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Utilization Management for Medications for Opioid Use Disorder (MOUD) in Medicaid

Findings from Claims Analysis

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Medicaid and CHIP Payment and Access Commission

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Overview

- Policy and research questions
- Background
- Methodology
- Review of key claims analysis findings
 - National trends in oral buprenorphine use, MOUD treatment continuity, opioid-related overdoses and emergency department (ED) visits
 - Prior authorization (PA) analysis
 - Daily dosage limits analysis
- Key takeaways and next steps



Policy and Research Questions

- Do utilization management strategies (i.e., PA, daily dosage limits, refill thresholds) enable states and managed care organizations (MCOs) to ensure appropriate and timely access to MOUD while also managing costs?
- What are the effects of removing PA for oral buprenorphine/naloxone on the use of MOUD and other clinical outcomes in Medicaid and the State Children's Health Insurance Program (CHIP)?
- What are the effects of raising the oral buprenorphine daily dosage limit to at least 32 mg/day on the use of MOUD and other clinical outcomes in Medicaid and CHIP?

The background features a dark blue field with several overlapping, semi-transparent light blue geometric shapes. These shapes include a large circle on the left, a vertical rectangle in the center, and a horizontal rectangle to the right of the center. The word "Background" is written in white, bold, sans-serif font, positioned in the upper left quadrant of the image.

Background

Utilization of MOUD in Medicaid

- As of fiscal year (FY) 2020, state Medicaid programs must cover all forms of FDA-approved MOUD and related counseling and behavioral therapies (Consolidated Appropriations Act, 2024; P.L. 118-42)
 - States and MCOs can apply utilization management strategies to MOUD, to ensure appropriate care, control costs, and reduce the potential for fraud, waste, and abuse
- In FY 2022, 71 percent of enrollees with opioid use disorder (OUD) used at least one type of MOUD
 - 57 percent of Medicaid enrollees with OUD received an oral formulation of buprenorphine
 - 28 percent received methadone, 6 percent received extended-release injectable naltrexone, and 3 percent received extended-release injectable buprenorphine

PA

- PA is the process by which medical providers request and receive approval for coverage from health care payers
- PA may reduce improper use of medications, but it can restrict access to MOUD by denying or delaying care
- Based on fee-for-service (FFS) Drug Utilization Review (DUR) reports, 47 states and DC provided at least one oral buprenorphine/naloxone product without PA in FY 2023, an increase from 41 states in FY 2019
- States can limit or prohibit PA for MOUD, based on medication type, inclusion on the state's preferred drug list (PDL), or time period

Daily Dosage Limits

- Daily dosage limits are the maximum daily amount of a drug that Medicaid will cover; excess amounts require PA or are not covered
- Daily dosage limits may pose barriers for those seeking OUD treatment by inhibiting patient-centered care and shared decision-making
- The FDA issued a December 2024 notice clarifying that “neither 16 nor 24 mg/day should be interpreted as maximum dosages” and that doses above 24 mg/day “may be appropriate for some patients”
 - Based on CMS FFS DUR reports, 38 states had daily dosage limits of 16 or 24 mg/day in FY 2023

