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**Office of Inspector General**



# Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns

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## Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns

### Key Results

- One-third of the 1.5 million Medicaid enrollees with opioid use disorder did not receive medication treatment (referred to as MOUD) in 2021.
- Certain demographic groups—including Black or African American enrollees; enrollees 18 years of age and younger; and enrollees with a disability and/or blindness—were less likely to receive MOUD.
- In 10 States, less than half of enrollees with opioid use disorder received MOUD.

### Why OIG Did This Review

Nearly 81,000 people died from opioid overdoses in the United States in 2021, an increase of 17 percent from the previous year.<sup>1</sup> Treating opioid use disorder with MOUD<sup>2</sup> is essential to reducing overdose deaths; however, many individuals in need experience difficulties accessing this potentially life-saving treatment. For example, the Office of Inspector General (OIG) found that fewer than one in five Medicare enrollees with opioid use disorder received MOUD in 2021.<sup>3</sup> Individuals seeking treatment often face barriers such as difficulty finding providers who are authorized and/or willing to prescribe or dispense MOUD and stigma surrounding its use.<sup>4</sup> For example, until recently, only providers with a Federal waiver could prescribe or administer buprenorphine for opioid use disorder in an office setting. Research also suggests that particular demographic groups, such as adolescents or people of certain races, may be less likely to receive MOUD.<sup>5</sup> Medicaid covers an estimated 40 percent of nonelderly adults with opioid use disorder, underscoring the program's key role in providing

access to MOUD.<sup>6</sup> In this data brief, we examine the extent to which Medicaid enrollees with opioid use disorder received MOUD in 2021.

### How OIG Did This Review

We used Medicaid claims data to determine the extent to which Medicaid enrollees with opioid use disorder received MOUD through Medicaid in 2021. Because Medicaid enrollees may be dually enrolled in Medicare, we also reviewed Medicare claims data to determine if enrollees who were enrolled in both programs received MOUD through Medicare. Additionally, we used Medicaid enrollment and eligibility data to examine how MOUD treatment rates differed among demographic groups.

### What OIG Recommends

Our findings underscore the need for continued efforts to increase the use of MOUD in Medicaid. Accordingly, we recommend that the Centers for Medicare & Medicaid Services (CMS) (1) encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may be underserved; and (2) encourage States and work with Federal partners to educate Medicaid and Children's Health Insurance Program (CHIP) enrollees about access to MOUD. CMS neither concurred nor nonconcurred with our recommendations. The agency instead stated that it already works with States to increase access to MOUD and ensure that enrollees are educated regarding access.

# MEDICATIONS FOR OPIOID USE DISORDER

- Opioid use disorder is a problematic pattern of opioid use that leads to clinically significant impairment or distress.<sup>7</sup> It is a chronic disease that can change the reward circuitry of the brain.<sup>8</sup>
- Certain medications decrease the risk of overdose mortality and improve quality of life for people with opioid use disorder.
- Three drugs are currently approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder: methadone, buprenorphine, and naltrexone.<sup>9</sup> These drugs are referred to as medications for opioid use disorder (MOUD).

## Methadone

Methadone is a controlled substance that reduces opioid cravings and withdrawal symptoms by blunting or blocking the effects of opioids. Only opioid treatment programs certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) are allowed to administer or dispense methadone for treatment of opioid use disorder in outpatient settings.<sup>10</sup> Typically, patients must visit opioid treatment programs to take their daily methadone dose under supervision.<sup>11</sup>

## Buprenorphine

Buprenorphine is a controlled substance that reduces opioid cravings and withdrawal symptoms by blocking the effects of opioids. Patients can generally access buprenorphine for opioid use disorder through opioid treatment programs or office-based providers. However, during this study's period of review, office-based providers were required to obtain a waiver through SAMHSA to (1) prescribe buprenorphine for a patient to receive at a pharmacy, or (2) administer buprenorphine (e.g., injectable buprenorphine) for opioid use disorder. Waivered providers were also limited in the number of patients they could treat. Federal law eliminated the waiver requirement in December 2022.<sup>12</sup>

## Naltrexone

Unlike buprenorphine and methadone, naltrexone is not a controlled substance.<sup>13</sup> It works by blocking the opioid receptors in the brain, which is reported to reduce opioid cravings. It can be prescribed or administered by any qualified health care provider but requires abstinence from opioids for several days before initiation.

## Medicaid and Children's Health Insurance Program (CHIP) Coverage of MOUD

State Medicaid programs are generally required to cover all FDA-approved medications for opioid use disorder from October 2020 to September 2025; however, three States were granted an exception due to provider shortages.<sup>14</sup> Additionally, States have been required to provide MOUD since October 2019 under CHIP.<sup>15</sup> States are permitted to apply utilization management controls (e.g., prior authorization requirements) to their MOUD coverage.

## Efforts to Increase MOUD Access in Medicaid

With support from the Centers for Medicare & Medicaid Services (CMS), States have implemented policies and practices to make MOUD more accessible in Medicaid, which is estimated to cover almost 40 percent of nonelderly adults with opioid use disorder.<sup>16</sup> For example, CMS has provided States with Federal policy guidance on implementing Medicaid MOUD coverage requirements.<sup>17</sup> CMS has also provided States with technical assistance to improve the care and outcomes of enrollees with substance use disorders (including opioid use disorder) and considers the use of MOUD to treat opioid use disorder to be a core health care quality measure for adult Medicaid enrollees.<sup>18</sup>

# USE OF MOUD AMONG MEDICAID ENROLLEES

## Two-thirds of Medicaid enrollees with opioid use disorder received MOUD through Medicaid or Medicare in 2021

In 2021, approximately 1.5 million people enrolled in Medicaid had opioid use disorder, representing nearly 2 percent of the total Medicaid population that year.<sup>19</sup> Two-thirds (more than 1 million) of these enrollees received MOUD that year through Medicaid or, for some dually eligible enrollees, Medicare.<sup>20</sup>

### Characteristics of enrollees with opioid use disorder\*

- Almost a quarter of Medicaid enrollees with opioid use disorder lived in New York, Ohio, or Pennsylvania.
- Nearly two-thirds were between the ages of 19 and 44.
- Ten percent had a disability and/or blindness.

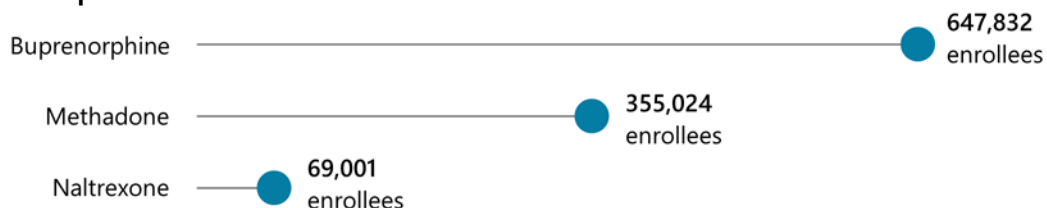
Source: OIG analysis of 2021 Medicaid enrollment and claims data.  
\*See Appendix A for additional characteristics of enrollees with opioid use disorder.

