Chapter 3:

Access to Medications for Opioid Use Disorder in Medicaid

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Key Points

- Opioid use disorder (OUD) is a chronic medical condition that disproportionately affects Medicaid beneficiaries who are more likely to experience health-related risk factors, which can put them at higher risk of overdose.
- Despite considerable policy efforts and recent declines in drug-related mortality, the number of opioid-related deaths in the United States remains high.
- Medications for opioid use disorder (MOUD)—methadone, buprenorphine, and extended-release injectable naltrexone—are effective treatments for OUD that can reduce the risk of overdose death and address socioeconomic costs associated with the opioid epidemic.
- In recent years, Congress and federal agencies have approved a variety of policies and funding to improve access to MOUD, including a requirement that state Medicaid agencies cover all forms of MOUD and associated counseling and behavioral therapies.
- While there has been improvement in rates of MOUD treatment over time, a substantial gap remains, with nearly 30 percent of beneficiaries with OUD not receiving MOUD. Moreover, there is considerable variation in MOUD treatment rates by states.
- MOUD use among Medicaid beneficiaries with OUD also varies across demographic groups, with the greatest disparities observed by age, eligibility group, and race and ethnicity.
- MACPAC identified a variety of factors that create barriers to MOUD and contribute to the treatment gap. Social stigma and limited provider availability are persistent challenges. Prior authorization for MOUD generally, and daily dosage caps for oral buprenorphine, are also commonly cited as barriers to timely and effective treatment.
- As part of the Commission's continued focus on access to behavioral health care, MACPAC's future work will examine the use of utilization management practices and how they affect MOUD access and treatment retention for Medicaid beneficiaries with OUD.

CHAPTER 3: Access to Medications for Opioid Use Disorder in Medicaid

Medicaid and the State Children's Health Insurance Program (CHIP) cover a substantial portion of the population with opioid use disorder (OUD) in the United States. In 2022, they were the primary source of coverage for nearly 40 percent of individuals age 12 to 64 with OUD, representing 1.9 million beneficiaries (MACPAC and SHADAC 2024).[1] OUD is a chronic medical condition involving complex interactions among brain circuits, genetics, environment, and social factors (ASAM 2019, NASEM 2019). Although rising rates of OUD were initially spurred by prescription medications, heroin and powerful synthetic opioids (e.g., illicit fentanyl) have become predominant and today account for most opioid misuse and related deaths (NCHS 2025, Volkow and Blanco 2020).

The importance of Medicaid's role in assisting with access to OUD treatment is underscored by the disproportionate share of drug overdose deaths among Medicaid beneficiaries relative to the general population. Medicaid beneficiaries, by virtue of their low income, are more likely to experience health-related risk factors such as unemployment and housing instability, which in turn can put them at higher risk for overdose (Grinspoon 2021, Pear et al. 2019, Yamamoto et al. 2019). In 2020, the drug overdose death rate was two times higher for Medicaid beneficiaries (54.6 per 100,000) compared to all U.S. residents (27.9 per 100,000). Medicaid beneficiaries accounted for nearly half of all overdose deaths, though they represented just a quarter of the U.S. population (Mark and Huber 2024).[2]

National data show a recent decline in drug-related mortality; however, the number of drug overdose deaths remains high. Between November 2023 and October 2024, approximately 84,000 people died from a drug overdose, most often involving the use of synthetic opioids such as illicit fentanyl (NCHS 2025). The latest national data show that although drug overdose death rates have decreased among white people, rates for other racial and ethnic groups generally have stayed the same or increased and are highest for Black and American Indian and Alaska Native people (Garnett and Miniño 2024).

Medications for opioid use disorder (MOUD) are an effective treatment for OUD that can reduce illicit opioid use and the risk of overdose death.[3] They have also been shown to reduce health care costs, loss of productivity, and involvement in the child welfare and criminal justice systems (SAMHSA 2021, NASEM 2019). The U.S. Food and Drug Administration (FDA) has approved three types of MOUD: methadone, buprenorphine, and extended-release injectable naltrexone. These medications are often offered in conjunction with counseling and other services (e.g., peer supports) to improve treatment retention and help patients manage their condition (SAMHSA 2021).

In recent years, Congress and federal agencies have approved a variety of policies and funding to improve access to MOUD. Some of these efforts have been specific to Medicaid, while others affect access to MOUD more broadly. Notably, Medicaid is now required to cover all forms of FDA-approved MOUD and associated counseling and behavioral therapies (§ 1905(a)(29) of the Social Security Act (the Act)). Congress also extended certain policies put into place to assist with access to MOUD during the COVID-19 public health emergency (PHE), such as additional flexibility to provide methadone take-home doses (SAMHSA 2024a).

Given these and other substantial federal policy changes and persistently high rates of opioid-related deaths, MACPAC undertook efforts to examine access to MOUD in Medicaid. This chapter presents findings from that work—drawing from the literature, stakeholder interviews, and an analysis of Medicaid claims data—and identifies areas for future Commission consideration.[4] It starts with background information about MOUD, followed by a discussion of recent Medicaid and non-Medicaid policies and funding that have affected access to MOUD. Next, we discuss MOUD coverage and present estimates of MOUD use, including how the benefit mandate, specifically additional coverage of methadone, affected utilization of MOUD. We then discuss three barriers to MOUD as identified through our work: social stigma; provider availability; and utilization management practices, including prior authorization. The chapter

ends with a discussion of the Commission's plans to further investigate the use of utilization management practices and how they affect Medicaid beneficiaries' receipt of timely and effective care.

Overview of MOUD

Strong evidence demonstrates the effectiveness of MOUD—methadone and buprenorphine in particular. In randomized clinical trials, methadone, buprenorphine, and extended-release naltrexone were each found to be more effective in reducing illicit opioid use compared to no medication. Treatment with methadone and buprenorphine has also been shown to reduce risk of overdose death by nearly 50 percent. Moreover, MOUD can help address the socioeconomic costs associated with the opioid epidemic, such as lost productivity and increased child welfare involvement, by enabling individuals to maintain employment and fulfill their responsibilities as caregivers. Individuals taking MOUD are also less likely to use costly acute care settings or be involved in the criminal justice system relative to those with OUD who are not receiving medication treatment (SAMHSA 2021, NASEM 2019).

Important distinctions exist between the different types and formulations of MOUD as well as varying federal rules for prescribing and dispensing each medication (Table 3-1).

Methadone

Methadone is a controlled substance that has been used for decades to treat OUD.[5] It is an opioid agonist that binds to and activates the brain's opioid receptors, suppressing painful withdrawal symptoms and controlling opioid cravings in addition to blunting or blocking the effects of other opioids if taken.[6] Methadone for the treatment of OUD is taken orally and is generally dispensed only at federally regulated opioid treatment programs (OTPs). Typically, patients must travel to an OTP to receive medication daily or near daily, though over time they may be permitted to receive take-home doses. OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body. Federal law requires OTPs to provide comprehensive addiction care, including counseling, toxicology screens, and other services (SAMHSA 2024b).

Buprenorphine

Buprenorphine is a partial opioid agonist that reduces withdrawal symptoms and cravings and blunts or blocks the effects of other opioids. It is a controlled substance that, compared to methadone, produces a less intense opioid-like effect and poses less risk for clinically significant drug interactions (SAMHSA 2021). Buprenorphine can be taken orally daily or administered via weekly or monthly extended-release injections. To reduce the risk of misuse, some oral formulations of buprenorphine include the overdose-reversal drug naloxone, which can cause uncomfortable withdrawal symptoms if the medication is injected or snorted. Buprenorphine can be accessed in OTPs, but it is more commonly prescribed in office-based settings. Any provider licensed by the U.S. Drug Enforcement Administration (DEA) may prescribe buprenorphine, so long as they are also permitted to do so under state law. Branded products include oral formulations of buprenorphine-naloxone known as Suboxone and Zubsolv and buprenorphine extended-release injections called Sublocade and Brixadi (FDA 2024a).

Naltrexone

Naltrexone is an opioid agonist that binds to opioid receptors but does not activate them. It prevents relapse because an individual who is taking naltrexone and uses opioids will not experience the sought-after feeling of euphoria. Compared to other types of MOUD, naltrexone is less effective in reducing the risk of overdose mortality and is used less commonly for OUD treatment (OIG 2024, Wakeman et al. 2020). Oral and extended-release injectable forms of naltrexone are available, but only the extended-release form known by the brand name Vivitrol is FDA approved to treat OUD.[7] Patients must undergo opioid withdrawal and remain abstinent before initiating naltrexone, which is administered monthly. Naltrexone is not a controlled substance and can be prescribed and dispensed by any clinician with prescribing authority (SAMHSA 2024c).

TABLE 3-1. Medications for Opioid Use Disorder

Medication	Controlled substance		Dispensing		Route of administration		Frequency of administration		
	Yes	No	Pharmacy[1]	OTP	Oral	Injectable	Daily	Weekly	Monthly
Methadone	✓	–	–	✓	✓	–	✓	–	–
Buprenorphine	✓	–	✓	✓	✓	✓	✓	✓	✓
Naltrexone	–	✓	✓	✓	–[2]	✓	–	–	✓

Notes: OTP is opioid treatment program. A controlled substance is a drug or other substance that is highly regulated by the government because of its abuse and dependency potential.

✓ Check indicates that the medication meets the criterion.

– Dash indicates that the medication does not meet the criterion.

[1] Extended-release formulations of buprenorphine and naltrexone must be administered by a health care professional.

[2] The oral formulation of naltrexone is not approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder.

Source: SAMHSA 2021

Although the standard of care for OUD includes counseling and other services that can support recovery, recent federal guidance emphasizes that treatment with MOUD should not be contingent upon someone receiving these additional services. There is evidence, for example, that patients benefit from buprenorphine treatment even when counseling services are not immediately available (HHS 2023a, NASEM 2019).