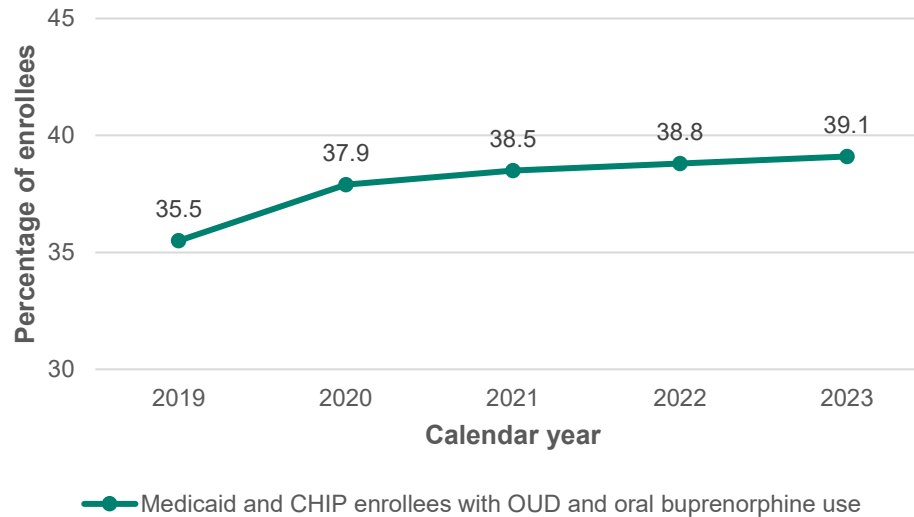
Methodology

- Conducted a synthetic difference-in-differences analysis using Transformed Medicaid Statistical Information System (T-MSIS) data to examine the effects of utilization management policy changes on utilization and clinical outcomes between CYs 2019 and 2023 in states that:
 - removed PA requirements for at least one oral buprenorphine/naloxone (“combination”) product compared to states that did not;
 - increased their daily dosage limit to at least 32 mg/day compared to states that did not
- Study population included full-benefit, non-dually-eligible Medicaid and CHIP enrollees age 16–64 with OUD
- Examined utilization and clinical outcomes:
 - Oral buprenorphine utilization (ever-use, volume-based, and one additional fill);
 - Opioid-related overdoses; and
 - Opioid-related ED visits

Review of Key Findings

Descriptive Trends

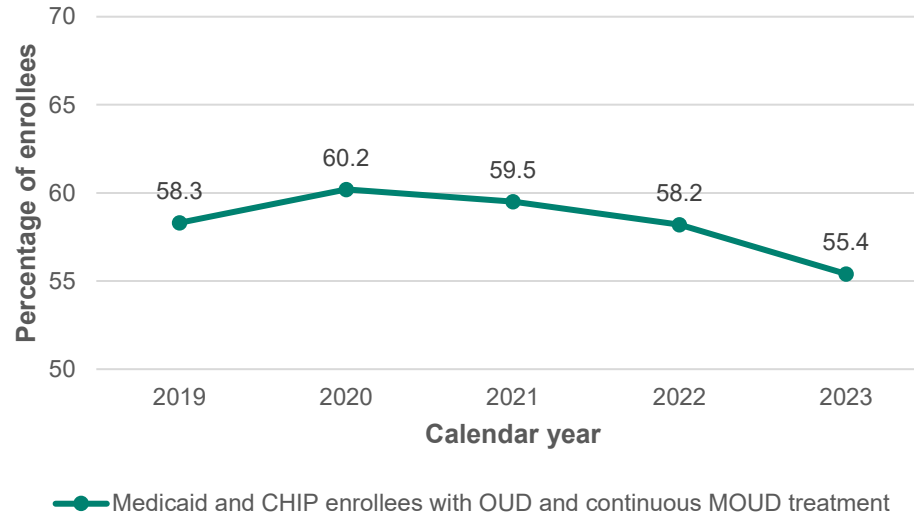
Share of Medicaid and CHIP Enrollees Age 16–64 with OUD and Oral Buprenorphine Use, CYs 2019 to 2023



Notes: CHIP is State Children’s Health Insurance Program. CY is calendar year. OUD is opioid use disorder. The study population included full-benefit, non-dually-eligible Medicaid and CHIP enrollees age 16–64 with OUD.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

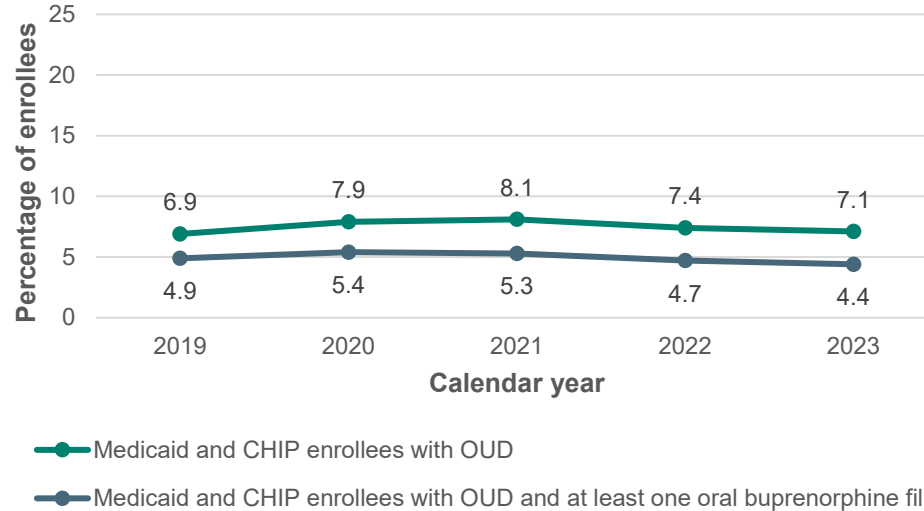
Share of Enrollees with OUD and At Least One Oral Buprenorphine Fill Who Experienced Treatment Continuity, CYs 2019 to 2023