## Buprenorphine was the most commonly used MOUD among enrollees with opioid use disorder

Most Medicaid enrollees with opioid use disorder who were treated with MOUD received buprenorphine, though methadone was also commonly used. A small proportion of enrollees whose opioid use disorder was treated with MOUD received naltrexone. Of the 1 million Medicaid enrollees with opioid use disorder who received MOUD in 2021, nearly 648,000 (65 percent) were prescribed or administered buprenorphine. The vast majority (97 percent) of the enrollees who received buprenorphine through Medicaid obtained their medication from a pharmacy to take at home.<sup>21</sup> At the time of our review, Federal law required that office-based providers obtain a waiver from SAMHSA to prescribe buprenorphine for opioid use disorder. The waiver requirement was removed in December 2022.<sup>22</sup>

Approximately 355,000 enrollees (35 percent) with opioid use disorder received methadone in 2021. Nearly all enrollees who were treated with methadone under Medicaid received the drug through opioid treatment programs. In general, only SAMHSA-certified opioid treatment programs are allowed to administer or dispense methadone for opioid use disorder, with patients typically visiting each day to receive their daily methadone dose under supervision.<sup>23</sup>

## Sixty-five percent of Medicaid enrollees with opioid use disorder received buprenorphine.

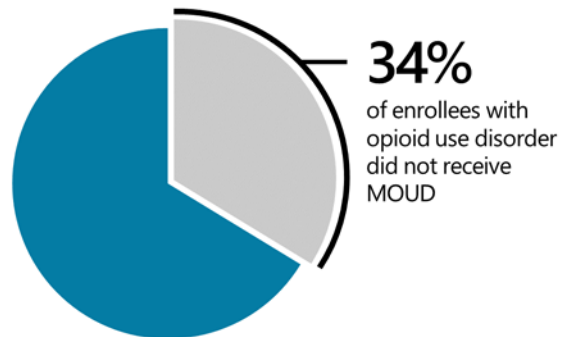


Source: OIG analysis of 2021 Medicaid and Medicare claims data.

Note: Because some enrollees received more than one type of MOUD, the sum of the figures displayed is greater than 1,004,368 (i.e., the total number of enrollees who received MOUD).

## More than half a million enrollees with opioid use disorder did not receive MOUD through Medicaid or Medicare in 2021

In 2021, more than 510,000 (approximately one-third) of the 1.5 million Medicaid enrollees with opioid use disorder did not receive MOUD through Medicaid or Medicare—despite Federal and State governments' relaxed restrictions surrounding MOUD access during the COVID-19 pandemic.<sup>24</sup> Some of these enrollees may have received MOUD through other sources such as self-pay or did not receive MOUD because it was not an appropriate treatment for their circumstances. Still, this finding suggests more effort is needed to ensure that all enrollees in need can access treatment through Medicaid. Further, if pandemic-related flexibilities end, the number of enrollees who are unable to access MOUD may be even higher in the future.



Source: OIG analysis of 2021 Medicaid and Medicare claims data.

In contrast, other recent policy changes may allow for expanded access to buprenorphine—the most commonly used MOUD among Medicaid enrollees. As of December 2022, any provider with a standard Drug Enforcement Agency (DEA) registration can prescribe or directly administer buprenorphine for opioid use disorder. Similarly, providers are no longer subject to patient limits, and therefore may expand the number of patients they treat with buprenorphine.<sup>25</sup>

# DISPARITIES IN MOUD USE AMONG MEDICAID ENROLLEES

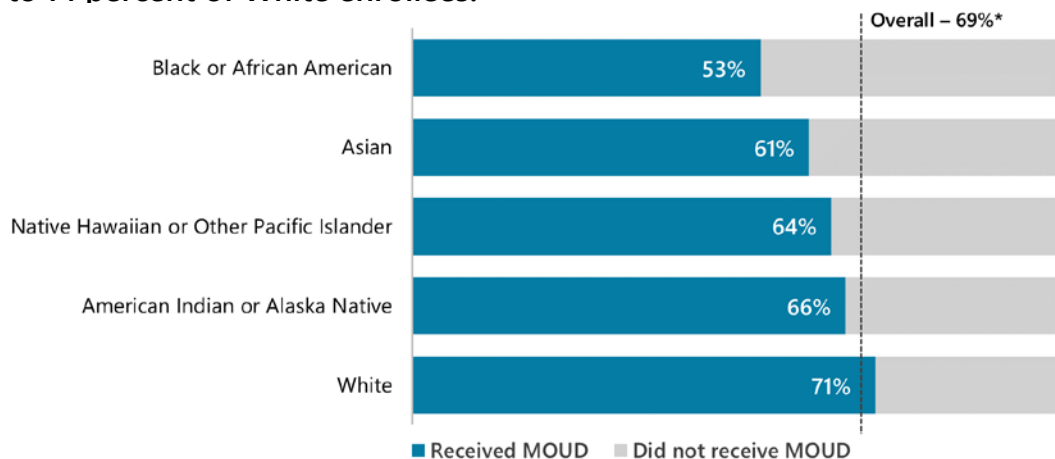
## Black/African American enrollees with opioid use disorder were less likely to receive MOUD

Research suggests that people of color may face significant barriers in accessing opioid use disorder treatment, which could result in racial and ethnic disparities in MOUD utilization. Barriers include shortages of MOUD providers in their communities, racial discrimination in health care settings, and increased stigma surrounding substance use disorders, including opioid use disorder.<sup>26</sup> To explore potential disparities among Medicaid enrollees, we examined data from 15 States that provide relatively complete and valid enrollee race and ethnicity data according to CMS.<sup>27</sup>

In the 15 States that we reviewed, almost three-quarters (71 percent) of enrollees with opioid use disorder who identified as White received MOUD in 2021 compared to approximately half (53 percent) of the enrollees with opioid use disorder who identified as Black or African American. The lower rate of MOUD use among Black/African American enrollees is especially concerning because overdose deaths have increased at greater rates among Black people.<sup>28</sup>

Enrollees with opioid use disorder who identified as Asian, Native Hawaiian/Other Pacific Islander, or American Indian/Alaska Native were also less likely to receive MOUD. MOUD utilization rates were similar between Medicaid enrollees with opioid use disorder who identified as Hispanic or Latino and those who did not.<sup>29</sup>

**In the 15 States with reliable Medicaid race/ethnicity data, only 53 percent of Black/African American enrollees with opioid use disorder received MOUD compared to 71 percent of White enrollees.**



Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.

\*The overall MOUD utilization rate among enrollees for whom race was populated in the 15 States with low-concern enrollee race/ethnicity data was 69 percent, which is slightly higher than the nationwide rate of 66 percent.

Note: Figures displayed are based on enrollees' voluntary self-identification of race and are limited to States with "low concern" enrollee race/ethnicity data per CMS's DQ Atlas. In these States, race was populated in the Transformed Medicaid Statistical Information System (T-MSIS) for 531,098 enrollees with opioid use disorder. Enrollees who selected multiple races were included in all corresponding race calculations. For example, an enrollee who selected "White" and "Asian" was included in our analyses of both races.

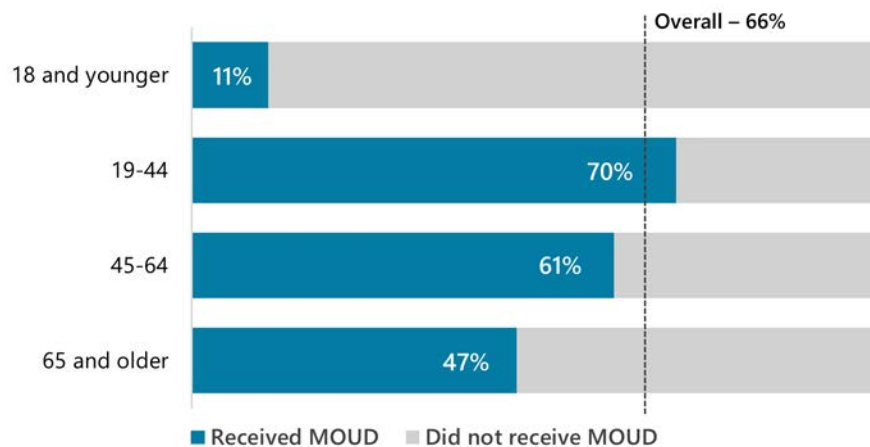
## Only 11 percent of Medicaid enrollees 18 years of age and younger with opioid use disorder received MOUD through Medicaid or Medicare

