



Minnesota Low-Barrier Medication for Opioid Use Disorder Workgroup

Findings and Recommendations

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Introduction

Opioid use disorder (OUD) is a complex and multifaceted public health challenge rooted in a web of biological, social, and structural factors. While the condition is complex, highly effective treatments exist, and people do recover when evidence-based care is accessible. The gold-standard of treatment for OUD is referred to as MOUD, medications for opioid use disorder. In 2022, a national survey found that 75% of people who need treatment for an OUD did not receive MOUD.¹ Furthermore, Minnesota's engagement rates in MOUD are below the national average.²

To better understand how the State might address this public health challenge, the Minnesota Department of Health (MDH) partnered with the Minnesota Department of Human Services (DHS) and the Office of Addiction and Recovery (OAR) to convene a Low-Barrier MOUD Workgroup. The Low-Barrier MOUD Workgroup brought together a broad range of experts experienced in delivering low-barrier care across Minnesota. The State tasked the Workgroup with identifying key barriers to care, prioritizing solutions, and making recommendations, with the goal of advancing statewide, equitable, and patient-centered access to MOUD. This report summarizes the Workgroup's activities and recommendations.

Definitions

Medications for opioid use disorder

FDA-approved MOUDs include methadone, buprenorphine, and naltrexone, with the strongest evidence supporting buprenorphine and methadone. MOUD is considered the gold standard of treatment for OUD and can reduce all-cause mortality by up to 50%.⁷ These evidence-based treatments work by stabilizing brain chemistry, reducing cravings, and mitigating withdrawal symptoms, enabling individuals to sustain recovery and reduce the risk of relapse.

MOUD not only saves lives by preventing overdose deaths, but also supports long-term recovery, reduces healthcare costs, and helps dismantle stigma by treating OUD as the medical condition it is. Because of the strict federal regulatory framework governing methadone and the comparatively limited effectiveness of naltrexone for many patients, this Workgroup focused exclusively on expanding access to buprenorphine. Methadone expansion is equally important and should be the focus of future work.

Low-barrier MOUD

Low-barrier MOUD is a care approach that increases access to treatment by prioritizing flexibility, rapid entry into care, and patient-centered practices. It removes unnecessary hurdles by emphasizing same day access, harm reduction and adaptable treatment options across a range of settings, including emergency departments, mobile medicine, syringe services programs, walk-in clinics, shelters, and telehealth. This approach ensures that individuals can begin treatment when they are ready, often the same day they seek help, and is especially critical for people at the highest risk of overdose and return to use.

Public health context

Minnesota continues to experience a significant burden of opioid-related morbidity and mortality. Despite recent reductions in fatal opioid-involved overdoses, data emphasizes the urgent need for increased access to evidence-based treatment:

- Accidental overdose was the leading cause of death for 15 – 44 year-olds in Minnesota in 2023.³
- 678 Minnesotans died of unintentional opioid-involved overdose in 2024.⁴
- There were 22,908 opioid-related hospital visits in 2024 which includes 3,594 non-fatal hospital-treated overdoses.⁵ The remaining visits were due to other opioid-related conditions such as withdrawal, intoxication without overdose, or complications from long-term opioid use.

MOUD is the gold standard of care for OUD, reducing mortality by over 50% and improving retention in treatment. Yet, access to MOUD remains limited: in 2021, Minnesota ranked 29th in MOUD utilization among its state Medicaid population.⁶

Workgroup overview

Members of the Low-Barrier MOUD Workgroup served voluntarily between June and December 2025. Their purpose was to identify barriers and recommend strategies to help expand access to low-barrier MOUD across Minnesota. Key deliverables included:

- Identify structural, policy, and clinical barriers to MOUD access in Minnesota.
- Develop strategies and recommendations to expand statewide low-barrier MOUD access.

Workgroup membership

In identifying prospective members for the Low-Barrier Workgroup, MDH, DHS and OAR intentionally sought experts with extensive experience providing MOUD and related services. Members represented a wide breadth of service providers across multiple disciplines, settings and regions to ensure that recommendations were practical, equitable, and informed by the realities of diverse care environments. A complete membership roster is available in [Appendix A](#).

The Low-Barrier MOUD Workgroup comprised a wide range of expertise. Members included clinicians across addiction medicine, family and emergency care, justice system clinicians, telehealth prescribers, pharmacists, and health system leaders. Members represented the perspectives of culturally diverse communities, community-based and safety-net providers, including harm reduction programs, Federally Qualified Health Care Centers (FQHCs), mobile medicine, and peer recovery organizations. Finally, public health and regulatory agencies such as local health departments, the Minnesota Board of Pharmacy, and the Office of Emergency Medical Services contributed essential insights.