Notes: CHIP is State Children's Health Insurance Program. CY is calendar year. MOUD is medications for opioid use disorder. MOUD treatment continuity was defined as at least 180 days of continuous treatment with any MOUD (including oral or injectable buprenorphine monoproducs, oral buprenorphine/naloxone combination products, methadone, and any form of naltrexone (oral or injectable)), with no gaps longer than seven days. The study population included full-benefit, non-dually-eligible Medicaid and CHIP enrollees age 16–64 with OUD.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

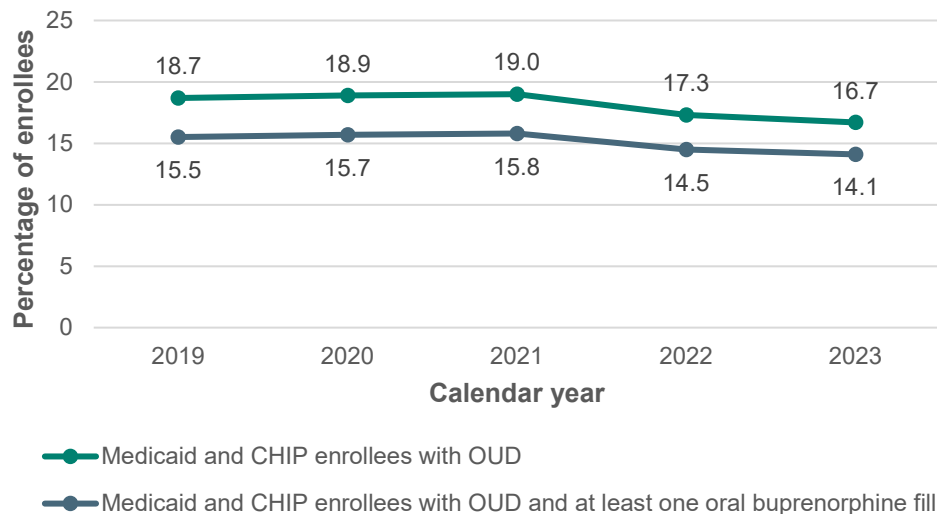
Share of Enrollees with OUD and an Opioid-Related Overdose, by Oral Buprenorphine Utilization, CYs 2019 to 2023



Notes: CHIP is State Children’s Health Insurance Program. CY is calendar year. OUD is opioid use disorder. The study population included full-benefit, non-dually-eligible Medicaid and CHIP enrollees age 16–64 with OUD.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Share of Enrollees with OUD and an Opioid-Related ED Visit, by Oral Buprenorphine Utilization, CYs 2019 to 2023