Although less than 1 percent of Medicaid enrollees with opioid use disorder were 18 years of age and younger, this age group faces unique challenges in accessing MOUD.<sup>30</sup> Despite increasing overdose deaths among children and adolescents, some providers may be hesitant to treat this age group with MOUD due to its limited approval for patients under the age of 18.<sup>31, 32</sup> However, providers may deem unapproved use to be medically appropriate for some younger patients.<sup>33</sup> Similarly, opioid treatment programs are permitted to treat patients under the age of 18 with MOUD in certain circumstances (e.g., if the patient has demonstrated failed attempts at non-drug treatment).<sup>34</sup> Still, some enrollees may be unable to find providers that offer or specialize in pediatric MOUD treatment. For example, a recent study found that only one in four adolescent residential addiction treatment facilities offer buprenorphine.<sup>35</sup>

In 2021, only 11 percent (1,439 of 12,938) of children and adolescent enrollees diagnosed with opioid use disorder received MOUD, compared to 70 percent of enrollees between the ages of 19 and 44. In other words, enrollees with opioid use disorder between the ages of 19 and 44 were approximately six times more likely to receive MOUD than enrollees 18 years of age and younger. Among children and adolescent enrollees with opioid use disorder, those under the age of 16 were especially less likely to receive treatment. Less than 3 percent of enrollees with opioid use disorder (162 of 6,094) in this age group received MOUD.

We also found that less than half of enrollees aged 65 and older with opioid use disorder received MOUD in 2021. Misunderstandings about opioid use disorder among older adults; complications related to treating their comorbidities; and lack of nursing facilities that are willing and/or able to provide MOUD may contribute to lower MOUD utilization among this age group.<sup>36, 37</sup>

### Enrollees 18 years of age and younger with opioid use disorder were least likely to receive MOUD.



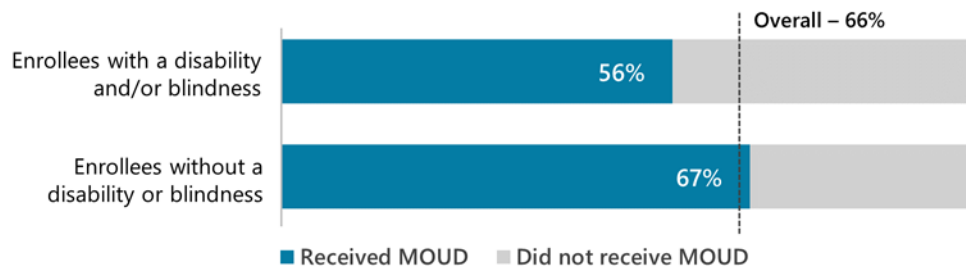
Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.

Note: Figures displayed represent 1,515,073 enrollees with opioid use disorder for whom age was known.

## Enrollees who had a disability and/or blindness were less likely to receive MOUD for their opioid use disorder

Only 56 percent of enrollees with opioid use disorder who had a disability and/or blindness received MOUD in 2021 as compared with 67 percent of those without a disability or blindness. People with disabilities may be less likely to receive MOUD because of insufficient accessibility at treatment centers or providers' offices. For example, providers may lack accessible parking and entrances at their facilities or may be unequipped to communicate with people whose vision or hearing is impaired.<sup>38</sup>

**Only 56 percent of enrollees with opioid use disorder who had a disability and/or blindness received MOUD.**



Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.

Note: Figures displayed represent 1,515,126 enrollees with opioid use disorder. We used eligibility data to identify enrollees who were eligible for Medicaid due to disability and/or blindness. Eligibility records may not have accurately captured the actual disability/blindness status of all enrollees in 2021 (i.e., 2021 eligibility redeterminations may not have been conducted if a State was offering continuous coverage).

We also examined differences in MOUD utilization by additional enrollee characteristics, such as sex, dual eligibility for Medicare, and pregnancy status. See Appendix B for details.



# STATE VARIATION IN MOUD USE

## Among individual States, the rate of MOUD utilization varied widely

Among individual States and Washington, D.C., the rate of opioid use disorder among Medicaid enrollees in 2021 ranged from less than 1 percent to 6 percent, with MOUD utilization varying widely. For example, only 37 percent of Medicaid enrollees with opioid use disorder in Illinois received MOUD compared to 89 percent of Medicaid enrollees with opioid use disorder in Rhode Island.

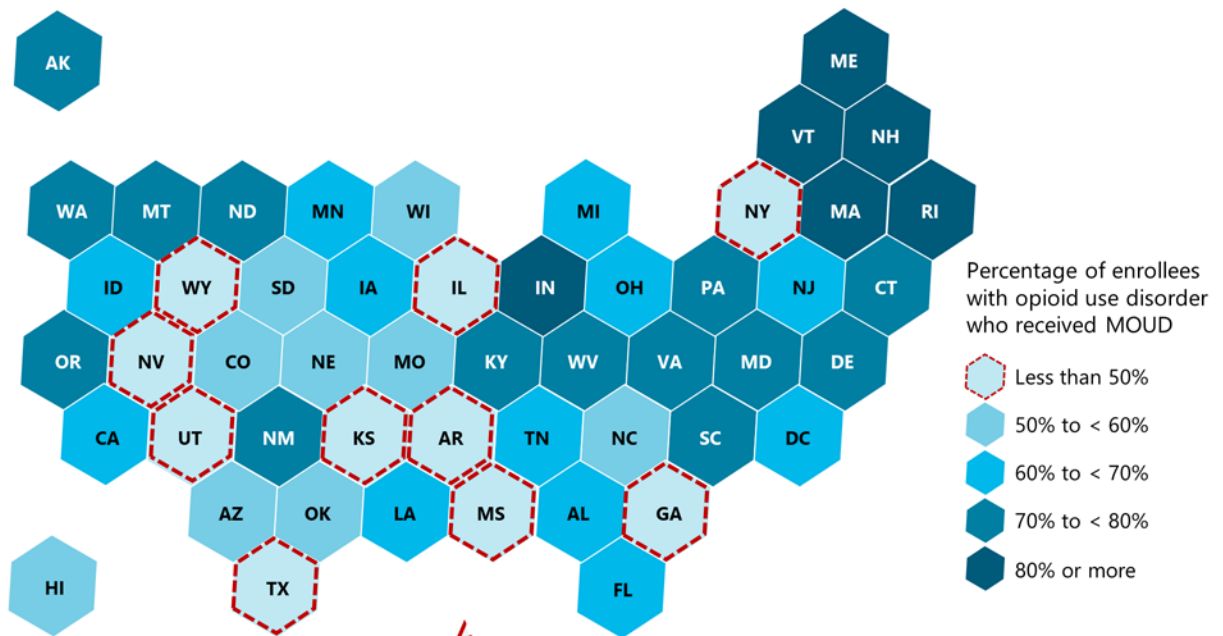
States have some flexibility in designing their coverage of MOUD, including whether to impose utilization management controls such as prior authorization and preferred drug lists.<sup>39</sup> Such benefit designs, as well as differences in access to providers (e.g., State restrictions on opening new opioid treatment programs, lack of mobile treatment programs that deliver MOUD, etc.), may contribute to the variation of MOUD utilization rates among States.

## In 10 States, less than half of enrollees with opioid use disorder received MOUD

In 10 States, less than half of enrollees with opioid use disorder received MOUD in 2021. In these 10 States, approximately 119,000 of 215,000 enrollees with opioid use disorder did not receive MOUD, representing nearly a quarter of all such enrollees nationwide.