The Workgroup represented geographic diversity across urban, suburban, and rural Minnesota, bringing insights from high-volume emergency departments, suburban systems, and rural communities that experience limited provider availability. This depth of perspectives enabled rich, cross-sector dialogue and practical problem-solving, delivering salient recommendations applicable to the State's care-delivery infrastructure.

Workgroup facilitation

The Office of Addiction and Recovery sponsored facilitation services for the project, which were provided by a Management Analysis and Development (MAD) facilitator. Using a participatory, mixed-methods approach, MAD helped the group provide insights, refine ideas, and build consensus on solutions. The facilitation process emphasized equity and collaboration, ensuring that members from diverse disciplines and regions could contribute meaningfully to the discussions.

Feedback was collected through surveys, structured virtual discussions, and individual interviews with members. To maintain accuracy and alignment, the process incorporated iterative refinement, with findings continuously reviewed, validated, and improved between sessions. This approach allowed the workgroup to develop well-informed, practical recommendations for expanding low-barrier MOUD access.

Defining barriers that impede access to MOUD

The Low-Barrier MOUD Workgroup identified a series of persistent and interrelated barriers that prevent timely and equitable access to MOUD across Minnesota. Collectively, these obstacles create a patchwork of care that is often unpredictable and difficult to navigate, not only for patients, but also for their care providers. Moreover, these barriers to care magnify the likelihood of harms for people with OUD. In total, the Workgroup identified nearly fifty specific barriers to care, that they subsequently summarized into four priority areas.

Patient level and community barriers

- Many people with OUD have significant mistrust of medical institutions and MOUD. Negative experiences in emergency departments (EDs), with EMS, withdrawal mismanagement, or the justice system create hesitancy to seek care. Additionally, patients commonly have past negative experiences with MOUD itself.
- People with OUD often have unmet basic needs such as housing, food, mental health care, and social support that take priority over treatment. Many seek care for more immediate needs like wound care, STI screenings, or medication refills, and only consider MOUD after trust is built through consistent, nonjudgmental care. Transportation challenges further limit access to both MOUD and other essential services.
- Stigma toward people with OUD is reinforced across multiple settings, including public discourse, community institutions, social and family networks, health care, and even within some substance use disorder treatment environments, creating barriers to engagement in medications for opioid use disorder and ongoing care.

Pharmacy barriers

- Some pharmacists have gaps in MOUD knowledge and training, leading to discomfort dispensing MOUD. Limited familiarity on drug interactions, dosing, and best practices, along with insufficient education on how to navigate common and preventable dispensing challenges such as brand versus generic processing or formulation substitutions, can result in avoidable delays or barriers to patient access.

- When medications are out of stock, pharmacists often do not assist the patient by locating another nearby pharmacy that carries the medication.
- Stigma toward MOUD and people who use drugs can significantly influence whether pharmacies choose to stock or dispense buprenorphine. This stigma contributes to geographic disparities in access, particularly in rural areas, where fewer pharmacies carry buprenorphine, and patients face greater barriers to treatment.
- Insufficient reimbursement creates barriers that limit buprenorphine availability at the pharmacy level.
- Pharmacists are hesitant to stock buprenorphine products due to concerns around Drug Enforcement Administration (DEA) wholesaler audits.
- Long-acting injectable (LAI) buprenorphine access is significantly hindered by complex procurement and billing processes, including benefit coverage distinctions between pharmacy and medical models and requirements to use specific plan-designated specialty pharmacies. These factors impede clinics' ability to offer same-day, low-barrier access to LAIs.

Systems level and structural barriers

- Inconsistency and lack of standardization limit access. MOUD availability varies by geography, setting, and time of day, with limited same-day or after-hour prescribing and medication access, particularly in rural areas. As a result, patients experience inconsistent and unpredictable processes for receiving MOUD prescriptions and obtaining medication, depending on where and how they enter care.
- Fragmentation between and within care systems persists. Care coordination and continuity is disjointed between EMS, EDs, Opioid Treatment Programs (OTPs), clinics and community providers; information sharing is limited, making it difficult to track care and measure outcomes.
- Provider readiness remains limited. Many clinicians report insufficient training and discomfort prescribing MOUD, with hesitation around initiating treatment. As inductions have become more complex in the fentanyl era, provider confidence and skills have fallen even further behind.
- Medical bias and stigma persist, not only towards people who use drugs, but also the treatment modality itself.
- MOUD is not consistently available in jail settings, limiting continuity of care during incarceration and after release. Even during brief periods of incarceration, disruptions in medication continuity can destabilize treatment and increase overdose risk upon release.
- Structural racism and implicit bias influence MOUD prescribing, affecting who receives MOUD and which medications are offered, contributing to disparities in access and outcomes.