Medicaid Policies Affecting MOUD

In recent years, federal legislation and subregulatory guidance have established requirements as well as new options for states to increase access to MOUD in Medicaid.[8]

MOUD benefit mandate

The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) requires state Medicaid programs to cover all forms of FDA-approved MOUD and related counseling and behavioral therapies for five years beginning October 1, 2020.[9] As of fiscal year (FY) 2017, all state Medicaid programs covered some form of buprenorphine and naltrexone, whereas 13 states did not cover methadone for the treatment of OUD (MACPAC and Acumen 2024).[10] Congress later made the MOUD benefit mandate permanent with the passage of the Consolidated Appropriations Act, 2024 (P.L. 118-42).[11]

The Centers for Medicare & Medicaid Services (CMS) expected states to conduct provider outreach and enrollment to increase the MOUD provider workforce as they prepared to implement the benefit mandate in 2020. States could apply for an exception to the coverage mandate if implementing the benefit was not feasible due to a shortage of qualified providers or facilities serving Medicaid enrollees (CMS 2020). CMS approved exceptions for provider shortage in three states and four territories, primarily due to a lack of OTPs providing methadone.[12] Requests for exceptions due to provider shortage must be reapproved at least every five years (CMS 2024b).

The state officials, beneficiary advocates, and other stakeholders we interviewed generally expressed positive views of the MOUD benefit mandate and congressional action to make it permanent. Coverage is an essential component of access, and therefore, the benefit mandate was an important step toward better access to MOUD for Medicaid beneficiaries,

particularly in states that added methadone coverage to comply with the mandate. Several stakeholders noted that in addition to ensuring payment for MOUD, the benefit mandate improved awareness of MOUD as an evidence-based treatment for OUD, which helped reduce stigma and more clearly establish MOUD as the standard of care.

Stakeholders noted that predictable and sustained funding for MOUD facilitates planning at the state and provider level. It also helps providers retain staff, which is critical given ongoing behavioral health workforce shortages. Moreover, a permanent MOUD benefit helps mainstream addiction treatment, which can assist with better integration of behavioral health and physical health care. Stakeholders noted that this comprehensive approach is important given the prevalence of serious physical health comorbidities (e.g., HIV, hepatitis C, cardiovascular disease) among beneficiaries with OUD and other types of substance use disorder (SUD).

Provider capacity demonstrations

The SUPPORT Act directed the Secretary of the U.S. Department of Health and Human Services, in consultation with CMS and other agencies, to conduct a demonstration project to increase the capacity of qualified Medicaid providers to deliver SUD treatment and recovery services. CMS awarded planning grants to 15 states and selected 5 of those states to participate in a three-year postplanning period beginning in the fall of 2021.[13]

Reports from the postplanning period indicate that the demonstration helped foster greater collaboration among state agencies and improved the capacity of their state Medicaid agencies to collect and share relevant data. All five states also reported increases in the number of Medicaid providers qualified to prescribe methadone and buprenorphine. However, states felt their efforts have been limited by a lack of administrative funding and uncertainty regarding the amount of federal funding available for demonstration activities.[14] The COVID-19 PHE also resulted in delayed implementation or cancellation of certain initiatives, as states had to set new priorities for resources to address the PHE (HHS 2024).

Section 1115 demonstrations

Stakeholders highlighted the importance of two demonstration opportunities that, among other goals, are designed to improve access to MOUD, including in institutional settings in which Medicaid is generally prohibited from paying for services.

SUD demonstrations. In 2017, CMS clarified how states can receive federal matching funds for services provided to beneficiaries receiving treatment for SUD in institutions for mental diseases (IMDs), which is otherwise generally prohibited under federal law. The demonstrations are intended to provide a full continuum of care to beneficiaries with SUD and OUD and to achieve specified milestones, including increased access to MOUD and a reduction in opioid-related deaths. Participating states must assess the availability of Medicaid-enrolled providers of medication-assisted treatment (MAT), including MOUD, and require residential treatment facilities to provide MOUD on site or assist with access off site (CMS 2017). As of March 2025, CMS approved Section 1115 demonstrations for SUD and OUD in 37 states, and 3 states have pending applications (KFF 2025).[15]

Reentry demonstrations. OUD and other SUDs are highly prevalent among individuals involved in the criminal justice system and contribute to poor health outcomes following incarceration (Maruschak et al. 2021). In 2023, CMS released guidance describing how states can receive federal matching funds for prerelease Medicaid services provided to incarcerated beneficiaries up to 90 days before their release, with the goal of improving care coordination and health outcomes as individuals reenter the community. At a minimum, states must cover prerelease MAT for all types of SUD, including OUD, as well as case management and a 30-day supply of prescription medications provided upon release, when clinically appropriate (CMS 2023a). As of March 2025, CMS approved Section 1115 reentry demonstrations in 19 states, and 9 states have pending applications (KFF 2025).[16]

State plan option for IMDs

In addition to the Section 1115 demonstration opportunity, the SUPPORT Act established an option for states to cover services for beneficiaries age 21 to 64 receiving withdrawal management or SUD

treatment services in IMDs under the state plan. The authority was time limited until Congress permanently extended it under the Consolidated Appropriations Act, 2024. Among other requirements, eligible IMDs must offer at least two forms of MAT on site, including at least one FDA-approved partial agonist (buprenorphine) and one agonist (naltrexone). Eligible IMDs must also offer behavioral therapies alongside MAT (CMS 2019). Two states currently use this authority to cover short-term residential and inpatient SUD treatment (Houston 2023).

Health homes

States can establish Medicaid health homes under the state plan that integrate physical and behavioral health care and long-term services and supports for beneficiaries with OUD and other chronic conditions. States receive federal matching funds (90 percent) for health home services for eight quarters following approval of their state plan amendment, and SUD-focused health homes receive an additional two quarters of enhanced federal funding. Health home services for which enhanced federal matching funds are available are comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referral to community and social support services. As of 2024, seven states have SUD health homes, three of which are solely focused on beneficiaries with OUD. Several other states have health homes focused on a broader array of chronic conditions, which may include OUD (CMS 2024c).[17] Opioid health homes are typically MOUD providers (e.g., OTPs) that also offer health home services (CMS 2020).

Other Federal Policies Affecting MOUD

Federal agencies have taken a number of recent steps to improve access to MOUD, including actions to safely enable treatment during the COVID-19 PHE. These actions also eliminated previously documented barriers to MOUD, such as limited flexibility to provide methadone take-home doses. Additionally, Congress approved legislation to increase the number of providers eligible to prescribe buprenorphine and provided grant funding that states use to pay for infrastructure and services that are not covered by Medicaid but are integral to the provision of MOUD.

Methadone dispensing

During the COVID-19 PHE, SAMHSA allowed OTPs to dispense up to 28 days of take-home methadone doses for stable patients being treated for OUD and up to 14 days of take-home doses for less stable patients. These flexibilities were scheduled to end a year after the end of the PHE or upon publication of a final rule addressing them. In 2024, SAMHSA issued a final rule that permanently extended those methadone take-home dosing options.[18] The final rule also makes other updates to OTP regulations and eliminates certain barriers to treatment admission, including that patients have a history of at least one year of opioid addiction and that patients younger than age 18 have at least two unsuccessful attempts at treatment before accessing care at an OTP. The rule also prohibits OTPs from denying MOUD to patients who do not receive counseling (SAMHSA 2024a).

Stakeholders expressed positive views about these federal policy changes and noted that states may need to update their OTP regulations and Medicaid payment methodologies to align with federal rules and adopt the new flexibilities offered. For example, if a state's weekly bundled rate for methadone is left unchanged, there is a disincentive for OTPs to provide more than one week of take-home doses. Some states passed emergency legislation to align their regulations and payment methods with the new federal rule; however, others may not take full advantage of the opportunities provided under the new rule.

Buprenorphine initiation via telehealth

At the start of the PHE, the DEA began permitting patients to initiate buprenorphine via telehealth without first receiving an in-person medical evaluation (DEA 2020). Several stakeholders noted that this policy increased access to MOUD and that the use of audio-only visits for buprenorphine prescribing was particularly helpful in rural states, where patients often have to travel long distances to see a provider in person. After extending the policy several times on

a short-term basis, DEA and SAMHSA published a final rule that permanently allows patients to receive up to a six-month supply of buprenorphine through a telehealth consultation with a provider, at which point the patient must complete an in-person visit to continue treatment (DEA 2025a).

Requirements for buprenorphine prescribers

The Consolidated Appropriations Act, 2023 (P.L. 117-328) permanently eliminated the requirement for providers to obtain a federal waiver (commonly referred to as a DATA-2000 or X-waiver) to prescribe buprenorphine for the treatment of OUD.[19] Any qualified provider with a standard DEA registration may now prescribe buprenorphine for OUD, as long as state scope-of-practice laws permit them to do so. The Consolidated Appropriations Act, 2023 also eliminated caps on the number of patients a prescriber can treat for OUD with buprenorphine at any given time. Providers applying for a new or renewed DEA registration must attest to having completed at least eight hours of training on OUD or other SUDs. Providers are not required to complete the training if they hold a current board certification in addiction medicine or addiction psychiatry or graduated within the past five years from a health professional education program (e.g., medical or advance practice nursing school) that required successful completion of an OUD or other SUD curriculum (SAMHSA 2024d).

Grant funds

Non-Medicaid grant funding has been a central component of state efforts to expand and sustain access to MOUD. MACPAC spoke to stakeholders about these funding sources, including the Substance Use Prevention, Treatment, and Recovery Services block grant and supplemental funding provided through the American Rescue Plan Act of 2021 (P.L. 117-2), before the U.S. Department of Health and Human Services announced that it would be terminating state grants and cooperative agreements funded by COVID-19 supplemental appropriations.[20] States described using these funds, as well as funding from State Targeted Response to the Opioid Crisis grants and State Opioid Response grants, to build infrastructure (e.g., to purchase vans for mobile MOUD treatment services), to pay for services that are not covered by their state's Medicaid program (e.g., harm reduction or peer support services), and to help MOUD providers remain financially viable when Medicaid reimbursement is not sufficient to fund the range of services provided.[21] States have also used grant funds to provide MOUD to justice-involved populations for whom Medicaid is not allowed to pay for services and for education and technical assistance to help providers obtain the federal waiver that until recently was required to prescribe buprenorphine.