We found that many of these States had significantly lower MOUD use compared to other States with similar rates of opioid use disorder. For example, approximately 2 percent of Medicaid enrollees in both New York and Virginia had opioid use disorder in 2021. However, only 47 percent of the enrollees in New York received MOUD compared to 79 percent of enrollees in Virginia. Similarly, 1 percent of enrollees in both Illinois and South Carolina had opioid use disorder, but enrollees in South Carolina were twice as likely to receive MOUD as enrollees in Illinois. See Appendix C for a full list of MOUD utilization rates by State.

**MOUD utilization rates among Medicaid enrollees varied widely by State in 2021, with less than 50 percent of enrollees receiving MOUD in 10 States.**



**States where less than 50% of enrollees with opioid use disorder received MOUD**

| State | Number of enrollees with opioid use disorder | Number of enrollees with opioid use disorder who received MOUD | Percentage who received MOUD |
|-------|--|--|------------------------------|
| IL    | 40,486                                       | 15,017   | 37%                          |
| MS    | 5,249  | 2,034  | 39%                          |
| GA    | 10,294                                       | 4,220  | 41%                          |
| KS    | 2,132  | 939  | 44%                          |
| NV    | 11,867                                       | 5,285  | 45%                          |
| TX    | 11,303                                       | 5,142  | 45%                          |
| NY    | 115,101                                      | 53,840   | 47%                          |
| AR    | 3,918  | 1,880  | 48%                          |
| UT    | 13,825                                       | 6,771  | 49%                          |
| WY*   | 486  | 242  | 50%                          |

Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.  
 \*Before rounding, Wyoming's rate of MOUD utilization was below 50 percent.

# CONCLUSION AND RECOMMENDATIONS

Access to MOUD is crucial to reduce overdose mortality and improve the quality of life of people with opioid use disorder. Medicaid is uniquely positioned to achieve these goals given that the program is estimated to cover almost 40 percent of nonelderly adults with opioid use disorder.<sup>40</sup> Although CMS and States have taken several steps in recent years to increase MOUD access in Medicaid, our findings demonstrate that a significant number of enrollees with opioid use disorder may not be receiving this life-saving treatment. OIG found that one-third of the 1.5 million Medicaid enrollees with opioid use disorder did not receive MOUD through Medicaid or Medicare in 2021. Enrollees in certain demographic groups—particularly those who identify as Black or African American or those under the age of 19—were less likely to receive MOUD than other enrollees. In addition, we identified wide geographic variation in treatment rates. Notably, in 10 States, less than half of enrollees with opioid use disorder received MOUD.

OIG recognizes that CMS's capacity to address the issues raised in this report is somewhat limited. However, as laws and regulations surrounding drug-related treatment continue to evolve, CMS should take further steps to increase the use of MOUD among Medicaid enrollees in need, especially among groups who may be underserved. Such efforts would align with CMS's Behavioral Health Strategy goals to strengthen equity and improve access to substance use disorder treatment, which includes MOUD.<sup>41</sup>

Our recommendations reinforce CMS's overall policy agenda for Medicaid and CHIP, which includes providing "actionable, timely technical assistance and guidance," and committing to "pursu[ing] every avenue to engage with providers and other stakeholders, especially people and their families who are covered by Medicaid and CHIP."<sup>42</sup>

## We recommend that CMS:

### Encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may be underserved

CMS should help States—especially those with low rates of MOUD use—identify and reduce barriers that hinder access to treatment. CMS could offer States technical assistance, collaborative learning opportunities, webinars, toolkits, and other resources. Through its Medicaid Innovation Accelerator Program, CMS offered States similar types of support from July 2014 through September 2020 for reducing substance use disorders.<sup>43</sup> CMS's initiatives should include efforts to identify and reduce disparities in MOUD use among the groups we found to be underserved (e.g., enrollees of certain races).

Complete and consistent enrollee race and ethnicity data are critical to (1) understand access challenges faced by certain racial and ethnic groups; (2) identify potential policies and programs that can reduce disparities; and (3) assess the effectiveness of the initiatives. However, only 15 States have relatively valid and complete race and ethnicity data, according to CMS.<sup>44</sup> This

prevented OIG from assessing racial and ethnic disparities in MOUD use nationwide for this study. As part of its efforts to reduce disparities in MOUD use, and in alignment with CMS's 2022-2032 Framework for Health Equity, the agency may therefore wish to continue helping States standardize and improve their Medicaid race and ethnicity data.<sup>45</sup>

## **Encourage States and work with Federal partners to educate Medicaid and CHIP enrollees about access to MOUD**

Until October 2020, State Medicaid programs were not explicitly required to cover MOUD.<sup>46</sup> Similarly, CHIP coverage of MOUD was not required until October 2019.<sup>47</sup> As a result, some enrollees may be unaware that they currently can obtain MOUD treatment under Medicaid and CHIP and should be informed about the mandatory coverage. Additionally, CMS should encourage States and work with Federal partners to educate enrollees about the increased availability of buprenorphine in office-based settings due to the recent removal of the waiver requirement.

For example, CMS could create a campaign to help disseminate this information to Medicaid and CHIP enrollees. As part of the campaign, CMS could create resources such as fact sheets, social media materials, etc. CMS could also work with its Federal partners, such as the Office of the Surgeon General, to educate Medicaid and CHIP enrollees about the benefits of MOUD.

Targeted campaigns and other similar initiatives will become even more critical if the end of the mandatory MOUD coverage period in 2025 results in States placing restrictions on MOUD. CMS should continue to stay apprised of State MOUD policies and encourage States to educate enrollees about any changes in MOUD coverage.

# AGENCY COMMENTS AND OIG RESPONSE

CMS neither concurred nor nonconcurred with our recommendations. The agency instead stated that it already works with States to increase access to MOUD and ensure that enrollees are educated regarding access.

In response to our recommendation that CMS encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may be underserved, the agency stated that it works with States to increase access to MOUD via the mandatory state plan benefit and substance use disorder Section 1115 demonstration initiatives. CMS also stated that it has imputed missing enrollee race and ethnicity data, which States can use to better understand where to target additional efforts.

OIG acknowledges and thanks CMS for its efforts; however, opportunities exist for additional action given our concerning finding that certain demographic groups were much less likely to receive MOUD. CMS should—in alignment with the agency's Behavioral Health Strategy—further work with States to reduce disparities in MOUD use, ensuring that more enrollees receive life-saving treatment. For example, CMS could offer States technical assistance, collaborative learning opportunities, webinars, toolkits, and other resources. CMS could also help States gather more complete self-reported enrollee race and ethnicity data, as self-identification—rather than imputation—is regarded as the preferred means for obtaining race and ethnicity information.<sup>48</sup>

In response to our recommendation that CMS encourage States and work with Federal partners to educate Medicaid and CHIP enrollees about access to MOUD, the agency stated that it stays apprised of State policy changes through the State plan amendment process and already works with States to ensure that enrollees are educated regarding access.

OIG recognizes CMS's efforts; however, we continue to recommend that CMS ensure that enrollees are educated about access to MOUD. The 2020-2025 MOUD coverage requirement in the SUPPORT for Patients and Communities Act represents a significant expansion in comprehensive Medicaid coverage of MOUD. Additionally, enrollees who were previously unable to access buprenorphine for opioid use disorder may be unaware that more providers can now prescribe buprenorphine due to the removal of the waiver requirement in late 2022. OIG believes that the rapidly evolving landscape of drug-related laws and regulations warrants concerted efforts to educate enrollees about expanded access beyond routine state plan amendment processes.

CMS noted that it anticipates that States will continue to cover a wide variety of MOUD after the SUPPORT for Patients and Communities Act coverage requirement expires in September 2025. We ask that CMS encourage States that ultimately continue coverage of MOUD beyond 2025 to advertise their coverage to enrollees through campaigns, social media posts, or other easily accessible materials. Additionally, OIG continues to encourage CMS to develop its own

educational materials in collaboration with Federal partners such as the Surgeon General and SAMHSA. State Medicaid programs could use such materials to educate enrollees about the availability and benefits of MOUD treatment or as models for developing their own materials.