Policy and payment barriers

- Insufficient reimbursement limits engagement. Providing MOUD is disincentivized across the entire care spectrum because reimbursement rates do not sufficiently cover the full costs of service delivery (and the medications).
- Administrative delays and regulations inhibit access to buprenorphine formulations, including long acting injectables. Managing prior authorizations, dose limitations, and utilization controls adds inefficiency, delays care and significantly impedes same-day access for patients who are ready to access treatment.

- Providers report that the complexity of navigating medical versus pharmacy benefits for reimbursement of long-acting injectable buprenorphine makes it difficult for clinics to offer these formulations to patients.

Despite ongoing efforts to expand access, the barriers identified by the Low-Barrier MOUD Workgroup reveal a system that is both fragmented and misaligned with the realities faced by Minnesotans living with OUD. Many people still cannot access timely, equitable, or appropriate care. These barriers are significant, but they are solvable, and the recommendations in this report outline clear opportunities to build a more responsive and effective continuum of care.

Recommendations and implementation pathways

Foundational principles

Important key themes consistently permeated the group's discussions around barriers to and solutions for addressing MOUD access. Due to the crucial nature of these themes, the facilitators chose to position them as foundational principles within the context of the report, rather than singular solutions. The Workgroup lifts these foundational principles as integral aspects of the report as a whole:

- Stigma surrounding OUD and MOUD is pervasive, impacting patients, their families and providers.
- There must be no wrong doors to seeking care for OUD, and access must be person-centered.
- Practically addressing OUD necessitates efforts that address structural racism, health disparities and historical trauma.
- People with OUD often have unmet basic needs such as housing, food, mental health care, and social support that take priority over seeking treatment for OUD.
- People who use drugs commonly have negative past experiences seeking healthcare, leading to deep mistrust.

The Low-Barrier MOUD Workgroup also recognizes that no single solution can end the opioid crisis. One of the most immediate and achievable ways to reduce harm is to make MOUD more accessible, consistent, and person-centered. Guided by these shared understandings, the workgroup developed a roadmap of actionable recommendations rooted in evidence. The following recommendations and implementation pathways are tangible, effective and pragmatic approaches for increasing access to MOUD in Minnesota.

The recommendations in this report are **presented in order of priority** as determined by the Workgroup. This prioritization reflects the areas expected to have the greatest impact on expanding access to MOUD in Minnesota. While all recommendations are important, those appearing first represent the most urgent and high-impact opportunities identified by the Workgroup.

Recommendation 1: Align Minnesota Medicaid policy with evidence-based practices to expand access to MOUD

Medicaid policy is a powerful lever for expanding access to MOUD. Successful treatment engagement and retention hinges on patients having access to the specific medications they need, without delays. Eliminating

unnecessary administrative barriers is shown to improve access to care, retention in treatment, and overall overdose risk.

Medicaid policy levers can also empower clinical best-practice. Clinicians treating OUD must have the flexibility to prescribe the most appropriate formulation, dosage, and duration of buprenorphine based on the medical needs of each patient. Right-size utilization controls enable individualized, person-centered treatment, increasing the likelihood of treatment engagement.

State and national context

Following national evidence-based recommendations, state Medicaid agencies across the country have enacted policies that make MOUD more accessible. These approaches demonstrate how targeted policy alignment can rapidly expand treatment capacity and reduce gaps in care.

- The FDA issued a labeling revision in support of therapeutic doses of buprenorphine of up to 32 mg/day in 2024. Several state Medicaid agencies have since changed their utilization management controls to reflect this guidance.⁷
- Minnesota removed prior authorization on methadone for the treatment of OUD roughly ten years ago.
- Health policy officials including the Centers for Medicare and Medicaid Services⁸, the Centers for Disease Control and Prevention⁹, and the American Society of Addiction Medicine¹⁰ have all advised removing prior authorization of MOUD. Several state Medicaid agencies have removed all or most prior authorizations on buprenorphine products.

Practical implications from the field

"Prior authorizations are a massive barrier to obtaining MOUD. While they may cause headaches for prescribers and clinics, I have seen prior authorizations be the final obstacle that prevents a patient from starting or continuing MOUD. It's heartbreaking."

- Emily Carroll, Family Nurse Practitioner, HealthFinders Collaborative & St. Olaf College

"MOUD is time sensitive. Even the slightest delay often leads to losing the important moment when a patient is ready to engage in care. Providing MOUD on the same day as a visit is essential to decreasing mortality risk and preventing future overdoses. Removing prior authorizations is essential to getting patients access to life saving medication in the critical moment when a patient says 'yes' to care."