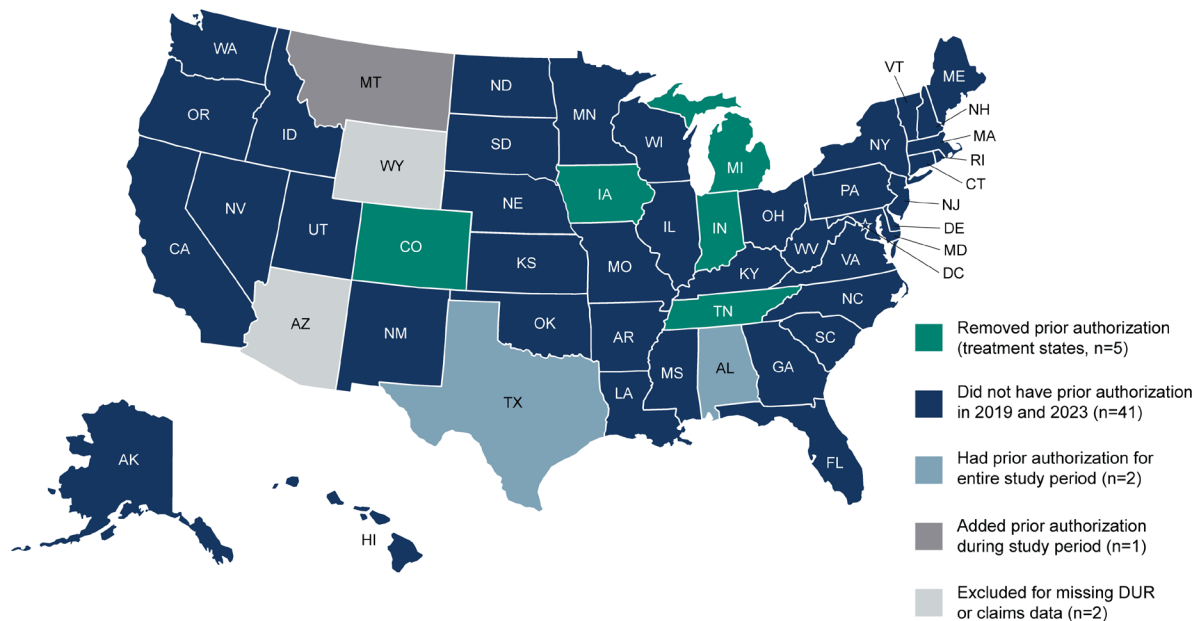
Notes: CHIP is State Children's Health Insurance Program. CY is calendar year. OUD is opioid use disorder. The study population included full-benefit, non-dually-eligible Medicaid and CHIP enrollees age 16–64 with OUD.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Review of Key Findings

Prior Authorization Model

PA Policy Changes for Oral Buprenorphine/Naloxone in State Fee-For-Service Medicaid Programs, FYs 2019 to 2023



Notes: FY is fiscal year. DUR is drug utilization review. The claims data were structured by calendar year (CY). While the DUR reports are structured by FY, the policies described in the DUR do not necessarily take effect at the beginning of the FY. Since neither FY nor CY would always line up perfectly with policy implementation, the claims, which are partitioned by CY by default, were not restructured to FY.

Source: MACPAC and Acumen LLC, 2026, analysis of FYs 2019–2023 Centers for Medicare & Medicaid Services (CMS) Fee-for-Service (FFS) National State DUR Annual Reports.

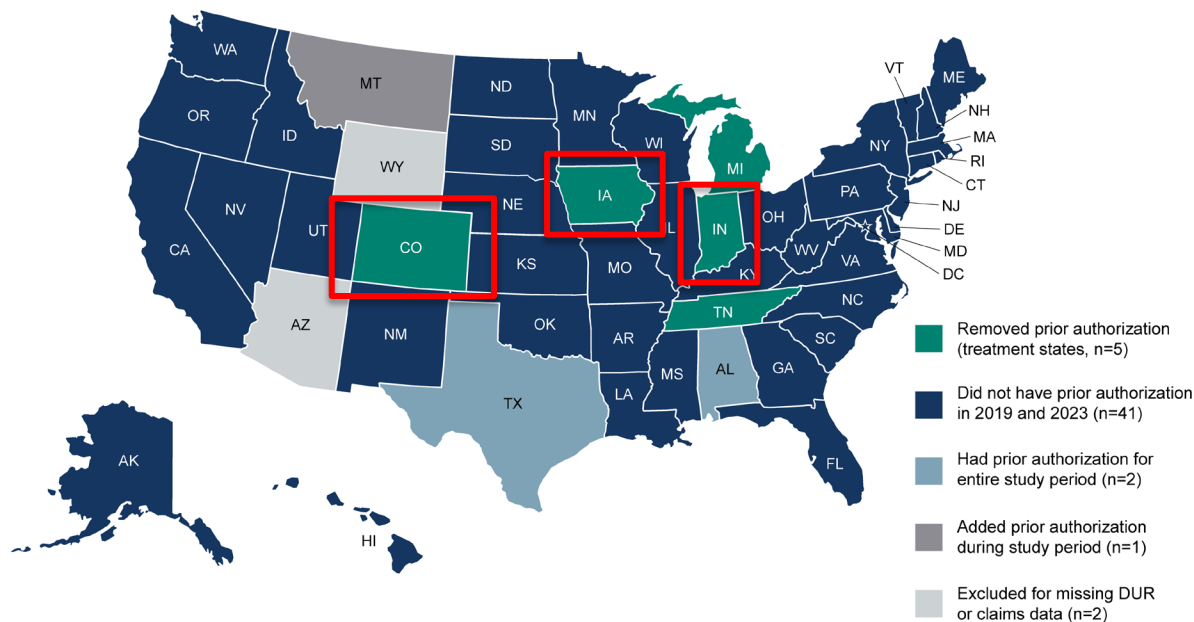
Estimated Impacts of PA Removal Among Medicaid and CHIP Enrollees Age 16–64 with OUD, CYs 2019 to 2023