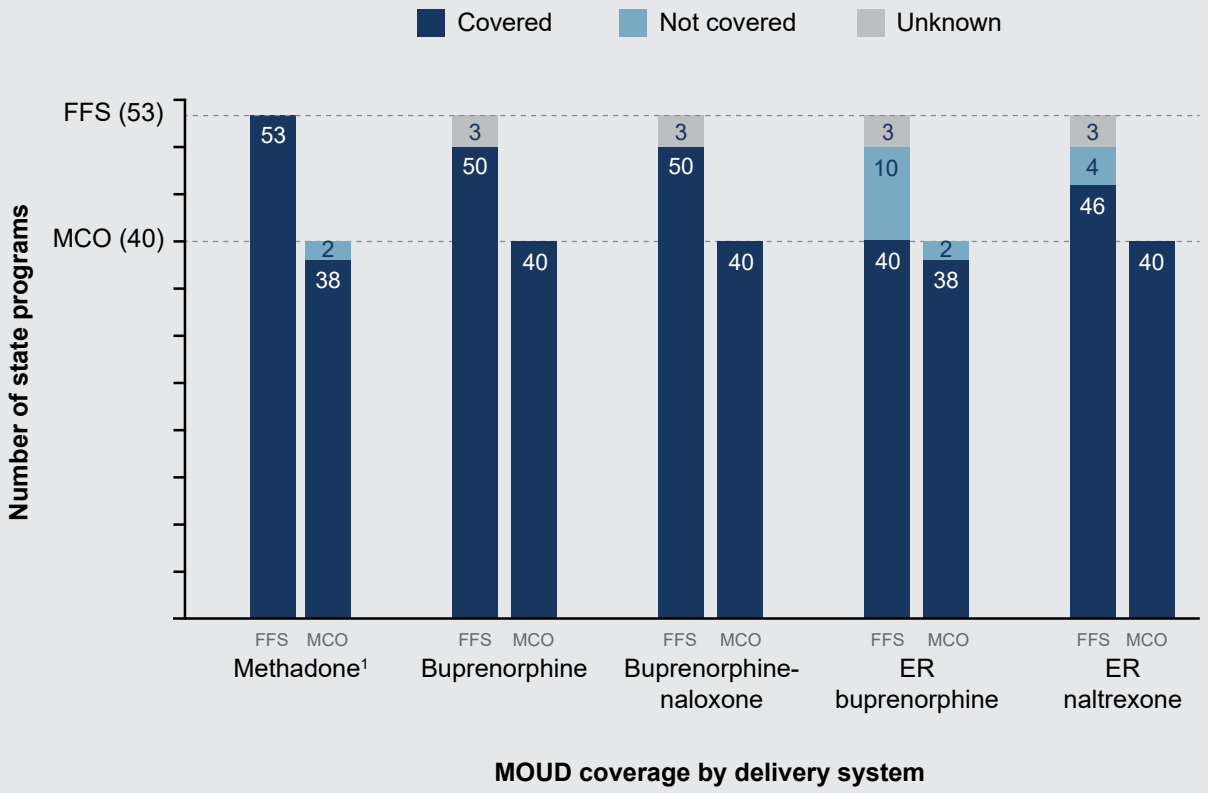
Grant funding has also supported community-based organizations that provide or refer Medicaid-eligible beneficiaries to MOUD, though they are not Medicaid-enrolled providers. For example, the Centers for Disease Control and Prevention provides funding for syringe services programs that, in addition to providing access to and disposal of sterile syringes and injection equipment, can offer an array of treatment and harm reduction services, including buprenorphine. These efforts and other community-based providers often provide services to people at high risk of an overdose who are typically hard to engage (e.g., unhoused individuals). They do this, for example, by employing peer recovery specialists with lived experience of SUD to conduct outreach to potential patients and by providing buprenorphine to individuals in non-traditional settings like parking lots and homeless encampments.

Coverage of MOUD

In a recent review of publicly available information, researchers were at times unable to identify evidence that Medicaid fee-for-service and managed care programs covered all forms of MOUD in every state (Figure 3-1).[22] The study, commissioned by SAMHSA, identified two states without documented managed care organization (MCO) coverage of methadone and two states without documented MCO coverage of extended-release buprenorphine. SAMHSA also did not find documentation of fee-for-service coverage of extended-release buprenorphine (10 states) and naltrexone (4 states). In two states and one territory, researchers were not able to identify whether fee for service covered any MOUD apart from methadone.[23]

Characterizing Medicaid coverage of MOUD can be challenging for several reasons. Every state (except

FIGURE 3-1. Medicaid Coverage of Medications for Opioid Use Disorder in Fee for Service and Managed Care, as Documented in Publicly Available Information, 2022–2023



Notes: FY is fiscal year. FFS is fee for service. MCO is managed care organization. ER buprenorphine is extended-release injectable buprenorphine. ER naltrexone is extended-release injectable naltrexone. MOUD is medications for opioid use disorder. This figure represents data on all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands based on a review of publicly available data sources.

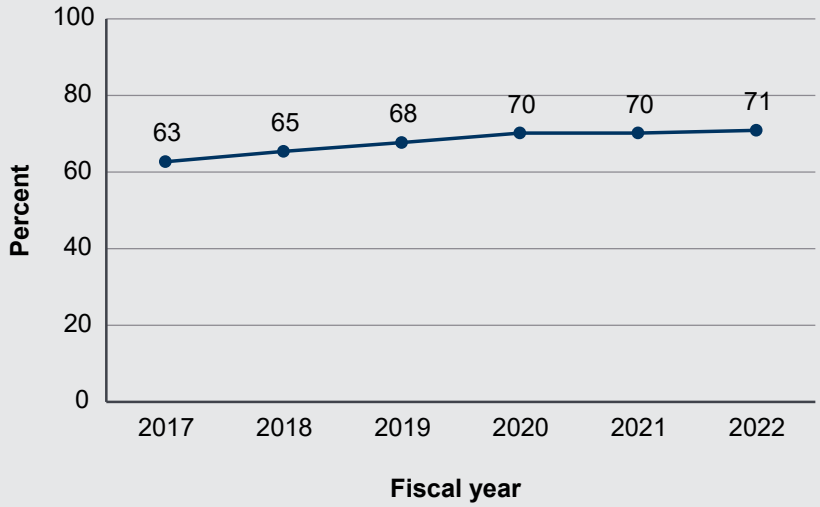
[1] The study identified South Dakota, the U.S. Virgin Islands, and Wyoming as covering methadone, though they were exempt from the MOUD benefit mandate due to a lack of Medicaid-enrolled opioid treatment programs (CMS 2024b).

Source: SAMHSA 2024e.

those that were exempt due to provider shortages) has amended their state plan to cover all forms of FDA-approved MOUD as a mandatory benefit, as required by the SUPPORT Act.[24] These medications are covered, although states and MCOs may control their use through prior authorization, clinical criteria, and other utilization management tools (CMS 2020).

Although every state complies with the MOUD benefit mandate, publicly available documentation of state and MCO coverage policies can be difficult to find. SAMHSA notes that although some states provide easily accessible formularies or comprehensive preferred drug lists, in other states, it is more difficult to identify MOUD coverage policies.[25] The authors observe that this lack of clarity can pose obstacles to the availability of medications by making it difficult for providers and beneficiaries to readily identify which forms of MOUD are covered without prior authorization and whether any other utilization management criteria apply (SAMHSA 2024e). However, in some instances, clinicians may have access to that information through electronic health records (ASAM 2021).

FIGURE 3-2. Share of Medicaid Beneficiaries Age 18–64 with Opioid Use Disorder Who Received Any Medication for Opioid Use Disorder in the United States, FY 2017–2022



Notes: FY is fiscal year. The figure shows the use of medications for opioid use disorder among individuals age 18 to 64 who were ever enrolled as a full-benefit, Medicaid-only beneficiary in a given fiscal year. Medications for opioid use disorder are methadone, buprenorphine, and extended-release injectable naltrexone. The analysis includes all 50 states and the District of Columbia, with the following exceptions: Illinois and New York were excluded for all years, and Maryland and Utah were excluded for FY 2017 due to data limitations.

Sources: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.

Documented Medicaid coverage of MOUD does not necessarily mean that access to or use of medications is widespread. The next section highlights findings from an analysis of Medicaid claims, which shows that the use of certain medications is extremely low or non-existent in some states, despite them being covered.

Utilization of MOUD

MACPAC contracted with Acumen LLC to examine MOUD use among Medicaid beneficiaries using data from the Transformed Medicaid Statistical Information System (T-MSIS). Specifically, we looked at national and state-level trends as well as variation in MOUD use by beneficiary demographic and health-related characteristics. We also assessed how the MOUD benefit mandate, specifically the addition of methadone coverage, affected utilization of MOUD.

The MOUD treatment rates presented in this section may differ from other available estimates due to differences in data sources and methodology. For information about our data sources and methodology, see Appendix 3A.

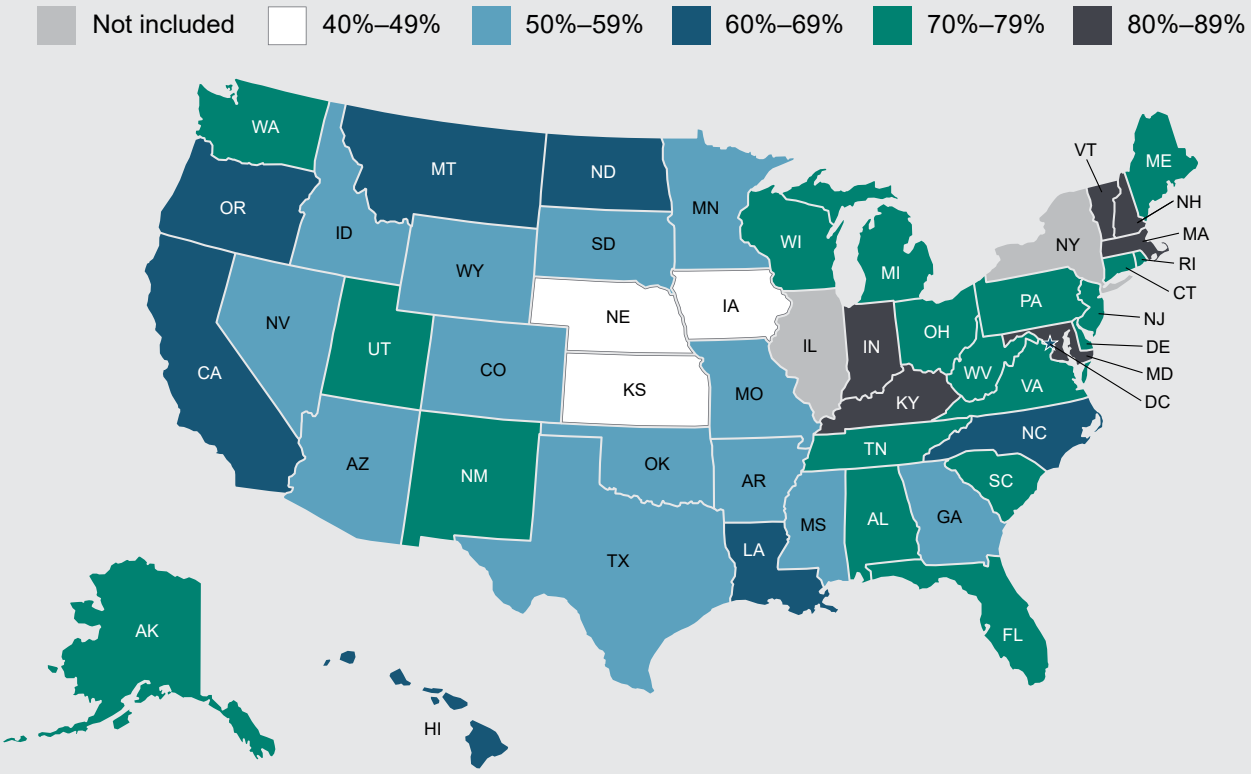
Any MOUD use

Although the share of Medicaid beneficiaries with OUD receiving MOUD has increased in recent years and is relatively high nationally, there is considerable variation across states.