- Dr. Tim Kummer, Emergency Physician, Hennepin Healthcare; Medical Director, Hennepin EMS Community Paramedics and Hennepin EMS Bridge Program

Implementation pathways

1. The State should remove prior authorization for all FDA-approved formulations of buprenorphine for OUD, including long-acting injectables.

2. The State should increase the dose cap on buprenorphine from 24 mg to 32 mg per day, aligning with national clinical guidelines and person-centered dosing.

By aligning Minnesota Medicaid policy with national best practices, Minnesota can remove barriers, support individualized care, and ensure timely access to life-saving treatment for OUD.

Recommendation 2: Expand MOUD service delivery into non-traditional, low-barrier settings

Minnesotans at greatest risk of overdose experience some of the most significant barriers to healthcare access. Barriers include stigma, transportation, language, being unhoused, and mistrust of institutions. Building MOUD availability in non-traditional, low-barrier settings capitalizes on the trust-building and rapport these organizations have fostered with people most at risk.

Integrating MOUD with public health and social services, such as wound care, STI treatment, and peer support, improves retention in care and expands reach to the highest-risk populations. Extending MOUD beyond traditional clinic settings and directly to people where they are creates opportunities for treatment engagement with trusted services providers.

State and national models

These state models embed MOUD and harm-reduction services in accessible community spaces to increase reach among people with high barriers to care while also maintaining safety and continuity.

- New York Drug User Health Hubs: Community-based programs include on-site MOUD (buprenorphine) and comprehensive services, creating “health hub” models for people who use drugs.
- California Street Medicine Collaborative consists of 25+ street-medicine teams statewide (vans/trailers/outreach) include prescribers, peer support, and mobile outreach.

Practical implications from the field

“So many people I provide care to do not have the luxury to focus on their health on “my time” (when I am available in clinic). Transportation challenges, housing access, identification, insurance, etc. all impact my patients. Having the ability to bring care to where they are dramatically increases access and improves their health. This allows people to stay alive long enough to stabilize and seek care when able.”

- Dr. Ryan Kelly, Associate Professor, University of Minnesota, Department of Internal Medicine, Co-Director Addiction Medicine Consult Team, Community University Health Care Center, Addiction and Primary Care

Implementation pathways

1. Develop and approve low-barrier MOUD standards for community-based service providers such as mobile medical units, shelters, syringe services programs, recovery community organizations, and community centers.
2. Provide state funding to existing community-based service providers to integrate low-barrier MOUD, either through onsite clinical staff or through a partnership with the statewide telehealth buprenorphine provider (Recommendation 4), into their existing service models. Establish a billing framework that clearly outlines allowable services, reimbursement pathways, and sustainable payment models.
 - Funding may be used to support buprenorphine bridging packs (Recommendation 5) and other essential implementation activities.
 - Integrate with the MN Low-Barrier MOUD website to enable real-time referrals and warm hand-offs between service providers (Recommendation 4).

By expanding MOUD and low-barrier standards of care to non-traditional, community-based environments, the State can support a “no wrong doors” care system. These models meet people where they are and strengthen the continuum of recovery through compassion, accessibility, and integration.

Recommendation 3: Standardize the provision of MOUD in emergency medicine as the statewide standard of care in Minnesota

Emergency Departments and Emergency Medical Services are among the most frequent points of contact for people experiencing opioid overdose or withdrawal. Establishing MOUD as the standard of care in these settings is a proven low-barrier strategy that improves treatment engagement, reduces repeat overdoses, and builds pathways to ongoing care.

By setting clear statewide standards, providing implementation support, and implementation funding, Minnesota can ensure that every patient who encounters the emergency system has timely access to evidence-based treatment, regardless of where or when they seek help. These standards must remain flexible and adaptable to quickly incorporate emerging best practices and evolving induction techniques, as the landscape of opioid use and treatment changes rapidly.

State and national models

- Massachusetts became the first state to require hospitals with EDs to be able to initiate MOUD, pairing the mandate (The Care Act¹¹) with operational guidance and training.
- California’s CA Bridge Program funded a comprehensive statewide expansion that made rapid MOUD initiation the norm in EDs and EMS, supporting healthcare organizations with implementation funding, supporting navigator roles, and ongoing training.

These models show that when states combine standards, training, and financial support, MOUD access expands rapidly in both hospital and prehospital settings.

Practical implications from the field

“Do I think it should be mandated that we have to treat people in the emergency department? My answer is yes! In my world, withdrawal is the heart attack of addiction. It’s our heart attack because if those people leave the emergency department, they use and they overdose and die. If we don’t do something, they die.”