Outcome	Average treatment effect on the treated (standard error)	<i>p</i> -value
Percentage of enrollees with at least one oral buprenorphine prescription fill	2.5 percentage points (1.4)	0.081
Oral buprenorphine fills per 1,000 enrollees with OUD (log)	12.8 percent (5.9)	0.030
Opioid-related overdoses in health care settings	-0.6 percentage points (0.4)	0.086
Opioid-related ED visits	-0.3 percentage points (0.5)	0.614

Notes: CHIP is State Children’s Health Insurance Program. CY is calendar year. OUD is opioid use disorder. ED is emergency department. Estimates are produced from the synthetic difference-in-differences model, which compares the average treatment effect in treated states to the average treatment effect in the synthetic control states. A *p*-value of 0.05 or lower is considered statistically significant; a *p*-value of 0.1 or lower is considered marginally statistically significant.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

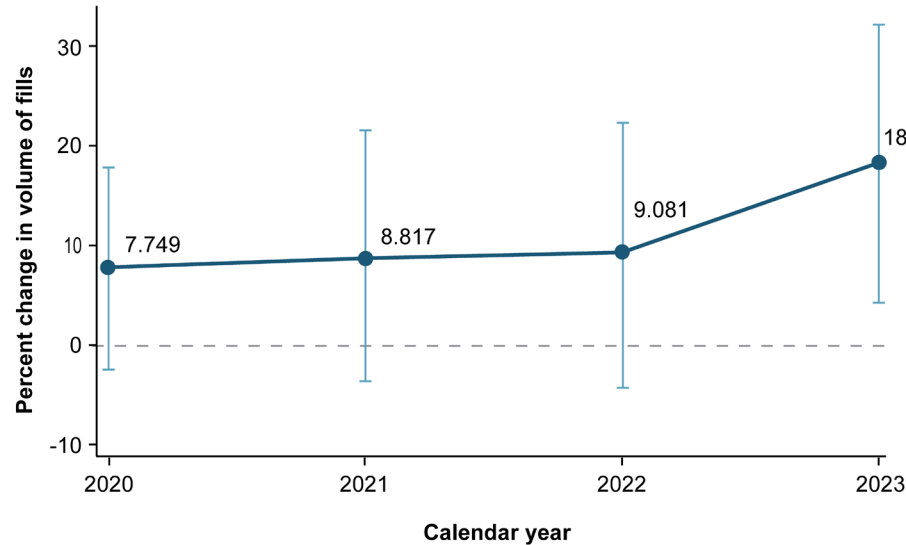
Three States Removed PA for Combination Product in 2020



Notes: DUR is drug utilization review. Five states removed prior authorization for at least one combination product during the study period. Three states (Indiana, Iowa, and Michigan) removed prior authorization in 2020. Colorado and Wyoming did so in 2022, and Tennessee followed in 2023.

Source: MACPAC and Acumen LLC, 2026, analysis of FYs 2019–2023 Centers for Medicare & Medicaid Services (CMS) Fee-for-Service (FFS) National State DUR Annual Reports (CMS 2025a–e).