We ask that CMS clarify in its Final Management Decision its concurrence or nonconcurrence with each recommendation and the steps it is taking to implement each recommendation.

For the full text of CMS's comments, see Appendix D.

# METHODOLOGY

## Data Analysis

### Identifying Enrollees with Opioid Use Disorder

States submit Medicaid and CHIP (hereinafter collectively referred to as “Medicaid”) data to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). We used T-MSIS claims data to identify Medicaid enrollees with opioid use disorder in the 50 States and Washington, D.C.<sup>49</sup> We considered an enrollee to have opioid use disorder if they had at least one 2021 Medicaid claim that included (1) an “opioid abuse” or “opioid dependence” diagnosis code or (2) a service from an opioid treatment program.<sup>50</sup>

### Identifying Enrollees Who Received Medications for Opioid Use Disorder

To determine the extent to which Medicaid enrollees received MOUD, we counted the number of Medicaid enrollees with opioid use disorder who had a Medicaid pharmacy, outpatient, or inpatient claim for buprenorphine, methadone, or naltrexone in 2021 in the 50 States or Washington, D.C.<sup>51</sup> Because Medicare is the primary payer for people dually enrolled in Medicare and Medicaid, we also determined the number of dual-eligible Medicaid enrollees who had a Medicare pharmacy, outpatient, or inpatient claim for buprenorphine, methadone, or naltrexone. We used Medicaid claims data to identify the most common settings in which enrollees received MOUD through Medicaid. We did not analyze the settings of Medicare-paid MOUD claims. We used Medicaid enrollment (e.g., sex) and eligibility (e.g., basis for eligibility) data to identify demographic disparities among enrollees who received MOUD.

## Limitations

This data brief relied on claims data to determine the extent to which Medicaid enrollees with opioid use disorder received MOUD. Because we used claims data rather than medical records to identify enrollees with opioid use disorder, we likely underestimated the actual number of enrollees in Medicaid who are in need of treatment.<sup>52</sup> In addition, because we did not examine medical records, we were unable to confirm the validity of the diagnosis code on the claim (e.g., whether the patient actually met diagnostic criteria for opioid use disorder, or whether a provider correctly used a diagnosis code, such as that of opioid dependence, etc.).

Further, our analysis may have underestimated the actual number of enrollees who received MOUD if they received treatment through sources that were not included in this review (e.g., other insurance or self-pay). Additionally, States may have misreported MOUD paid for by their Medicaid or CHIP programs. Although T-MSIS is the most comprehensive national Medicaid and CHIP data set, its size, complexity, and frequency of updates influence the quality of its data.<sup>53</sup> We did not independently verify the completeness or accuracy of the data.

We did not assess whether the enrollees included in our study were continuously covered by Medicaid in 2021. In other words, some enrollees may not have received MOUD through Medicaid because they were enrolled in the program for only a short period of time. However, we anticipate the number of people who disenrolled from Medicaid to be low in 2021 due to provisions that mandated continuous Medicaid enrollment during most of the Public Health Emergency in order to receive a temporary Federal medical assistance percentage increase.<sup>54</sup>

Some enrollees with opioid use disorder may not have received MOUD if they or their provider determined that MOUD was not an appropriate treatment option. For example, some providers may prefer to treat patients under the age of 18 with alternative therapies such as counseling. We did not examine whether enrollees received forms of treatment other than MOUD.

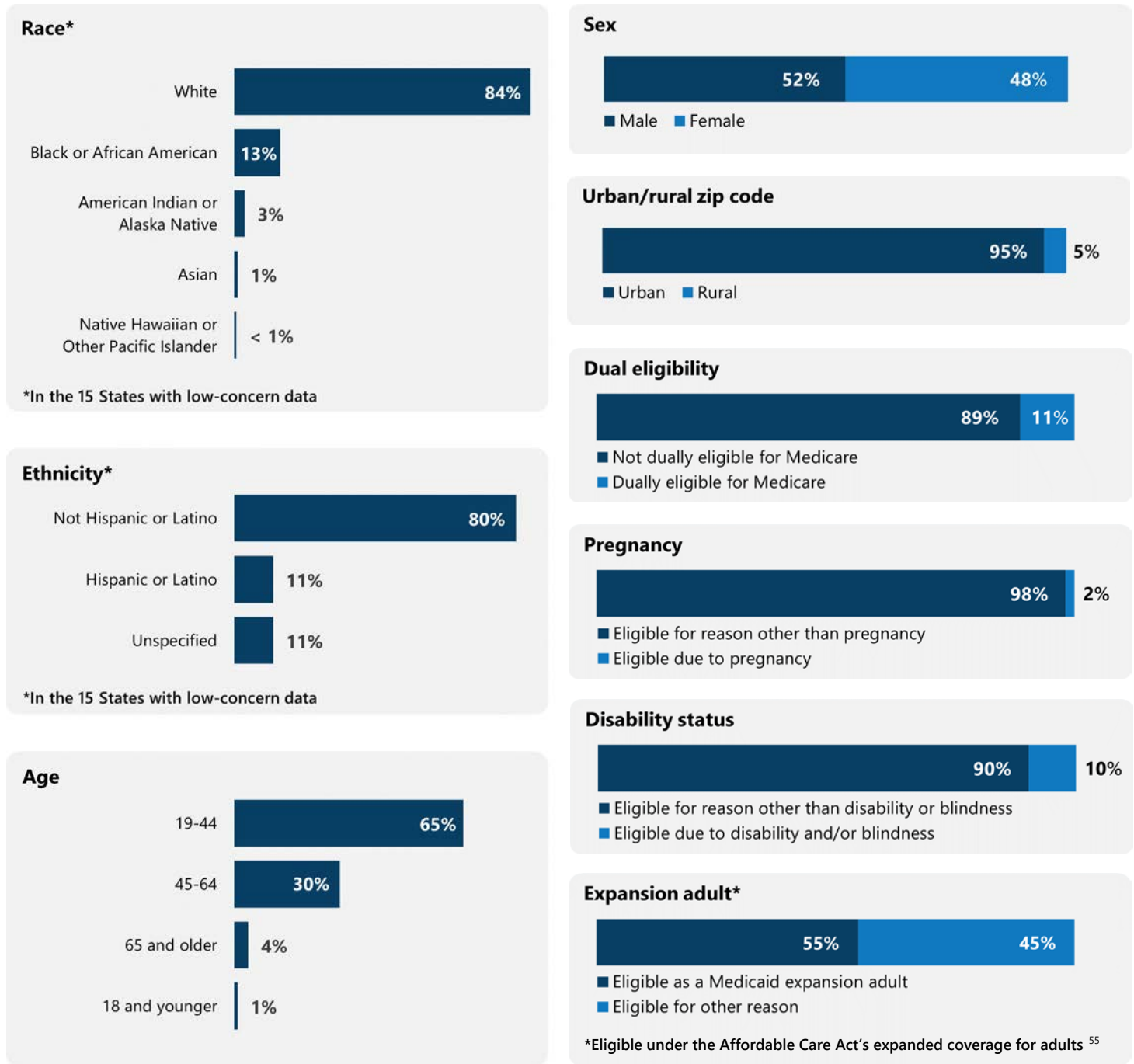
## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.



