatment gap for mental health conditions and substance use disorders is an important step toward improving the management of OUD and the mental health conditions that are often occurring and whose prevalence increases with age. Parity in Medicare also has the potential to incentivize a broader cadre of behavioral health providers to accept Medicare insurance thus improving the continuum of services available to promote the health and well being of older adults with OUD.[46]

Invest in research and demonstration projects to generate novel, clinically-important, and policy-relevant evidence to address OUD in older adults.

The intersections of OUD, its treatment, and aging are understudied. Rigorous research is needed to inform tailored care and enable the selection of multi-level interventions to advance age-friendly care including treatment and recovery services for older adults with OUD. Such research may encompass assembling national longitudinal cohorts to study trajectories of aging among adults with OUD with the goal of understanding the evolution of care and outcomes during and after transitions to older adulthood. Implementation science research is also needed to identify, test, and scale interventions tailored to older adults with OUD. Medicare demonstrations to test new ways to deliver, cover, and pay for services to address OUD in older adults also deserve attention.

---

[45] Pestaina, K. (2018). Mental Health Parity at a Crossroads. In *KFF*. https://www.kff.org/mental-health/issue-brief/mental-health-parity-at-a-crossroads/

[46] Zhu, J. M., Meiselbach, M. K., Drake, C., & Polsky, D. (2023). Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets. *Health affairs (Project Hope)*, *42*(7), 909–918. https://doi.org/10.1377/hlthaff.2022.01547