National estimates

In 2022, approximately 1.4 million Medicaid beneficiaries age 18 to 64 with OUD received some form of MOUD. The share of beneficiaries with OUD receiving MOUD increased from 63 percent in FY 2017 to 71 percent in FY 2022 (Figure 3-2). Access to MOUD was likely affected by several factors during this period, including federal and state initiatives to improve the availability of MOUD providers and the onset of the COVID-19 PHE in early 2020. Although there has been improvement in rates of MOUD treatment over time, a substantial gap remains, with nearly 30 percent of beneficiaries with OUD not receiving MOUD. We discuss stigma, provider shortages, and other factors that contribute to the treatment gap later in the chapter.

FIGURE 3-3. Share of Adult Medicaid Beneficiaries Age 18–64 with Opioid Use Disorder Who Received Any Medication for Opioid Use Disorder by State, FY 2022



Notes: FY is fiscal year. The figure shows use of medications for opioid use disorder among individuals age 18 to 64 who were ever enrolled as a full-benefit, Medicaid-only beneficiary in FY 2022. Medications for opioid use disorder are methadone, buprenorphine, and extended-release injectable naltrexone. Illinois and New York were excluded due to data limitations.

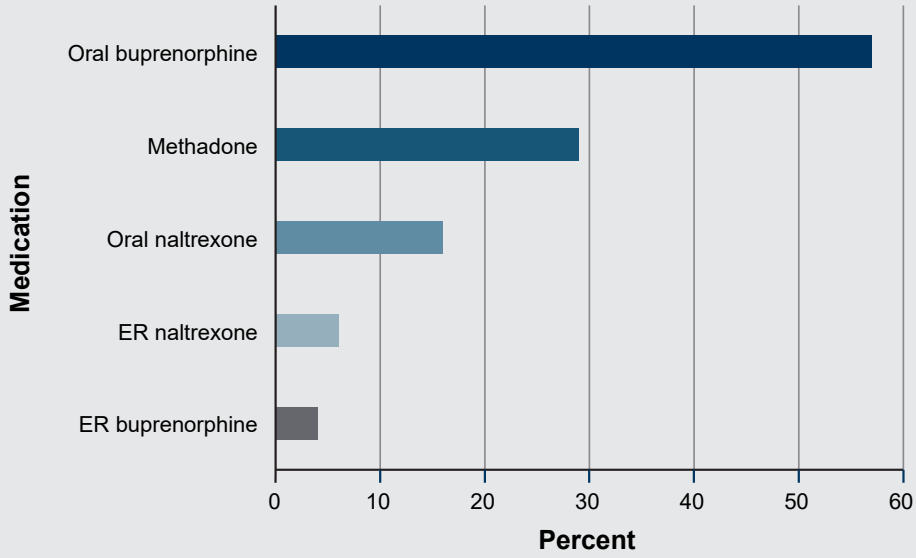
Source: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.

Our findings are generally consistent with those of other studies using T-MSIS data to analyze MOUD use among Medicaid beneficiaries with OUD (Saunders et al. 2024, HHS 2023b).[26] However, they are considerably higher than MOUD treatment rates observed in studies using national survey data. For example, our analysis of data from the 2022 National Survey on Drug Use and Health found that only 24 percent of beneficiaries with OUD received MOUD in the past year (MACPAC and SHADAC 2024).[27] This is partly because the National Survey on Drug Use and Health relies on self-reported data rather than diagnoses or claims for OUD-related services and therefore tends to identify more beneficiaries with OUD.[28]

State estimates

MOUD use among beneficiaries with OUD varies by state, ranging from 42 percent in Iowa to 84 percent in Vermont in FY 2022 (Figure 3-3). This is consistent with other studies that found wide variation in MOUD treatment rates across the states and likely reflects differences in the availability of MOUD providers, among other factors (KFF 2025, Clemans-Cope et al. 2019).

FIGURE 3-4. Share of Adult Medicaid Beneficiaries Age 18–64 with Opioid Use Disorder Receiving Medications for Opioid Use Disorder and Oral Naltrexone by Medication, FY 2022



Notes: FY is fiscal year. ER naltrexone is extended-release injectable naltrexone. ER buprenorphine is extended-release injectable buprenorphine. Medicaid beneficiaries may have had claims for more than one type of medication, and therefore, the sum of the percentages exceeds 100. Illinois and New York were excluded due to data limitations.

Source: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.

Use of specific medications

In FY 2022, Medicaid beneficiaries with OUD most commonly received an oral formulation of buprenorphine, followed by methadone, extended-release injectable naltrexone, and extended-release injectable buprenorphine (Figure 3-4). Roughly 16 percent of beneficiaries with OUD had a claim for oral naltrexone, though it is not FDA approved for the treatment of OUD and has not been found to be effective in clinical trials (Minozzi et al. 2011).[29] Off-label use of oral naltrexone for OUD is particularly common in states such as Iowa and Nebraska, where roughly half of beneficiaries receiving MOUD were treated with oral naltrexone.

Although use of extended-release injectable formulations is low overall, it is particularly low in certain states (Appendix 3B, Table 3B-1). In FY 2022, Arkansas, the District of Columbia, Idaho, South Dakota, Texas, and Wyoming each had 10 or fewer beneficiaries with claims for extended-release injectable buprenorphine.[30] Similarly, 10 or fewer beneficiaries were treated with extended-release injectable naltrexone in Mississippi, South Dakota, and Wyoming. Findings from our qualitative research suggest that low utilization of extended-release injectable formulations is likely the result of several factors, including a limited availability of providers administering these medications, utilization management policies intended to steer patients toward less costly oral formulations, and patient preference.

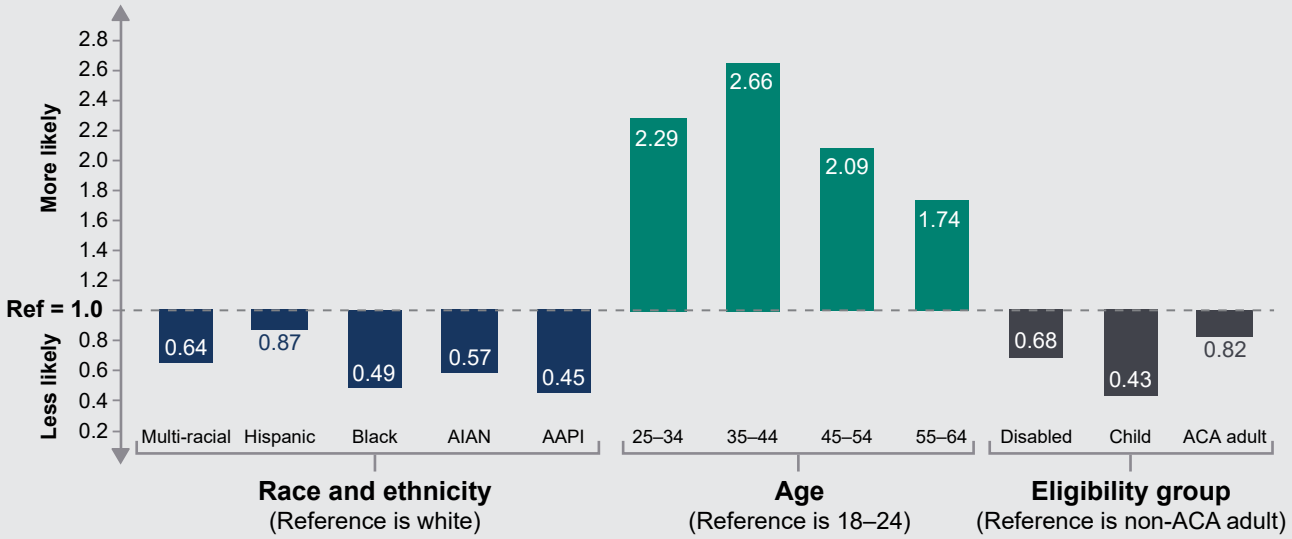
Use of methadone was particularly low in some states. In FY 2022, fewer than 1 in 5 beneficiaries receiving MOUD were treated with methadone in 17 states.[31] Relatively low use of methadone in some states may reflect limited availability of OTPs, which are the only providers authorized to dispense methadone under federal law (42 CFR Part 8). Although more stable patients may be permitted to receive take-home doses, beneficiaries typically must travel to an OTP to receive medication daily or near daily, which can pose barriers to access.

Variations in MOUD use among beneficiaries

Use of MOUD among Medicaid beneficiaries with OUD varied across demographic groups, with the greatest disparities observed by age, eligibility group, and race and ethnicity (Figure 3-5). In FY 2021, white beneficiaries were more likely than any other racial or ethnic group to receive MOUD. Rates of MOUD use were lowest among Black and Asian American and Pacific Islander beneficiaries with OUD, who were about half as likely to receive MOUD compared to their white counterparts. Other studies show similar disparities in the use of any MOUD as well as the type of MOUD received, with people of racial and ethnic minority groups being more likely to receive methadone and less likely to receive buprenorphine relative to white people with OUD (Nedjat et al. 2024).