- Dr. Kurt DeVine; Medical Director, CentraCare Addiction Services

“80-90% of people struggling with OUD are not getting essential medications or enrolled in any form of treatment. As a primary interface between untreated OUD in the community and behavioral health systems, the emergency department presents a unique opportunity to fill that gap.”

- Dr. Dziwe Ntaba, Director, Community Engagement & Education, Masonic Institute for the Developing Brain; Assistant Professor of Emergency Medicine, University of Minnesota Medical School

Implementation pathway(s) for emergency departments

1. Execute a funded mandate, with a compliance window, to integrate MOUD in all Minnesota emergency departments.
2. Create a funded statewide program to integrate MOUD in Minnesota emergency departments (mandated or voluntary) through a competitively awarded agreement to:
 - Develop and publish statewide standards and sample protocols for ED MOUD initiation including long-acting injectable formulations of buprenorphine, buprenorphine bridging packs, and ED linkage to care roles.
 - Establish a Minnesota technical assistance hub to train clinicians, nurses, and pharmacists, and linkage to care roles in evidence-based emergency induction and linkage workflows.
 - Provide one-time implementation funding for Minnesota emergency departments to integrate MOUD into the emergency department.
 - Integrate with the MN Low-Barrier MOUD website (Recommendation 4) to enable real-time referrals and warm hand-offs to ongoing care beyond the acute setting.
3. Leverage value-based purchasing strategies to accelerate MOUD integration in Minnesota emergency departments.

Implementation pathways for emergency medical services

1. Provide state funding through a competitively awarded agreement(s) to develop statewide resources for field initiation, buprenorphine bridging packs, and warm hand-offs to ongoing care.
 - Create a dedicated EMS technical assistance hub to train providers on substance use disorder, assessment, administration, and referral workflows.
 - Provide one-time implementation funding for Minnesota EMS organizations to integrate MOUD into their existing service model.

- Integrate EMS referrals into the MN Low-Barrier MOUD website (Recommendation 4) for seamless post-overdose follow-up, tele-buprenorphine bridging, and warm hand-offs to ongoing care beyond the acute setting.
2. Through legislative action, simplify the authorization of the dispensation of 3-7 day bridging medication packs of buprenorphine under a standing order of an ambulance service medical director.

By defining ED- and EMS-initiated MOUD as the statewide standard of care, Minnesota can create a unified, “no-wrong-door” system where every emergency encounter becomes an opportunity to provide protection from a future overdose as well as a pathway to recovery.

Recommendation 4: Establish a statewide telehealth bridging buprenorphine hotline with integrated referral network for ongoing care

Telehealth is critical to expanding the provision of MOUD. A telehealth buprenorphine hotline directly addresses key barriers such as transportation, limited provider availability and clinic operating hours. Evidence shows that telehealth buprenorphine access improves treatment initiation and retention, especially in underserved areas. Funding a statewide, state-supported telehealth buprenorphine hotline will help ensure Minnesotans anywhere can start MOUD without treatment delays.

Successful telehealth models for MOUD also incorporate care coordination and telephonic nursing-support for at-home inductions. Care coordinators facilitate warm hand-offs for ongoing care in the local community via an integrated referral network of existing MOUD providers. Additionally, a companion website offering public information about MOUD access points in local communities supports the telehealth buprenorphine hotline.

State and national models

Several states have demonstrated the effectiveness of centralized, virtual MOUD services:

- Seattle & King County Tele-Buprenorphine Program provides rapid access to buprenorphine prescriptions via telehealth and linkage to local care.
- New York MATTERS Network, a statewide digital referral platform, links EDs, clinics, and pharmacies for same-day MOUD and follow-up.

Practical implications from the field

“As a rural community clinic, we do not have the internal resources or connections found in larger systems. The idea of a reliable, one-stop-shop for connecting myself and patients with other low-barrier MOUD resources across the state is extremely appealing.”

- Emily Carroll, Family Nurse Practitioner, HealthFinders Collaborative & St. Olaf College

“It is so hard within the current system to meet patient’s needs. So much of this requires patients meeting our schedules instead of us meeting theirs. When are these patients ready for help? It is not during office hours.”

- Dr. Tim Kummer, Emergency Physician, Hennepin Healthcare; Medical Director, Hennepin EMS Community Paramedics and Hennepin EMS Bridge Program

Implementation pathways

1. Provide state funding through a competitively awarded agreement(s) to launch a statewide tele-buprenorphine hotline with nursing support for home inductions, care coordination and warm hand-offs to ongoing care.
 - Telehealth buprenorphine provider may also serve as the MOUD provider for nontraditional low-barrier settings funded in Recommendation 2.
2. Launch a state-supported Minnesota Low-barrier MOUD website and referral network. The website will include a statewide list of low-barrier MOUD providers, telehealth buprenorphine hotline information, and tools for clinicians. The website will build upon existing resource directories.