# APPENDIX A

## Characteristics of Medicaid enrollees with opioid use disorder in 2021

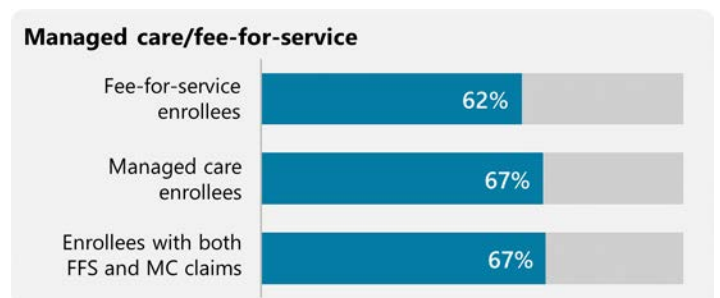
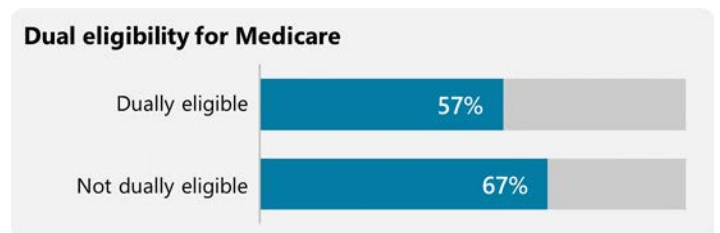
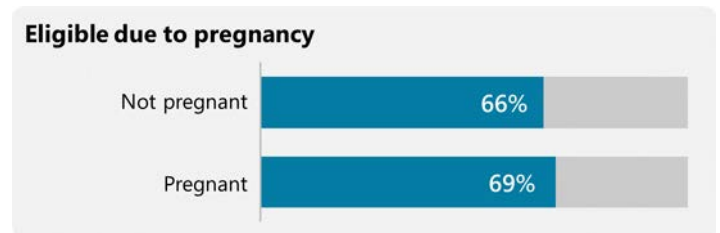
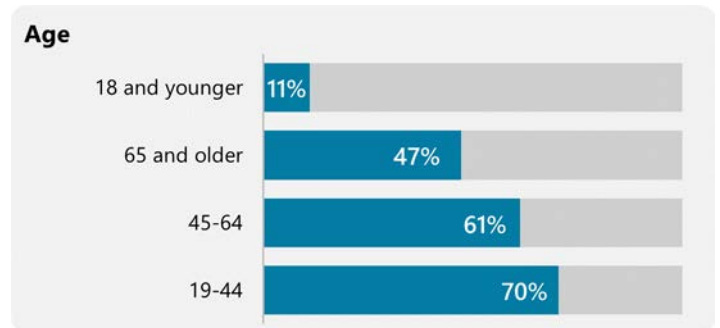
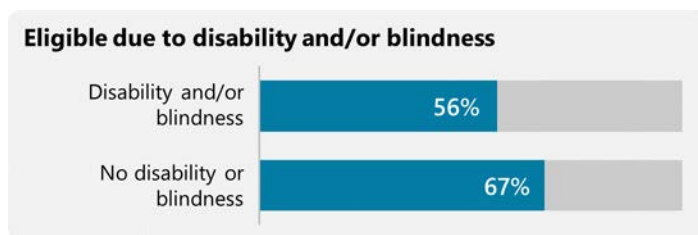
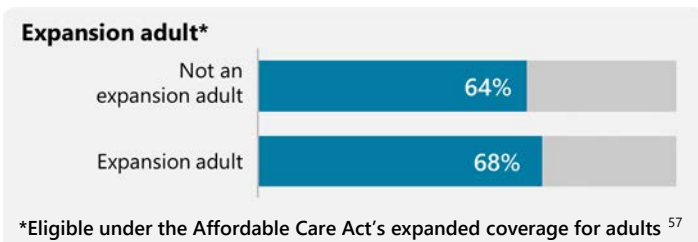
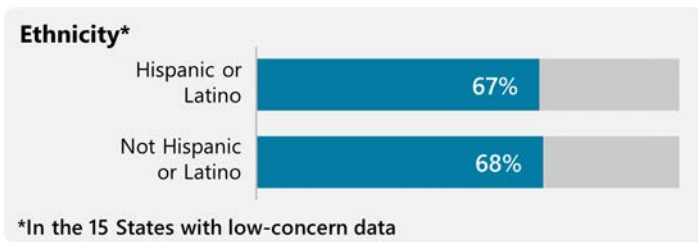
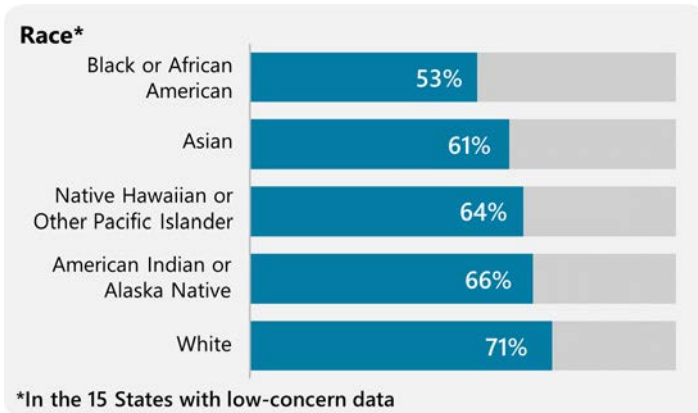


Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.<sup>56</sup>  
 Note: The summaries of race and ethnicity are based on enrollees' voluntary self-identification. Percentages sum to more than 100 percent because some enrollees selected multiple races, and some selected multiple ethnicities. Race was unspecified for less than .1 percent of enrollees.

# APPENDIX B

## Differences in the rate of MOUD utilization among Medicaid enrollees with opioid use disorder, by enrollee characteristics

■ Percentage within characteristic group who received MOUD



Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.<sup>58</sup>

Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns, OEI-BL-22-00260

# APPENDIX C

## Rates of opioid use disorder and MOUD utilization among Medicaid enrollees in 2021, by State

| State                | Percentage of State Medicaid population with opioid use disorder | Number of enrollees with opioid use disorder | Number of enrollees with opioid use disorder who received MOUD | Percentage of enrollees with opioid use disorder who received MOUD |
|----------------------|--|--|--|--|
| Rhode Island         | 3%   | 9,734  | 8,635  | 89%  |
| Vermont              | 6%   | 10,031                                       | 8,849  | 88%  |
| New Hampshire        | 5%   | 11,911                                       | 9,894  | 83%  |
| Indiana              | 3%   | 43,368                                       | 35,996   | 83%  |
| Massachusetts        | 4%   | 74,128                                       | 60,767   | 82%  |
| Maine                | 5%   | 16,502                                       | 13,485   | 82%  |
| Virginia             | 2%   | 42,141                                       | 33,316   | 79%  |
| Washington           | 3%   | 54,491                                       | 42,806   | 79%  |
| Connecticut          | 4%   | 36,056                                       | 28,150   | 78%  |
| West Virginia        | 6%   | 34,263                                       | 26,627   | 78%  |
| Maryland             | 4%   | 63,970                                       | 48,943   | 77%  |
| Delaware             | 4%   | 11,883                                       | 9,072  | 76%  |
| Montana              | 2%   | 6,375  | 4,837  | 76%  |
| South Carolina       | 1%   | 8,899  | 6,735  | 76%  |
| Alaska               | 2%   | 6,207  | 4,634  | 75%  |
| Kentucky             | 5%   | 79,794                                       | 59,447   | 75%  |
| Oregon               | 2%   | 28,839                                       | 21,443   | 74%  |
| New Mexico           | 3%   | 21,846                                       | 15,918   | 73%  |
| Pennsylvania         | 3%   | 113,467                                      | 80,410   | 71%  |
| North Dakota         | 2%   | 2,254  | 1,590  | 71%  |
| Ohio                 | 4%   | 116,072                                      | 79,468   | 68%  |
| District of Columbia | 1%   | 3,829  | 2,604  | 68%  |
| Iowa                 | 1%   | 5,545  | 3,746  | 68%  |
| Tennessee            | 2%   | 30,689                                       | 20,568   | 67%  |
| Alabama              | 1%   | 10,935                                       | 7,265  | 66%  |
| Louisiana            | 2%   | 28,302                                       | 18,550   | 66%  |
| California           | 1%   | 97,729                                       | 63,458   | 65%  |
| Michigan             | 2%   | 49,368                                       | 31,961   | 65%  |
| Minnesota            | 2%   | 24,896                                       | 15,968   | 64%  |
| New Jersey           | 3%   | 55,133                                       | 34,703   | 63%  |