Our analysis also found notable differences in MOUD use by age and eligibility group (Figure 3-5). Young adults age 18 to 24 were roughly two to three times less likely to receive MOUD than other adults younger than age 65. Conversely, MOUD use was most common among beneficiaries age 35 to 44. Examining MOUD use by eligibility group, we found that non-expansion adults with OUD were more likely to receive MOUD compared to beneficiaries with OUD in other eligibility groups.[32] Children and beneficiaries enrolled on the basis of a disability had the lowest odds of receiving MOUD, relative to non-expansion adults. This is consistent with other studies that have found lower odds of receiving MOUD for Medicaid beneficiaries with disabilities than for beneficiaries without disabilities (Thomas et al. 2023, MODRN 2021).

FIGURE 3-5. Odds of Beneficiaries with Opioid Use Disorder Receiving Any Medication for Opioid Use Disorder by Demographic Groups, FY 2021



Notes: FY is fiscal year. Black is Black, non-Hispanic. AIAN is American Indian and Alaska Native. AAPI is Asian American and Pacific Islander. ACA is Patient Protection and Affordable Care Act (P.L. 111-148). Odds ratios compare the likelihood of one group receiving any medication for opioid use disorder compared to that of another group, known as the "reference category," which is equal to one. White beneficiaries is the reference category to which other racial and ethnic groups are compared. Beneficiaries age 18 to 24 is the reference category for other age groups. Non-ACA adult is the reference category for other eligibility groups and represents adults who are not enrolled through the ACA Medicaid expansion. All associations reported are statistically significant ($p < .001$).

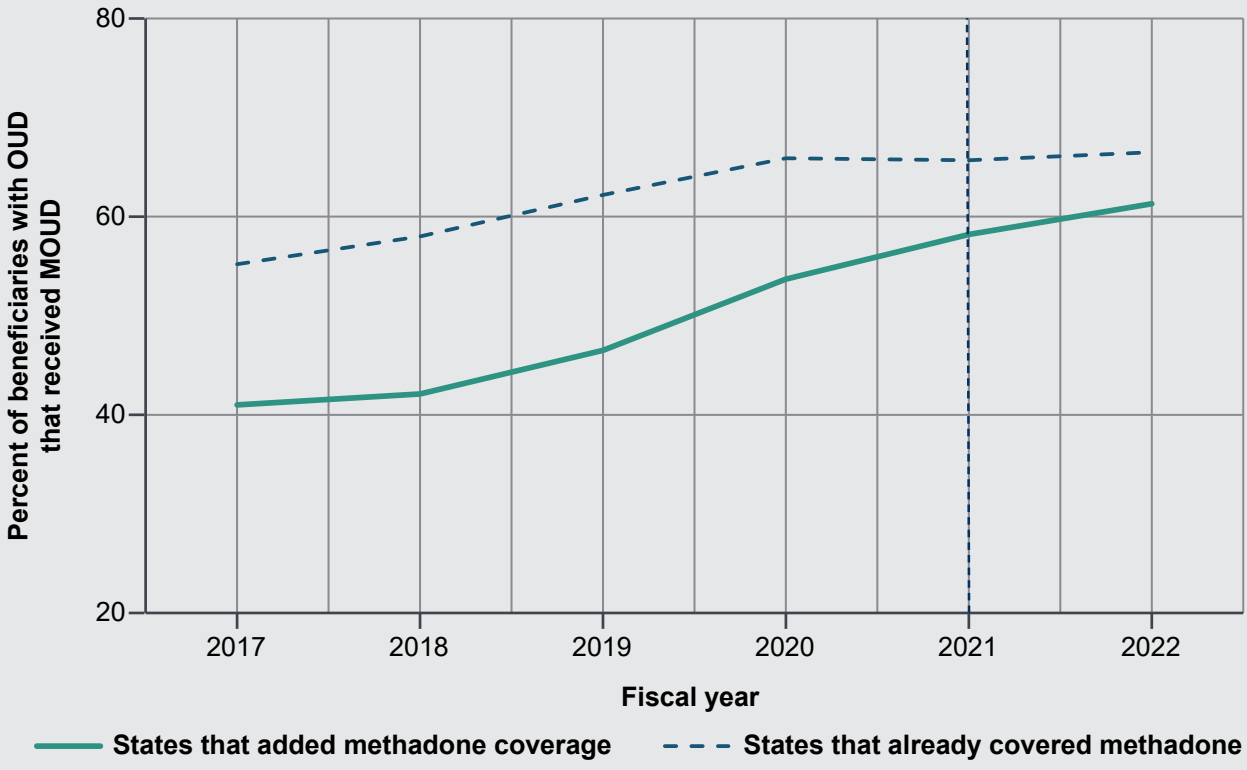
Source: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.

Effect of the MOUD benefit mandate

MACPAC sought to understand how the MOUD benefit mandate affected utilization of MOUD by evaluating the main outcome associated with the mandate: the addition of methadone coverage in states that had not previously covered it. In 2018, when Congress approved the MOUD benefit mandate, methadone was the only type of MOUD not covered in all states. Using Medicaid claims data, we identified 11 states that did not cover methadone at the time but subsequently added it.[33] Most of these states began coverage for methadone before FY 2021, as required, while others began covering methadone after the benefit mandate took effect in October 2020.

Our analysis shows that the percentage of beneficiaries with OUD using any form of MOUD increased more in states that added methadone coverage compared to those that had already covered all forms of MOUD (Figure 3-6). Overall, expanded methadone coverage was associated with an increase in MOUD use that was nearly 6 percentage points higher than the increase in MOUD use in states that already covered methadone. In other words, the addition of methadone coverage increased overall MOUD use and narrowed the gap in treatment rates between states that previously had not covered methadone and those that had.

FIGURE 3-6. Trends in Use of Medications for Opioid Use Disorder among Beneficiaries with Opioid Use Disorder in States that Added Methadone and States that Previously Covered Methadone, FYs 2017–2022



Notes: FY is fiscal year. OUD is opioid use disorder. MOUD is medications for opioid use disorder. This figure shows trends in MOUD use for states that added methadone coverage compared to similar states that already covered methadone during the study period. It excludes states with data quality issues and states that received an exemption to the federal requirement for states to cover all forms of MOUD (South Dakota and Wyoming), which took effect in FY 2021. MOUD are methadone, buprenorphine, and extended-release injectable naltrexone.

Source: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.

Limitations

Several limitations should be considered when assessing the results of this analysis. First, there were many other local, state, and federal policy changes addressing MOUD access during the study period, and therefore, changes in MOUD coverage and use cannot solely be attributed to the MOUD benefit mandate. The study period spans the height of the COVID-19 pandemic, during which treatment access was affected by social distancing requirements in addition to a number of new policies intended to mitigate access barriers (e.g., additional flexibility to offer buprenorphine via telehealth and methadone take-home doses). Although the factors motivating state decisions to add methadone coverage are beyond the scope of this analysis, it is likely that some states were already moving toward covering methadone independent of the federal policy change, while others added coverage to comply with the new requirement. Additionally, the analysis uses a broad definition of MOUD treatment: Beneficiaries are counted as having received MOUD if they had at least one MOUD claim. In that regard, the analysis measures access to MOUD rather than whether a beneficiary was engaged in more sustained, long-term treatment.

Barriers to MOUD

To examine factors that contribute to the MOUD treatment gap, MACPAC conducted a literature review and interviews with state Medicaid agency officials and MCO representatives as well as federal officials, beneficiary advocates, national associations, and other experts (Appendix 3A). Although there have been considerable federal, state, and local efforts to improve access to MOUD in recent years, social stigma and limited provider availability are persistent challenges. Prior authorization for MOUD generally, and daily dosage caps for oral buprenorphine, are also commonly cited as barriers to timely and effective treatment.

Stigma

Stakeholders reflected on the persistence of stigma and misinformation surrounding the use of methadone and buprenorphine, which tend to be labeled as so-called replacement drugs because they are themselves opioids and controlled substances. Consequently, there are abstinence-only treatment programs and facilities—often a step down from residential treatment (e.g., sober living or halfway houses)—that do not permit the use of methadone or buprenorphine and require patients to taper off these medications (Carroll et al. 2024, Facher 2024). This can cause severe harm and even overdose death for individuals who are receiving MOUD treatment and need or have been court ordered to stay in those settings as they transition back into the community. Moreover, stakeholders noted that abstinence-only policies may violate federal antidiscrimination laws such as the Americans with Disabilities Act (P.L. 101-336), which prohibits discrimination against individuals who are taking legally prescribed MOUD (DOJ 2022).[34] Courts and government agencies within the criminal legal system and family court systems have also prohibited or restricted the use of MOUD (LAC 2024).

Stigma can also reinforce structural barriers to MOUD, particularly for methadone. For example, 22 states have zoning laws that are more restrictive for OTPs than they are for other medical facilities, which can make it harder to identify new locations and ensure convenient access to OTPs. In some instances, state and pharmacy board regulations also limit access to methadone by requiring OTPs to obtain a license from the board of pharmacy or to have a pharmacist on staff. Additionally, some states require providers to obtain a certificate of need (i.e., a legal document demonstrating the need for new facility services that requires local approval) to establish an OTP. States regulations may pose such a barrier to entry that there is effectively a moratorium on new programs (Doyle 2022).

Stakeholders discussed how fear of running afoul of DEA regulations prevents some retail pharmacies from dispensing buprenorphine or increasing their buprenorphine supply, making it more difficult for patients to access the medication. Although federal regulations do not limit the quantity of buprenorphine a pharmacy can order, the DEA requires suppliers to monitor pharmacy orders of controlled substances through a centralized database, and suppliers have a legal duty to notify the DEA of pharmacy orders of opioid products that are atypically large or otherwise considered suspicious (DEA 2025b). Officials from one state Medicaid agency said pharmacies that run out of buprenorphine partway through the month are not

replenishing their supply to avoid DEA scrutiny. Some pharmacies are still using years-old monthly quotas for stocking buprenorphine and are unwilling to increase their supply, even as they have seen the increased need for buprenorphine in the community.