Telehealth access for MOUD is a vital lifeline ensuring equitable access to MOUD, especially for rural and underserved communities. By eliminating key logistical barriers to accessing care, telehealth empowers more people with OUD to initiate and maintain their recovery journey.

Recommendation 5: Expand availability of buprenorphine bridging packs and long-acting injectable (LAI) buprenorphine

Delays between the healthcare encounter where the prescription was written and a local pharmacy dispensing the medication frequently result in treatment drop-off and relapse risk. Expanding access to take-home buprenorphine medication during the healthcare encounter (i.e. buprenorphine bridging packs) would close this critical gap by ensuring patients leave healthcare encounters with sufficient medication until they are able to fill their prescription at a local pharmacy.

LAI formulations of buprenorphine represent another critical tool in low-barrier care models. Injectable formulations offer important advantages in specific clinical scenarios; for example, LAI's are particularly effective for patients who struggle with medication adherence, who are unhoused, or when diversion is a concern. Unfortunately, there are significantly high administrative barriers associated with LAI access that must be addressed.

State and national models

The following states have successfully increased the provision of bridging packs and LAI buprenorphine.

- Several states including Wisconsin, Pennsylvania, Washington, Oregon, New York and Vermont have removed prior authorizations on LAI formulations of buprenorphine.
- Washington appropriated opioid settlement funds for small clinics to cover the cost and administration of long acting injectables.

Practical implications from the field

“There is a huge difference between trying to fill an MOUD prescription at the pharmacy, compared to being handed a starter pack of medication or receiving a long-acting injectable at the point of care... Getting stabilizing meds on board at the earliest opportunity buys precious time in sobriety to navigate the many barriers to long term recovery like insurance paperwork, lengthy assessments, getting off the street and onto waiting lists, etc.”

- Dr. Dziwe Ntaba, Director, Community Engagement & Education, Masonic Institute for the Developing Brain; Assistant Professor of Emergency Medicine, University of Minnesota Medical School

“Due to the barriers clinics have accessing LAIs, I have to tell patients, ‘Sorry, I can't obtain them for you at this clinic [long-acting injectable medication]. Let's try to get you to the ED.’ If only 5-10% of these patients are able to get to the ED, what happens to the rest?”

- Dr. Ryan Kelly, Associate Professor, University of Minnesota, Department of Internal Medicine, Co-Director Addiction Medicine Consult Team, Community University Health Care Center, Addiction and Primary Care

Implementation pathways

1. Approve and disseminate physician dispensing guidance for buprenorphine bridging packs across a variety of settings (EMS, SSPs, mobile/street medicine, EDs).
 - Establish a state contact to provide guidance, training, and support to care settings implementing practitioner dispensing models (e.g., EMS, Syringe service programs (SSPs), mobile/street medicine, EDs).
2. Revise policy to ensure that individuals enrolled in the Minnesota Restricted Recipient Program (MRRP) have reliable same-day access to buprenorphine, including the receipt of “bridging packs” to maintain continuity of care and reduce unnecessary emergency department utilization until the individual can obtain a prescription from their designated prescriber and fill it at their designated pharmacy.
3. Increase Access to Long-Acting Injectable (LAI) buprenorphine
 - Enact dual benefit coverage for long-acting injectable formulations of buprenorphine in both Medicaid Fee-For-Service and Managed Care plans.
 - Carve-out LAI's from bundled payment structures, primarily diagnosis-related group (DRG) and prospective payment system (PPS).

Other considerations include:

- Establish and fund a distribution program to help sites acquire LAI medications directly without the financial burden of buy-and-bill.
- Create guidance and technical assistance for Risk Evaluation Mitigation Strategies (REMS) certification (by the FDA).

By taking these steps, Minnesota can help ensure patients leave care settings with sufficient medication and a clear path to maintenance treatment.

Alignment with other state efforts

The recommendations and implementation pathways described above are closely aligned with those made by State leadership and other advisors with expertise treating OUD. The following intersections validate the significance of the Workgroup’s recommendations.

The One Minnesota Strategic Plan

This statewide effort to tackle Minnesota’s most pressing challenges aspired to attain a 5% reduction in opioid-related deaths by 2027.¹² The initial goal of a 5% reduction was accomplished, and a new goal is under development.