Effects of PA Removal on Volume of Oral Buprenorphine Fills Among Enrollees with OUD, CYs 2019 to 2023

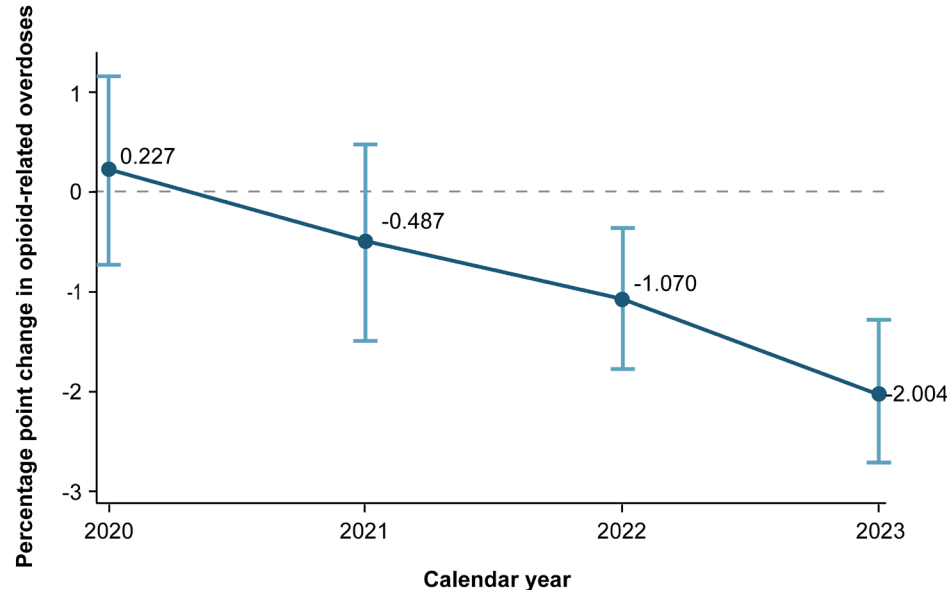


By the end of year three, the volume of oral buprenorphine fills increased by **18.3 percent**

Notes: CHIP is State Children's Health Insurance Program. CY is calendar year. Pretreatment trends could not be assessed because only one annual pretreatment period was available (CY 2019). The light blue error bars represent 95 percent confidence intervals for each estimate.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Effects of PA Removal on Opioid-Related Overdoses in Health Care Settings Among Enrollees with OUD, CYs 2019 to 2023

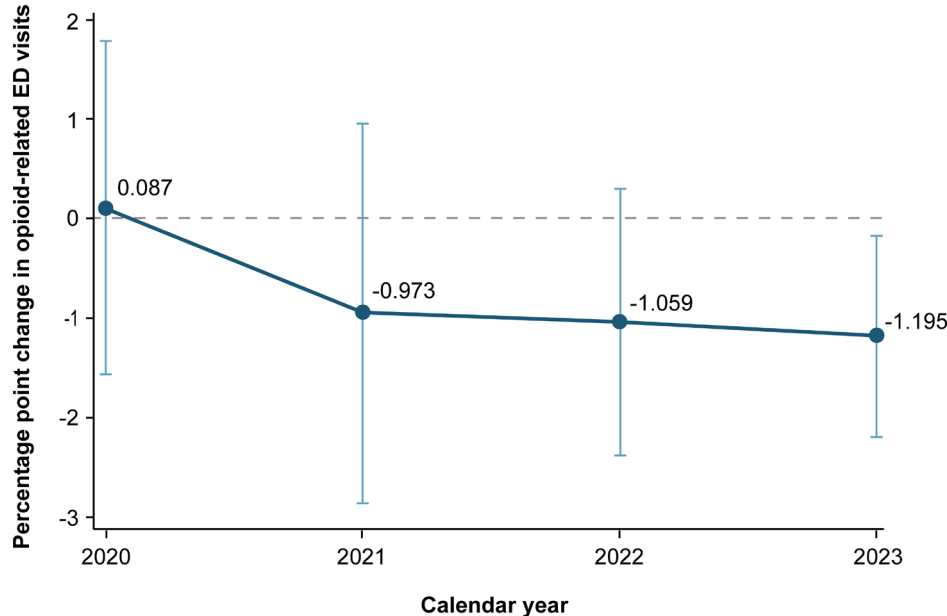


By the end of year three, opioid-related overdoses declined by **2.0 percentage points** ←