Complex federal regulations regarding patient privacy can also contribute to stigma and dissuade providers from offering MOUD. Some stakeholders noted that federal rules governing confidentiality of SUD treatment records under 42 CFR Part 2 (Part 2) can make primary care providers hesitant to prescribe MOUD, out of concern that doing so will make their practices subject to additional federal regulatory requirements. Other stakeholders noted that Part 2 does not apply to the vast majority of primary care providers who prescribe MOUD; when Part 2 does apply, it serves an important function in promoting access to treatment and protecting individuals against stigma and discrimination. There is optimism that a recent federal rule aligning certain Part 2 requirements with Health Insurance Portability and Accountability Act (P.L. 104-191) rules could help mitigate some of these challenges, though some stakeholders suggested a continued need for education to reassure primary care providers and administrators.[35] The Commission has examined issues related to Part 2 in its prior work and issued recommendations in its June 2018 report to Congress calling for additional federal guidance and technical assistance to address the confusion among providers and other stakeholders (MACPAC 2018).[36] Since then, Congress and SAMHSA have funded a center of excellence to provide additional guidance and technical assistance on HIPAA, Part 2, and other behavioral health privacy topics (SAMHSA 2024g).

Stigma can be alleviated through efforts to change public perceptions about OUD and the medications used to treat it. By requiring states to cover MOUD, the SUPPORT Act helped establish it as the standard of care for MOUD and reduced stigma among policymakers and providers. To address stigma and provider hesitancy, state Medicaid programs and MCOs have conducted outreach to educate their providers and community leaders on the benefits of MOUD. For example, one state reported that a strong case for the evidence supporting methadone for OUD treatment has made OTPs a well-established part of their OUD treatment system. States have also worked to help providers understand complex federal regulations that may prevent them from getting involved in MOUD treatment. For example, one state Medicaid agency described working with its state's behavioral health agency to release informational bulletins and meet with providers to address concerns about pharmacies stocking and dispensing buprenorphine.

Provider availability

Stigma and a host of other factors contribute to the limited availability of MOUD providers. In 2022, 34 percent of U.S. counties did not have any OTPs or buprenorphine providers serving Medicaid enrollees. More than half of these counties (57 percent) did not have any MOUD providers, whereas the remaining counties had MOUD providers that did not see Medicaid patients. Most OTPs treated Medicaid enrollees, while most office-based buprenorphine providers did not (OIG 2024).[37] This is consistent with research showing less access to buprenorphine treatment in low-income areas with high concentrations of people with racial and ethnic minority backgrounds (Drake et al. 2024). Conversely, OTPs dispensing methadone tend to be located in low-income and urban communities with higher proportions of residents who belong to minority groups (Jehan et al. 2024).

Among other challenges, stakeholders cited the overall behavioral health workforce shortage as a key limiting factor. Efforts to recruit other provider types, such as primary care and obstetrics and gynecology providers, can be hindered by stigma and the complexity of treating patients with OUD. Those who are not addiction specialists may not have the training or support to care for patients with OUD, particularly those with polysubstance use, other health or mental health conditions, and social needs. To address these challenges, states report using State Opioid Response grant funding to recruit and provide ongoing support to office-based buprenorphine prescribers, including through investments in additional case management staff. States may also support teleconsultation models, such as Project ECHO, which offer MOUD providers regular access to guidance from addiction specialists.

Payment is another factor that can deter providers from offering MOUD or participating in Medicaid, though stakeholders we interviewed had varying

perspectives on whether reimbursement rates were a barrier to increasing provider availability. Some MOUD providers do not accept Medicaid, and low Medicaid reimbursement rates can make them reluctant to participate. Moreover, many patients with OUD have complex needs that require more time or additional services (e.g., care coordination) that may not be adequately covered by Medicaid.

Stakeholders noted that the financial risks associated with offering injections of extended-release buprenorphine are of particular concern to many providers. There are costs associated with provider training, proper medication storage, and space to observe patients after injection. Moreover, extended-release buprenorphine is relatively expensive (up to $1,200 per dose) and must be administered within 45 days of delivery to the patient for whom it was prescribed. Providers who order the medication from a specialty pharmacy upon prescribing it risk assuming the cost of the medication if the patient does not return for their dose within that 45-day window. Although providers can avoid that risk by purchasing and stocking the medication, that so-called buy-and-bill approach requires a large up-front investment for the purchase of the medication, which may not be recouped unless all doses are administered.

Stakeholders described how federal, state, and local regulations limit the availability of methadone providers. As previously noted, methadone dispensing is limited to OTPs that are certified by SAMHSA, independently accredited, and compliant with a host of federal requirements. State and local restrictions such as zoning laws and certificate of need requirements create additional barriers to expanding OTPs in some states. Several states are trying to address these challenges through the use of mobile OTP units that can extend the reach of the OTP facilities with which they are affiliated. There are also federal efforts to expand the use of satellite medication units for dispensing methadone in alternate locations such as certified community behavioral health clinics, community mental health centers, and primary care clinics. Fixed units are locked medication storage containers, which are supervised by a nurse and associated with an OTP facility.

MOUD prescribing in the emergency department is another avenue for expanding access to MOUD. Some states have passed laws requiring emergency departments to prescribe MOUD or to provide a warm handoff to other providers who can initiate treatment. Stakeholders noted that integrating MOUD prescribing into routine emergency department practice can be difficult because providers may lack familiarity or training in providing these medications. However, some health systems have embraced opportunities to provide MOUD in emergency departments and to collaborate with other providers to ensure adequate support and continuity of care.

Utilization management

States and MCOs establish utilization management policies such as prior authorization to ensure the delivery of appropriate care and address other goals, such as controlling costs and reducing the potential for fraud, waste, and abuse. However, stakeholders noted that these approaches may delay or result in the denial of potentially life-saving care. Several stakeholders expressed concerns about the general use of prior authorization for MOUD as well as dosage limits for oral buprenorphine that cannot be overridden without prior approval.

Prior authorization

Many stakeholders we interviewed are supportive of removing prior authorization requirements for MOUD, which they contend delay patient care, create administrative hurdles for providers, and contribute to stigma. In the view of one addiction medicine specialist, treatment delays create the risk that patients waiting for medications will overdose or not reengage once their treatment is authorized. He and other interviewees emphasized the need to remove barriers and capitalize on every opportunity to engage individuals with OUD in treatment.

A few stakeholders highlighted the role of prior authorization in preventing medication diversion and ensuring beneficiaries receive high-quality care.[38] However, other interviewees emphasized that concerns about medication diversion are overstated, noting that eliminating prior authorization in many states has increased access to MOUD without notable increases in diversion. Moreover, MOUD that is diverted is most often used to avoid the painful effects of opioid withdrawal, not to get high. The lack of evidence that removal of prior authorization contributes to diversion and the fact that methadone

and buprenorphine overdose rates have remained relatively flat over time raises questions about the basis for concerns about diversion of MOUD. One interviewee said, "The benefits of removing these barriers in terms of initiating treatment and maintaining people on treatment in an uninterrupted fashion outweigh any of these hypothetical risks that are not really grounded in the evidence." Moreover, several stakeholders noted that other effective methods are in place to prevent potential fraud, waste, and abuse, such as pharmacy edits that flag problematic prescribing practices (e.g., overprescribing) at the point of sale.

Buprenorphine prescribing limits

States may impose caps on the dosage of buprenorphine that can be prescribed on a single day to align with clinical standards and FDA labeling. In FY 2022, 73 percent of MCOs reported having a daily dosage limit of 24 mg for oral buprenorphine and buprenorphine-naloxone combination drugs (CMS 2023b). Often, providers cannot prescribe above this limit without receiving prior authorization. However, these policies do not reflect the evolving nature of the opioid crisis and the reality that individuals with OUD who use illicit fentanyl may need higher doses of buprenorphine to stabilize. Amid rising fentanyl use and related deaths, providers have struggled to secure coverage of 32 mg daily doses for patients who require a higher dose to stave off cravings and prevent opioid withdrawal. When higher doses are not approved, patients may have to accept a lower, less effective dose or pay for the extra quantity out of pocket.

Seeking to provide more patient-centered care and improve treatment retention, some states have raised the buprenorphine dosage cap to 32 mg per day. Additionally, the FDA recently began encouraging buprenorphine labeling changes to clarify that higher doses may be appropriate for some patients. The agency notes that current labeling has been misinterpreted as suggesting a maximum dosage of 16 or 24 mg per day, despite the absence of an explicit maximum dosage. The FDA's recommendations seek to clarify that daily doses of oral buprenorphine can be adjusted for each patient based on their individual therapeutic need and that daily doses higher than 24 mg per day may be required to keep patients in treatment and suppress opioid withdrawal (FDA 2024b).

Looking Ahead

Despite considerable policy efforts and recent declines in drug-related mortality, the number of opioid-related deaths in the United States remains alarmingly high. As part of its continued focus on access to behavioral health services for Medicaid beneficiaries, MACPAC will continue to examine factors affecting access to MOUD. Although many of the access challenges discussed in this chapter are not specific to Medicaid, utilization management, such as prior authorization, are typically within the program's purview. Building on its findings to date, MACPAC's future work will examine the use of these policies and their effects on timely and effective MOUD treatment.

Endnotes

[1] MACPAC contracted with the State Health Access Data Assistance Center to produce estimates of OUD prevalence and treatment based on an analysis of self-reported data from the National Survey on Drug Use and Health (NSDUH). The NSDUH is a federal survey of non-institutionalized individuals age 12 to 64 conducted annually in all 50 states and the District of Columbia. The 2022 NSDUH classified respondents as having an OUD if they met criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, for having a heroin use disorder or a prescription pain use disorder. The definition of OUD therefore does not account for respondents' use of illegally made fentanyl, which may be mixed with heroin, substituted for heroin entirely, or sold as counterfeit prescription drugs (SAMHSA 2023).

[2] This study examined the prevalence of overdose deaths related to opioids as well as other drugs (e.g., cocaine) (Mark and Huber 2024).

[3] MOUD is a term that describes medications approved for the treatment of OUD. Medication-assisted treatment refers to MOUD and medications used to treat other substance use disorders.

[4] MACPAC contracted with Acumen LLC to interview state Medicaid agency officials in six states as well as state behavioral health agency officials and managed care organization representatives in a subset of those states. We also conducted interviews with federal officials, beneficiary advocates, national associations, and other experts.

Interviews were conducted between July and September 2024. See Appendix 3A for information on stakeholder interview methods.

[5] A controlled substance is a drug or other substance that is highly regulated by the government because of its abuse and dependency potential. Controlled substances with known medical use are available by prescription, whereas those without a known medical use (e.g., heroin) are illegal in the United States (DEA n.d.).

[6] Opioid agonists are substances that stimulate physiological activity at the cell receptors in the central nervous system that are normally stimulated by opioids (SAMHSA 2021).

[7] Oral naltrexone is approved for the treatment of alcohol use disorder.