Governor’s Advisory Council on Opioids, Substance Use and Addiction

This Council, focused on expanding access to evidence-based treatments and recovery support systems, published a 2024 Recommendations to the Governor’s Subcabinet on Opioids, Substance Use, and Addiction.¹³ One specific recommendation included in this report was to create incentivized rates to support increasing MOUD providers in rural communities.

Task Force on Holistic and Effective Responses to Illicit Drug Use

The purpose of this task force was to review and analyze approaches to address illicit drug use in Minnesota. Their 2025 legislative report recommends strategies that align with this report and include the following:¹⁴

- Create resources for paramedics to initiate buprenorphine in the field
- Require public and private health insurers to cover all formulations of MOUD’s without prior authorization
- Pass a comprehensive Model Substance Use Disorder Treatment in Emergency Settings Act
- Direct state agencies to expand access to telehealth treatment for SUD
- Review state policies for processes that may impede access to medications for opioid use disorder in non-specialty settings, including at syringe services programs and primary care clinics, and pass policies to address those barriers.

MOUD in Jails Workgroup

This work group, convened by the Office of Addiction and Recovery and co-chaired by the Minnesota Medical Association and Minnesota Sheriff’s Association, brought together partners across healthcare and criminal justice sectors in Minnesota to develop recommendations that improve treatment during and after incarceration in jail. In their Final Report to the Governor’s Subcabinet on Opioids, Substance Use, and Addiction,¹⁵ they included a recommendation that overlapped with this report:

- Develop a statewide tele-bupe (buprenorphine via telehealth) bridging hotline with an interoperable referral network to connect individuals for ongoing care in the community.

The Low-Barrier MOUD Workgroup's recommendations align closely with previous State initiatives, reinforcing Minnesota's broader strategy to reduce opioid-related harms. This alignment underscores the significance and legitimacy of the Workgroup's proposal.

Research in Action Report

The Research in Action landscape assessment on MOUD use and access for Black and Indigenous communities closely aligns with the Low-Barrier MOUD Workgroup report. Despite using different methods and lenses, both reports identify shared priorities, including the need for flexible, low-barrier service delivery, person-centered and culturally responsive care, stigma reduction, and expanded community-based access to MOUD. Together, the findings reinforce a consistent, statewide direction for improving equitable access to MOUD in Minnesota.

Opportunities for Future Work

Notably, this report did not address several other complex and pervasive issues that remain essential to improving access to MOUD in Minnesota. The Workgroup acknowledges that broader systemic factors, including stigma, access to mental health services, social determinants of health, structural racism and trauma, profoundly influence treatment access and outcomes. These issues require dedicated, systemic prioritization beyond the immediate focus of this report.

Pharmacy-related barriers to MOUD access represent another priority. Members ranked this issue as high importance and high impact. Challenges included dispensing limitations, medication stock shortages, and pharmacy workflow barriers across community and hospital settings. A future workgroup with more pharmacy expertise could meaningfully advance statewide low-barrier access to MOUD.

Finally, this report concentrated on expanding access to buprenorphine. While buprenorphine is a critical and flexible option for low-barrier models, methadone remains equally important and is a cornerstone of evidence-based treatment. Expanding methadone access, including regulatory, operational, and community considerations, represents an additional area for future statewide focus.

The Workgroup did not examine MOUD access considerations for specific populations. These areas may require targeted attention, culturally responsive engagement, and tailored recommendations that fall beyond the bounds of this initial report but should be prioritized in future work.

Conclusion

Opioid use disorder continues to pose a profound public health challenge in Minnesota, demanding strategic, coordinated, and patient-centered responses. The Low-Barrier MOUD Workgroup has identified critical barriers across patient, pharmacy, systems, and policy domains, and has outlined pragmatic, evidence-based recommendations to expand access to life-saving medications. These recommendations emphasize flexibility and evidence-based practice, ensuring that every Minnesotan, regardless of geography, circumstance, or background, can engage in treatment when they are ready.

The path forward requires sustained commitment from policymakers, healthcare providers, community organizations and people with lived experience. By aligning Medicaid policy with best practices, embedding MOUD in non-traditional and emergency settings, leveraging telehealth, and expanding medication access, Minnesota can build a “no wrong door” system of care. This framework is designed to build trust, dismantle stigma, and promote long-term recovery, while also reducing overdoses in Minnesota.

Practical Implications from the field

“We need to act. If there is any way to mitigate the harms that happen to families and individuals themselves...to leave any tool on the table seems unnecessarily cruel, inefficient and unhelpful.”

- Emily Carroll, Family Nurse Practitioner, HealthFinders Collaborative & St. Olaf College

“We have not fixed some of the most basic of problems for these patients, that being access to care and access to medications. I have a million dollars of grants...but so many barriers prevent me from actually providing the care and medications. This low-barrier thing, it has to happen.”