Notes: CHIP is State Children's Health Insurance Program. CY is calendar year. Pretreatment trends could not be assessed because only one annual pretreatment period was available (CY 2019). The light blue error bars represent 95 percent confidence intervals for each estimate.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Effects of PA Removal on Opioid-Related ED Visits Among Enrollees with OUD, CYs 2019 to 2023



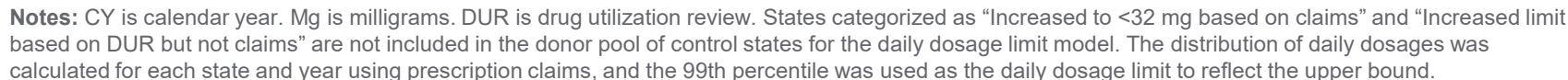
By the end of year three, opioid-related ED visits declined by **1.2 percentage points** ←

Notes: CHIP is State Children's Health Insurance Program. CY is calendar year. ED is emergency department. Pretreatment trends could not be assessed because only one annual pretreatment period was available (CY 2019). The light blue error bars represent 95 percent confidence intervals for each estimate.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Review of Key Findings

Daily Dosage Limit Model



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Estimated Impacts of Increasing Daily Dosage Limit to At Least 32 Mg/day on Selected Outcomes Among Medicaid and CHIP Enrollees Age 16–64 with OUD, CYs 2019 to 2023

Outcome	Average treatment effect on the treated (standard error)	<i>p</i> -value
Percentage with at least one additional oral buprenorphine fill	-0.6 percentage points (0.5)	0.227
Opioid-related overdoses in health care settings	-0.13 percentage points (0.3)	0.660
Opioid-related ED visits	-1.2 percentage points (0.5)	0.020

Notes: CHIP is State Children’s Health Insurance Program. CY is calendar year. OUD is opioid use disorder. ED is emergency department. Estimates are produced from the synthetic difference-in-differences model, which compares the average treatment effect in treated states to the average treatment effect in the synthetic control states. A *p*-value of 0.05 or lower is considered statistically significant; a *p*-value of 0.1 or lower is considered marginally statistically significant.

Source: MACPAC and Acumen LLC, 2026, analysis of CYs 2019–2023 Transformed Medicaid Statistical Information System (T-MSIS) data.

Limitations

- Claims data do not record use of PA, while question on PA in the DUR reports does not represent the totality of PA requirements for MOUD in a state Medicaid program
- We reviewed FFS DUR reports, not managed care DUR reports
- No data on baseline PA rates for states
- States may still be in the process of increasing their daily dosage limits given December 2024 FDA labeling guidance
- Models were policy-specific and did not account for overlapping policy changes



Key Takeaways and Next Steps

Key Takeaways on PA

- Removing PA for at least one combination product was associated with an increase in oral buprenorphine fills, and decreases in opioid-related overdoses and ED visits over time
- Our findings on removing PA are consistent with other studies
- Our interviews found that PA can cause several days' worth of delays in getting access to medication and some consider it to be an ineffective utilization management policy compared to retrospective reviews or point-of-sale safety edits

Key Takeaways on Daily Dosage Limits

- Increasing daily dosage limit to at least 32 mg/day was associated with a decrease in ED visits
- No evidence that increasing the daily dosage limit for oral buprenorphine to at least 32 mg/day increased the rate of opioid-related overdoses
- Our interviews with several providers also indicated that dosage limits may be a barrier for populations that need higher doses to stabilize; inadequate doses of buprenorphine can “destabilize” patients and put them at risk of relapses or overdose
- According to our review of FY 2023 FFS DUR reports and CY 2023 claims data, two states still limit daily dosages to 16 mg/day

Next Steps

- We welcome feedback and questions from the Commission about the findings presented today
- Commissioners' feedback on the following would be helpful:
 - Factors contributing to national declines in MOUD treatment continuity
 - Particular findings Commissioners would like to see emphasized in the June chapter
 - Whether the evidence collected during this project suggests the need for particular federal or state policy changes that MACPAC could consider
- Based on Commission feedback, staff may return with draft policy options in January
- Findings from the literature review, stakeholder interviews, and the claims analysis will be synthesized and included in a chapter for the Commission's June 2027 report to Congress

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