[8] The discussion of recent Medicaid policies affecting access to MOUD is not exhaustive. Other policies and programs, such as federal mental health parity requirements and certified community behavioral health centers, are also intended to increase access to MOUD, among other goals (§ 1905(a)(31) of the Social Security Act, 42 CFR 438.3(n) and subpart K).

[9] Federal law defines the required MOUD benefit as including counseling services and behavioral therapy related to the drugs and biologics covered under the new mandatory benefit. States have flexibility to specify which counseling services and behavioral therapy are included in the mandatory benefit (CMS 2020).

[10] We identified states as covering methadone for the treatment of OUD if they had more than 10 beneficiaries with OUD who had methadone claims in a given fiscal year, because having a small number of beneficiaries with claims for methadone (10 or fewer) could indicate miscoding or other data quality issues.

[11] The MOUD benefit mandate does not apply to alternative benefit plans that do not align with the state plan. Consequently, some alternative benefit plans may not cover all forms of FDA-approved MOUD. All but four states that expanded Medicaid to low-income adults under the Patient Protection and Affordable Care Act (P.L. 111-148) provide that population with an alternative benefit plan that includes state plan benefits and therefore includes coverage for all forms of FDA-approved MOUD (CMS 2024a). States may also require other Medicaid populations to receive care through alternative benefit plans (Baumrucker 2018).

[12] The seven states and territories with approved exception requests are American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Hawaii, South Dakota, Wyoming, and the U.S. Virgin Islands (CMS 2024b).

[13] The states that received planning grants are Alabama, Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Virginia, Washington, and West Virginia. The states selected to participate in the postplanning period are Connecticut, Delaware, Illinois, Nevada, and West Virginia (HHS 2024).

[14] Federal reimbursement for the postplanning period is based on a complex formula, and states reported difficulty predicting how much federal funding they would receive (HHS 2024).

[15] As of March 2025, CMS approved Section 1115 demonstrations for SUD and OUD in Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. States with new pending applications are Alabama, Arizona, and Arkansas (KFF 2025).

[16] As of March 2025, CMS approved Section 1115 reentry demonstrations in Arizona, California, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, and West Virginia. States with pending applications are Arkansas, Connecticut, District of Columbia, Louisiana, Minnesota, Nevada, New Jersey, New York, and Rhode Island (KFF 2025).

[17] The three states with opioid health homes are Maine, Rhode Island, and Vermont. States with SUD health homes are Maryland, Michigan, North Carolina, and Wisconsin (CMS 2024c).

[18] In the first 14 days of treatment, the take-home supply is limited to a maximum supply of seven days' worth of take-home medication. Between 15 and 30 days of treatment, the take-home supply maximum is 14 days. After 31 days, patients can receive a take-home supply up to 28 days (SAMHSA 2024a).

[19] The "X" designation comes from the unique DEA number starting with the letter "X" given to providers who obtained the waiver (Healy et al. 2023). DATA-2000 refers to the Drug Addiction Treatment Act of 2000, which created the exception and waiver process for certain providers seeking to prescribe buprenorphine for OUD.

[20] Citing the end of the PHE, on March 24, 2025, the U.S. Department of Health and Human Services (HHS) terminated $11.4 billion in state grants and cooperative agreements funded by COVID-19 supplemental appropriations, including supplemental Substance Use Prevention, Treatment, and Recovery Services block grant funding that had not yet expired (HHS 2025, Weixel 2025). A federal judge issued a temporary restraining order as the result of legal action brought by 22 states and the District of Columbia, which cited the provider cuts and elimination of SUD treatment and recovery services among other harms caused by the unexpected and abrupt terminations (order granting temporary restraining order, State of Colorado et al. v. U.S. Department of Health and Human Services et al., No. 1:25-cv-00121-MSM-LDA (D.R.I. 2025)). Future court rulings will determine whether HHS can ultimately move forward in rescinding the funds.

[21] State Targeted Response to the Opioid Crisis grants were authorized under the 21st Century Cures Act (P.L. 114-255) and the SUPPORT Act and funded through appropriations. Funding for State Opioid Response grants was first provided in the Consolidated Appropriations Act, 2018 (P.L. 115-141). The two programs were effectively merged under the Consolidated Appropriations Act, 2023, which amended the Cures Act by replacing the State Targeted Response to the Opioid Crisis authorization with an authorization for the State Opioid Response grants.

[22] To assess coverage, SAMHSA reviewed state-level Medicaid drug utilization data, state Medicaid fee-for-service and managed care organization formularies, state preferred drug lists, the national master Medicaid rebate agreement, and other sources such as state regulatory announcements and state plan amendments (SAMHSA 2024e).

[23] Researchers were unable to identify most fee-for-service MOUD coverage policies in Hawaii, Kansas, and the U.S. Virgin Islands (SAMHSA 2024e).

[24] In addition to the MOUD benefit mandate, state Medicaid programs generally must cover nearly all of a participating manufacturer's FDA-approved drugs when prescribed for a medically accepted indication under the Medicaid Drug Rebate Program (§ 1927 of the Social Security Act). Physician-administered drugs, such as extended-release injectable buprenorphine and naltrexone, may be included in the Medicaid Drug Rebate Program if payment for that drug is made separately from other services (i.e., it is not part of a bundled payment). Methadone for OUD is paid for as part of a bundled set of services delivered in an OTP and is therefore not covered under the Medicaid Drug Rebate Program.

[25] A preferred drug list provides a list of drugs that are considered preferred and that are generally covered without prior authorization. Preferred drug lists generally include lower-cost drugs such as generic versions or drugs for which the MCO or state has negotiated a rebate in exchange for preferred status (Ovsag et al. 2008). Preferred drug lists must be developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state (Section 1927(d)(4)(A) of the Social Security Act). For managed care, this list of preferred drugs is called a "formulary" (MACPAC 2024).

[26] T-MSIS collects Medicaid and CHIP data from states, territories, and the District of Columbia and is the largest national resource of beneficiary information (CMS 2025). Differences in methodology may explain differences in our results compared to those from other studies using T-MSIS to identify rates of MOUD use among Medicaid beneficiaries. For example, KFF's analysis includes youth, a population with lower use of MOUD, whereas ours does not (Saunders et al. 2024). Similarly, HHS includes the overdose-reversal drug naloxone in its definition of medications used to treat OUD, whereas ours includes only medications approved for long-term treatment of OUD (HHS 2023).

[27] Results from the 2022 NSDUH were the most recent data available at the time of our analysis.

[28] NSDUH reflects responses from people who may not have a clinically identified or diagnosed case of OUD; however, the survey may still underestimate the prevalence of OUD and other SUDs. This is because the NSDUH excludes people who do not have an address, such as those who are unhoused, institutionalized, or incarcerated—populations that tend to have higher rates of SUD (SAMHSA 2023).

[29] It is unlikely that these claims reflect treatment for a co-occurring alcohol use disorder, as the analysis excluded beneficiaries with claims for naltrexone associated with an alcohol use disorder diagnosis. See Appendix 3A for more information about our methodology.

[30] Arkansas had no claims for extended-release injectable buprenorphine.

[31] This does not include South Dakota and Wyoming, which received exceptions to the MOUD benefit mandate due to their lack of OTPs providing methadone to Medicaid beneficiaries.

[32] Non-expansion adults refers to adults who were not enrolled through the Patient Protection and Affordable Care Act Medicaid expansion.

[33] The 11 states that did not cover methadone and subsequently added coverage are Arkansas, Idaho, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, North Dakota, Oklahoma, South Carolina, and Tennessee. We identified states as covering methadone if they had more than 10 beneficiaries with methadone claims in a given fiscal year, because having a small number of beneficiaries with claims for methadone (10 or fewer) could indicate miscoding or other data quality issues. South Dakota and Wyoming did not cover methadone when the SUPPORT Act was passed but were not included in this analysis because they received exceptions to the MOUD benefit mandate because they lacked Medicaid-enrolled OTPs.

[34] The Americans with Disabilities Act prohibits discrimination on the basis of disability, which is defined as a physical or mental impairment that substantially limits one or more major life activities. People with OUD often have a disability because they have a drug addiction that substantially limits on or more of their major life activities. The Americans with Disabilities Act also protects people who are in recovery who would be considered to have a disability in the absence of access to treatment or recovery services (DOJ 2022).

[35] On February 8, 2024, SAMHSA and the HHS Office for Civil Rights issued a final rule that aligns certain aspects of Part 2 requirements with Health Insurance Portability and Accountability Act privacy rules, as required by the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) (SAMHSA 2024f).

[36] In its June 2018 report to Congress, MACPAC recommended that the Secretary of the U.S. Department of Health and Human Services direct relevant agencies to issue joint subregulatory guidance that addresses Medicaid and CHIP provider and plan needs for clarification of key Part 2 provisions and direct a coordinated effort by relevant agencies to provide education and technical assistance on Part 2 (MACPAC 2018).

[37] Florida was excluded from the analysis due to data quality issues (OIG 2024).

[38] Medication diversion involves the diversion of drugs from legal and medically necessary uses toward those that are illegal and typically not medically authorized (CMS 2012). Legally dispensed methadone and buprenorphine are most commonly diverted to individuals with OUD to control opioid withdrawal and cravings (NIDA 2018).

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APPENDIX 3A: Methods

Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data

MACPAC contracted with Acumen LLC to examine medications for opioid use disorder (MOUD) use among Medicaid beneficiaries. The study population included Medicaid beneficiaries age 18 to 64 who were not dually enrolled in Medicare and Medicaid and who were validly enrolled in Medicaid and receiving full benefits for at least one month of the year. Beneficiaries age 17 and younger were generally excluded because treatment guidelines limit access to methadone for this population, and buprenorphine is indicated for individuals age 16 and older with opioid use disorder (OUD). Dually eligible beneficiaries, including beneficiaries older than age 65, were excluded because of the possibility that those with OUD could have received MOUD through Medicare.

Our analysis relied on Transformed Medicaid Statistical Information System (T-MSIS) data from fiscal years (FYs) 2017 through 2022, supplemented by the Centers for Medicare & Medicaid Services Race and Ethnicity Imputation file, which was available only for FYs 2017 through 2021. The file contains an indirectly estimated probability of each race and ethnicity category for each beneficiary and is used to impute missing race and ethnicity information. We used eligibility and claims data to identify Medicaid beneficiaries' demographic characteristics (with the exception of race and ethnicity), their MOUD utilization, and other health conditions. Due to data limitations, Illinois and New York were excluded for all years, and Maryland and Utah were excluded for FY 2017.