- Dr. Kurt DeVine; Medical Director, CentraCare Addiction Services

“I wish people with OUD would have a system that works for them and not against them... We have an opportunity to save people’s lives and to decrease suffering from substance use disorder. These recommendations take us a giant step forward in caring for a population that needs our care the most.”

- Dr. Tim Kummer, Emergency Physician, Hennepin Healthcare; Medical Director, Hennepin EMS Community Paramedics and Hennepin EMS Bridge Program

The Workgroup’s findings make clear that progress is both possible and urgent. With collective action and continued investment, Minnesota can advance low-barrier, person-centered care, ensuring that treatment for opioid use disorder is accessible for all.

Appendix A: Membership Roster

Member Name	Credentials	Title/Specialty	Organization Representing in Work Group	Region
Alex Hubbell	MD	Addiction Medicine	M Health Fairview & North Memorial	Metro
Brock Reed	PharmD	Controlled Substances Reporting Director	Minnesota Board of Pharmacy	Statewide
Courtney Nguyen	RN	Behavioral Health & Addiction Services Coord.	CCM Health	Montevideo
Craig Uthe	MD	Family Medicine	Sanford Health	Northeast Minnesota
Dylan Ferguson	MA	Director	Minnesota Office of EMS	Statewide
Dziwe Ntaba	MD	Emergency Medicine	Minneapolis Health Department - Opioid Response Team	Minneapolis
Elise Woodward	APRN, CNP	Associate Medical Director	Hennepin Healthcare	Hennepin County
Emily Carroll	DNP, CNP, RN	Primary and Community Care	HealthFinders Collaborative	Rice County
Gretchen Colbenson	MD	Internal Medicine	Mayo Clinic	Southeast Minnesota
Joe Corser	MD	Emergency, Family and Addiction Medicine	Sanford Health	Bemidji
Jordan Hanson	MA, LADC	Chief Executive Officer	YourPath	Statewide
Kari Rabie	MD	Addiction Medicine and Family Medicine	Native American Community Clinic	Minneapolis
Kat Donnelly	FNP, RN, PHN	Family Nurse Practitioner	Healthcare for the Homeless	St. Paul
Kelly Black	PhD	Substance Use and Addiction Care Mgr.	Essentia Health	Northeast Minnesota
Kim Price	RN	Harm Reduction Supervisor	Red Door Clinic	Hennepin County
Kurt DeVine	MD	Addiction and Family Medicine	CentraCare	St. Cloud
Meg Thomas	MPH	Harm Reduction Coordinator	Hennepin County Public Health	Hennepin County
Natalie Winchell	PharmD	Pharmacy Operations Manager	Olmsted Medical Center	Southeast Minnesota

Member Name	Credentials	Title/Specialty	Organization Representing in Work Group	Region
Robert Levy	MD	Addiction and Family Medicine	University of Minnesota Medical School	Statewide
Ryan Kelly	MD	Addiction Medicine, Harm Reduction, Internal Medicine & Pediatrics	Community-University Health Care Center	Minneapolis
Samantha Guthman	MS, LMFT	Director of Operations, Addiction Services	Allina Health	Metro
Samuel Boadu	DNP, APRN	Primary Care	Open Cities Health	St. Paul
Tim Kummer	MD	Emergency Medicine	Hennepin Healthcare	Hennepin County
Wendy Jones	MA	Executive Director	Minnesota Alliance of Recovery Community Organizations	Statewide
Weston Merrick	PhD	Principle Manager of Impact & Evaluation Unit	Minnesota Management & Budget	Statewide

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- ⁵ Minnesota Hospital Discharge Data, Injury Prevention and Mental Health Section, Minnesota Department of Health, 2024.
- ⁶ [Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns](#)
- ⁷ [Federal Register: Modifications to Labeling of Buprenorphine-Containing Transmucosal Products for the Treatment of Opioid Dependence](#)
- ⁸ <https://www.cms.gov/files/document/receipt-buprenorphine-and-naltrexone-opioid-use-disorder-medicare-inequities-and-state-policies.pdf>
- ⁹ <https://www.cdc.gov/overdose-prevention/media/pdfs/2024/03/Evidence-based-strategies-for-prevention-of-opioid-overdose.pdf>
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- ¹³ https://mn.gov/mmb/assets/gacosua-year-end-report-2024_tcm1059-670056.pdf
- ¹⁴ [Task Force on Holistic and Effective Responses to Illicit Drug Use](#)
- ¹⁵ https://mn.gov/mmb/assets/moud-in-jails-report-2025_tcm1059-706461.pdf