We identified beneficiaries with OUD using diagnosis and procedure codes according to methodology from the Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse, supplemented by clinical review. Oral naltrexone, which is approved by the U.S. Food and Drug Administration for alcohol use disorder and is sometimes prescribed off label for OUD, was included in the OUD definition to align with the Chronic Conditions Data Warehouse definition. However, beneficiaries with claims for oral naltrexone associated with an alcohol use disorder diagnosis were not classified as having OUD, because it was assumed that they were being treated for alcohol use disorder (rather than OUD). Claims for scans and laboratory tests were excluded to avoid overcounting beneficiaries with OUD based on scans or laboratory tests alone.

MOUD use was defined broadly to include beneficiaries who had at least one MOUD claim in a given year for methadone, buprenorphine, or extended-release injectable naltrexone. Oral naltrexone was not included in overall estimates of MOUD use because it is not indicated for the treatment of OUD. However, utilization of oral naltrexone was examined separately to provide insight into its off-label use.

We used descriptive analyses to show trends in MOUD use among Medicaid beneficiaries with OUD and multivariate logistic regression to assess whether MOUD use varied by beneficiary demographic and health-related characteristics.

To assess the effect of the MOUD benefit mandate, we used a quasi-experimental, synthetic difference-in-differences evaluation design to compare changes in MOUD use in the states that added methadone coverage to changes in MOUD use in similar states that covered methadone before the federal benefit mandate. A synthetic control was constructed for each treated state (the 11 states that added methadone coverage) such that the baseline trends in MOUD use were parallel between the treated states and synthetic comparison states. A final set of matching variables (e.g., Medicaid expansion status, rate of overdose death) was used to create the synthetic comparisons. We then compared the average difference in MOUD utilization in the pretreatment and posttreatment years for the treated and synthetic control states to estimate the treatment effect.

Stakeholder interviews

MACPAC contracted with Acumen to conduct 18 stakeholder interviews between July and September 2024. We interviewed state Medicaid agency officials in six states as well as state behavioral health agency officials and managed care organization representatives in a subset of those states. The states selected vary in their geographic location, share of the population living in rural areas, Medicaid expansion status, managed care organization penetration rate, and MOUD coverage changes that occurred around the time the benefit mandate took effect. MACPAC also conducted interviews with federal officials, beneficiary advocates, provider and state associations, and other national experts.

TABLE 3A-1. Interviewees by Type

Interviewee Type	Interviewees
Federal agency	Centers for Medicare & Medicaid Services Substance Abuse and Mental Health Services Administration
State Medicaid agency	Connecticut Georgia Idaho Louisiana South Dakota Tennessee
State behavioral health agency	Connecticut Idaho South Dakota
Managed care organization	BlueCare (Tennessee) Peach State (Georgia) Aetna Better Health (Louisiana) AmeriHealth Caritas Louisiana (Louisiana)
Other national expert	American Society of Addiction Medicine National Association of State Alcohol and Drug Abuse Directors Addiction Medicine Specialist and Researcher at the University of Colorado
Beneficiary advocate	Legal Action Center

APPENDIX 3B: Medications for Opioid Use Disorder Use by State and Medication

TABLE 3B-1. Number and Share of Medicaid Beneficiaries with at Least One Claim for Medications for Opioid Use Disorder by State and Medication, FY 2022

State	Number of beneficiaries with OUD	Methadone		Buprenorphine				Naltrexone			
		Oral		Oral		ER		Oral		ER	
		#	%	#	%	#	%	#	%	#	%
Alabama	9,396	2,504	32.2%	5,004	64.3%	48	0.6%	399	5.1%	24	0.3%
Alaska	7,405	1,157	18.0	3,615	56.3	655	10.2	1,184	18.4	862	13.4
Arizona	53,577	15,291	39.8	15,883	41.4	426	1.1	8,754	22.8	2,934	7.6
Arkansas	4,463	21	0.7	2,392	84.0	–	0.0	415	14.6	46	1.6
California	118,352	34,420	37.3	39,123	42.4	2,528	2.7	18,758	20.3	5,432	5.9
Colorado	35,361	4,372	17.4	11,813	47.0	1,007	4.0	8,438	33.6	2,621	10.4
Connecticut	35,878	15,867	54.0	9,929	33.8	636	2.2	4,195	14.3	1,358	4.6
Delaware	10,799	5,150	56.3	3,640	39.8	46	0.5	829	9.1	525	5.7
District of Columbia	3,300	823	30.8	1,334	50.0	*	0.3	547	20.5	139	5.2
Florida	28,605	9,682	42.8	10,856	48.0	135	0.6	2,613	11.6	306	1.4
Georgia	8,736	1,984	32.9	2,938	48.7	24	0.4	1,191	19.7	60	1.0
Hawaii	2,805	681	29.9	1,191	52.3	25	1.1	445	19.5	29	1.3
Idaho	7,910	192	3.3	3,617	62.1	*	0.1	2,026	34.8	241	4.1
Indiana	52,597	9,683	20.4	31,326	65.9	865	1.8	7,998	16.8	3,502	7.4
Iowa	8,815	1,610	22.8	2,083	29.5	137	1.9	3,535	50.1	158	2.2
Kansas	2,733	334	19.1	796	45.6	27	1.5	640	36.6	54	3.1
Kentucky	75,168	9,184	14.6	48,140	76.4	2,887	4.6	6,080	9.7	5,970	9.5
Louisiana	35,595	4,663	18.2	17,646	69.0	1,661	6.5	3,714	14.5	1,434	5.6
Maine	19,353	4,461	27.6	10,640	65.9	422	2.6	1,531	9.5	241	1.5
Maryland	59,356	23,693	47.0	25,089	49.8	1,698	3.4	3,561	7.1	2,047	4.1
Massachusetts	62,914	21,633	38.5	28,125	50.1	2,637	4.7	7,971	14.2	3,598	6.4
Michigan	52,073	9,498	22.3	24,892	58.3	2,374	5.6	6,879	16.1	4,098	9.6

TABLE 3B-1. (continued)

State	Number of beneficiaries with OUD	Methadone		Buprenorphine				Naltrexone			
		Oral		Oral		ER		Oral		ER	
		#	%	#	%	#	%	#	%	#	%
Minnesota	27,874	5,252	23.6%	10,588	47.6%	364	1.6%	7,170	32.3%	449	2.0%
Mississippi	3,718	127	5.3	1,944	81.7	22	0.9	319	13.4	*	0.3
Missouri	20,253	2,159	15.2	7,872	55.5	169	1.2	4,155	29.3	1,211	8.5
Montana	7,232	1,083	17.2	3,843	61.0	255	4.0	1,529	24.3	202	3.2
Nebraska	3,064	322	11.9	995	36.7	23	0.8	1,401	51.7	109	4.0
Nevada	13,645	2,713	31.2	4,137	47.6	60	0.7	2,082	23.9	311	3.6
New Hampshire	11,997	3,320	30.8	6,459	59.9	589	5.5	1,300	12.0	433	4.0
New Jersey	50,541	15,565	41.1	20,254	53.5	801	2.1	3,334	8.8	2,439	6.4
New Mexico	22,880	7,737	38.0	8,673	42.6	231	1.1	4,392	21.6	920	4.5
North Carolina	33,480	7,554	32.1	14,618	62.0	563	2.4	1,833	7.8	350	1.5
North Dakota	2,750	759	32.8	1,061	45.8	71	3.1	515	22.2	133	5.7
Ohio	108,918	14,772	16.5	62,851	70.2	3,392	3.8	13,436	15.0	9,257	10.3
Oklahoma	13,836	2,289	22.4	5,658	55.5	143	1.4	2,344	23.0	248	2.4
Oregon	34,746	7,517	26.8	15,447	55.0	886	3.2	6,221	22.2	648	2.3
Pennsylvania	111,642	18,884	20.9	61,397	67.9	9,282	10.3	9,145	10.1	6,442	7.1
Rhode Island	9,828	3,948	43.4	3,942	43.3	118	1.3	1,493	16.4	214	2.4
South Carolina	9,957	2,795	35.1	4,743	59.5	108	1.4	678	8.5	113	1.4
South Dakota	780	–	0.0	416	63.0	*	1.4	251	38.0	*	0.3
Tennessee	25,161	3,108	15.0	15,968	77.2	752	3.6	1,462	7.1	1,659	8.0
Texas	10,747	2,560	31.2	3,264	39.7	*	0.1	2,445	29.8	126	1.5
Utah	14,983	3,172	26.1	6,955	57.2	969	8.0	1,932	15.9	1,297	10.7
Vermont	10,085	3,177	35.0	5,832	64.3	172	1.9	730	8.1	110	1.2
Virginia	48,150	13,348	33.1	24,459	60.7	890	2.2	4,937	12.3	1,091	2.7
Washington	61,980	14,564	29.3	30,002	60.3	789	1.6	7,224	14.5	2,458	4.9
West Virginia	34,478	4,478	16.2	21,474	77.8	840	3.0	1,977	7.2	2,145	7.8
Wisconsin	27,789	7,838	34.4	11,259	49.4	823	3.6	4,311	18.9	2,077	9.1
Wyoming	455	–	0.0	240	71.0	*	0.3	100	29.6	*	2.1

TABLE 3B-1. (continued)

Notes: FY is fiscal year. OUD is opioid use disorder. ER buprenorphine is extended-release injectable buprenorphine. ER naltrexone is extended-release injectable naltrexone. The table shows the use of MOUD among individuals age 18 to 64 with OUD who were ever enrolled as a full-benefit, Medicaid-only beneficiary in FY 2022 as reported by states in the Transformed Medicaid Statistical Information System (T-MSIS). The first column reflects the person counts of Medicaid beneficiaries with OUD as identified using diagnosis and procedure codes in T-MSIS. Oral naltrexone is not approved by the U.S. Food and Drug Administration for OUD, though it is sometimes prescribed off label to individuals with OUD. Beneficiaries may have had claims for more than one type of medication, and therefore, the sum of the percentages may exceed 100 for some states. Illinois and New York were excluded due to data limitations.

* Asterisk indicates values 1 to 10.

– Dash indicates a value of zero.

Source: MACPAC and Acumen LLC, 2024, Analysis of Transformed Medicaid Statistical Information System (T-MSIS) Data.