| State          | Percentage of State Medicaid population with opioid use disorder | Number of enrollees with opioid use disorder | Number of enrollees with opioid use disorder who received MOUD | Percentage of enrollees with opioid use disorder who received MOUD |
|----------------|--|--|--|--|
| Idaho          | 2%   | 6,642  | 4,081  | 61%  |
| Florida        | 1%   | 26,433                                       | 16,088   | 61%  |
| South Dakota   | 0%   | 495  | 294  | 59%  |
| Colorado       | 2%   | 25,602                                       | 14,975   | 58%  |
| Hawaii         | 1%   | 2,794  | 1,550  | 55%  |
| Arizona        | 3%   | 55,884                                       | 30,847   | 55%  |
| Nebraska       | 0%   | 1,580  | 868  | 55%  |
| Wisconsin      | 3%   | 36,275                                       | 19,892   | 55%  |
| Missouri       | 1%   | 14,900                                       | 8,111  | 54%  |
| North Carolina | 2%   | 32,948                                       | 17,702   | 54%  |
| Oklahoma       | 1%   | 10,518                                       | 5,606  | 53%  |
| Wyoming        | 1%   | 486  | 242  | 50%  |
| Utah           | 3%   | 13,825                                       | 6,771  | 49%  |
| Arkansas       | 0%   | 3,918  | 1,880  | 48%  |
| New York       | 2%   | 115,101                                      | 53,840   | 47%  |
| Texas          | 0%   | 11,303                                       | 5,142  | 45%  |
| Nevada         | 1%   | 11,867                                       | 5,285  | 45%  |
| Kansas         | 0%   | 2,132  | 939  | 44%  |
| Georgia        | 0%   | 10,294                                       | 4,220  | 41%  |
| Mississippi    | 1%   | 5,249  | 2,034  | 39%  |
| Illinois       | 1%   | 40,486                                       | 15,017   | 37%  |

Source: OIG analysis of 2021 Medicaid enrollment data and Medicaid/Medicare claims data.

Note: Some enrollees were associated with multiple States.

# APPENDIX D

## Agency Comments

Following this page are the official comments from CMS.



**DATE:** September 7, 2023

**TO:** Ann Maxwell  
Deputy Inspector General for Evaluation and Inspections

**FROM:** Chiquita Brooks-LaSure *Chiquita LaS*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns (OEI-BL-22-00260)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that Medicaid beneficiaries who have an opioid use disorder (OUD) have access to appropriate treatment, including medications for opioid use disorder (MOUD). Ensuring access to these benefits and addressing equity concerns is an important part of combatting the nation's opioid epidemic, and CMS has been actively engaged in the work necessary to meet these goals.

Substance use disorders (SUD) impact the lives of millions of Americans, including individuals that are enrolled in the Medicaid program. CMS is committed to helping states effectively serve Medicaid beneficiaries with SUDs. Through the Substance Use-Disorder Prevention that Promotes Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act), CMS has implemented several measures to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to fight deadly illicit synthetic drugs.

CMS has created a comprehensive approach to combat the opioid crisis that focuses on prevention, treatment, and data. One initiative that CMS has already implemented as part of this comprehensive approach is the approval of section 1115 demonstrations designed to improve access to SUD treatment, including new flexibility to cover inpatient and residential treatment in institutions for mental disease. Through section 1115 demonstrations, CMS is partnering with states to test approaches to increasing access to the full continuum of care for SUD, including medication assisted treatment (MAT). Currently, there are 35 states participating in SUD demonstration projects. CMS requires that states closely monitor and evaluate the SUD demonstrations; states provide routine updates on demonstration progress via monitoring calls with CMS, systematically develop and submit structured monitoring reports with metrics data and narrative information on implementation and operational progress and challenges, and contract with independent contractors to conduct mid-point assessment and evaluation of the demonstrations. To supplement state monitoring and evaluation efforts, CMS also is undertaking a federal cross-state analysis and meta-evaluation of the SUD demonstrations.

As of June 20, 2022, monitoring metrics data reported by 26 states with SUD demonstrations showed that 23 of these states experienced consistent improvement in MAT utilization. In addition, between December 2020 and July 2021, 31 states and the District of Columbia participated in key informant interviews as part of the SUD meta-evaluation to facilitate understanding of state experiences in expanding MAT for beneficiaries in residential settings. The study provides recommendations for strategies to address state-reported challenges, including conducting outreach and education to providers on the appropriateness of MAT.

Medicaid is a state/federal partnership, administered by states according to federal requirements. States retain responsibility for administration of their Medicaid programs, including informing beneficiaries of coverage options. Therefore, states have undertaken efforts to educate or inform Medicaid beneficiaries on availability of MAT coverage, including centralized resources to connect individuals with SUD treatment providers. For example, some states are providing centralized call centers or service locators and conducting public forums and stakeholder meetings related to their SUD demonstrations. In addition, some states added MAT-specific clauses to residential provider standards, including requiring residential providers to inform beneficiaries about all their options for MAT. Furthermore, several states informed the public about the MAT coverage in the Medicaid program via educational web pages, news releases, or other media releases.

The SUPPORT for Patients and Communities Act generally requires states to cover all drugs and biologicals approved or licensed by the Food and Drug Administration (FDA) used for MAT to treat OUD until September 2025, and the Medicaid Drug Rebate Program (MDRP) requires that state Medicaid programs cover all of a participating manufacturer's Covered Outpatient Drugs when prescribed for a medically accepted indication. As a result, states must cover all forms of MAT medications that are produced by manufacturers participating in the MDRP. Therefore, even after 2025, CMS anticipates that states will continue to cover a wide variety of MOUD.

In addition, through technical assistance, CMS continues to help states to effectively design, deliver and pay for services to treat SUD for Medicaid beneficiaries. And, as stated above, CMS also believes that accurate data are a key part of addressing equity concerns. To that end, CMS has provided states with technical assistance on T-MSIS data submission since 2018 on topics such as how to accurately report demographics data. However, states cannot require beneficiaries to provide race and ethnicity data. Therefore, CMS has imputed race and ethnicity data for all states and beneficiaries in T-MSIS where such information was absent. These data are available in public files, and states can use these data to better understand where to target additional efforts.

OIG's recommendations and CMS' responses are below.

**OIG Recommendation**

CMS should encourage and support States' efforts to reduce barriers to MOUD, especially among groups who may be underserved.

**CMS Response**

CMS appreciates OIG's acknowledgement of the importance of this work. As stated above, CMS continues to work with states to increase access to MOUD via the mandatory state plan benefit and SUD section 1115 demonstration initiatives. In addition, as discussed above, states cannot require enrollees to provide race and ethnicity information. Therefore, CMS has imputed race

and ethnicity data for all states and beneficiaries in T-MSIS where such information was absent. These data are available in public files for states and researchers.

**OIG Recommendation**

CMS should encourage States and work with Federal partners to educate Medicaid and CHIP enrollees about access to MOUD.

**CMS Response**

As stated above, Medicaid is administered by states, according to federal requirements. States are responsible for informing beneficiaries about available access to benefits. In addition, CMS stays apprised of state policy changes through the state plan amendment (SPA) process. States must have a CMS-approved SPA detailing how they will administer their Medicaid program within federal rules. CMS must approve any changes to the State plan. Given CMS already works with states to ensure enrollees are educated regarding access through the efforts described above, and stays apprised of state policy changes through the SPA process, we continue to recommend that OIG remove this recommendation.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.



# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

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This report was prepared under the direction of Dave Tawes, Regional Inspector General for Evaluation and Inspections in the Baltimore Regional Office; Heather Barton, Deputy Regional Inspector General; and Louise Schoggen, Assistant Regional Inspector General.

## Contact

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# ENDNOTES

<sup>1</sup> Centers for Disease Control (CDC), National Center for Health Statistics: Provisional Drug Overdose Death Counts. Accessed at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> on May 23, 2023.

<sup>2</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) currently recommends using the term “medications for opioid use disorders” (MOUD) instead of the historically used term “medication-assisted treatment” (MAT). The term “MAT” implies that medication plays a secondary role to other approaches while the term “MOUD” reinforces the idea that medication is its own treatment form. 87 FR 77330-77365 (December 16, 2022). As of March 2023, the U.S. Food and Drug Administration (FDA) has approved three medications for opioid use disorder: methadone, buprenorphine, and naltrexone.

<sup>3</sup> The Office of Inspector General, *Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries*, OEI-02-22-00390, September 2022.

<sup>4</sup> U.S. Government Accountability Office, *Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access*, GAO-16-833, September 2016. Comanici, K., et al., “Understanding the Role of Community Pharmacies in Current Medication for Opioid Use Disorder Care Practices,” *Journal of the American Pharmacists Association*, Volume 63, Issue 1, January 2023.

<sup>5</sup> Mauro, P., et al., “Use of Medication for Opioid Use Disorder Among US Adolescents and Adults with Need for Opioid Treatment, 2019,” *Journal of the American Medical Association*, Volume 5, Issue 3, March 2022. Andraka-Christou, B., “Addressing Racial and Ethnic Disparities in the Use of Medications For Opioid Use Disorder,” *Health Affairs*, Volume 40, Issue 6, June 2021.

<sup>6</sup> Orgera, K., and Tolbert, J., “The Opioid Epidemic and Medicaid’s Role in Facilitating Access to Treatment,” Kaiser Family Foundation, May 24, 2019. Accessed at <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/> on April 19, 2023.

<sup>7</sup> *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, 2013.

<sup>8</sup> U.S. Department of Health and Human Services, *Facing Addiction in America: The Surgeon General’s Spotlight on Opioids*, September 2018.

<sup>9</sup> FDA, “Information about Medication-Assisted Treatment (MAT),” last updated May 23, 2023. Accessed at <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat> on June 23, 2023. We did not include naloxone in our review because it is not considered a medication to treat opioid use disorder. Naloxone is a medicine that rapidly reverses an opioid overdose. See National Institute on Drug Abuse, “Naloxone DrugFacts,” January 2022. Accessed at <https://nida.nih.gov/publications/drugfacts/naloxone> on April 20, 2023.

<sup>10</sup> “Opioid treatment program” refers to a program or practitioner that provides opioid agonist treatment medications (i.e., methadone and buprenorphine) to individuals with opioid use disorder. Opioid treatment programs provide additional substance use services such as counseling and toxicology testing.

<sup>11</sup> Over time, patients can receive up to one month’s worth of methadone take-home doses. See 42 CFR § 8.12(i). Also see SAMHSA, *Federal Guidelines for Opioid Treatment Programs*, January 2015. SAMHSA has also increased the flexibility in dispensing take-home doses of methadone in response to the COVID-19 pandemic. See SAMHSA, *Opioid Treatment Program (OTP) Guidance*, March 2020. See also SAMHSA, *Methadone Take-Home Flexibilities Extension Guidance*, last updated May 1, 2023.

<sup>12</sup> The Consolidated Appropriations Act, 2023, repealed the requirement that providers need a waiver to prescribe buprenorphine for opioid use disorder. As of December 2022, all providers with a standard Drug Enforcement Agency registration may prescribe buprenorphine for opioid use disorder (in accordance with State law). Separately, the Consolidated

Appropriations Act, 2023, introduced a requirement for providers to satisfy a one-time training requirement related to treating and managing patients with opioid or other substance use disorders. See Sections 1262-1263 of the Consolidated Appropriations Act, 2023 (P.L. 117-328).

<sup>13</sup> Naltrexone also differs from methadone and buprenorphine in that it is an opioid antagonist whereas methadone is an opioid agonist and buprenorphine is an opioid partial agonist.

<sup>14</sup> See Section 1006(b) of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) (P.L. 115-271). Although Hawaii, South Dakota, and Wyoming were granted an exception from the requirement to cover all FDA-approved MOUDs, each of the three States covered or reimbursed some form of buprenorphine or naltrexone in 2021.

<sup>15</sup> Section 5022 of the SUPPORT for Patients and Communities Act (P.L. 115-271) required child health and pregnancy-related assistance under the Children's Health Insurance Program (CHIP) to "include coverage of mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad array of mental health symptoms and disorders, including substance use disorders." As part of compliance with these requirements, States are generally required to provide coverage of MOUD. CMS issued the following Federal policy guidance to notify States: CMS, "Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program (SHO# 20-002)." Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf> on July 5, 2023.

<sup>16</sup> Orgera, K., and Tolbert, J., "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment," Kaiser Family Foundation, May 24, 2019. Accessed at <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/> on April 19, 2023.

<sup>17</sup> Section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) generally requires States to cover MOUD until September 2025. CMS issued the following Federal policy guidance to notify States: CMS, "Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment (SHO# 20-005)." Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf> on March 16, 2022.

<sup>18</sup> For example, CMS's Medicaid Innovation Accelerator Program helped Medicaid agencies enhance their substance use disorder programs through technical assistance, webinars, and other tools. Learn more at <https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html>. The 2023 and 2024 Core Set of Adult Health Care Quality Measures for Medicaid can be accessed at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-core-set.pdf>.

<sup>19</sup> We considered an enrollee to have opioid use disorder if they had at least one 2021 claim paid through Medicaid or CHIP that included (1) an opioid use disorder diagnosis code or (2) service from an opioid treatment program. Because less than 1 percent of the individuals in this review were below the age of 19 (i.e., potentially eligible for CHIP coverage), we collectively refer to our study population as "Medicaid enrollees" and refer to Medicaid or CHIP claims as "Medicaid claims."

<sup>20</sup> Of the 1,004,368 Medicaid enrollees who received MOUD, 91 percent were treated through Medicaid only; 6 percent were treated through Medicare only; and 3 percent were treated through both Medicaid and Medicare. Enrollees may have received MOUD through sources other than Medicaid or Medicare (e.g., self-pay).

<sup>21</sup> We did not analyze the settings of Medicare-paid MOUD claims.

<sup>22</sup> The Drug Addiction Treatment Act of 2000 (Title XXXV of the Children's Health Act of 2000, P.L. No. 106-310) allowed providers to obtain a waiver to prescribe Schedule III, IV, and V drugs—including buprenorphine—for substance use disorder treatment in office settings. The Consolidated Appropriations Act, 2023, removed the waiver requirement.

<sup>23</sup> During this study's period of review, States were permitted to request an exception to allow certain patients to receive take-home doses of MOUD, including methadone, from opioid treatment programs. See SAMHSA, *Opioid Treatment Program (OTP) Guidance*, last updated March 19, 2020.

<sup>24</sup> Pandemic-related flexibilities included relaxed regulations surrounding take-home methadone and allowing providers to prescribe MOUD via telehealth.

<sup>25</sup> See Section 1262 of the Consolidated Appropriations Act, 2023 (P.L. 117-328).

<sup>26</sup> Andraka-Christou, B., "Addressing Racial and Ethnic Disparities in the Use of Medications For Opioid Use Disorder," *Health Affairs*, Volume 40, Issue 6, June 2021. Mark, T., et al., "Improving Research on Racial Disparities in Access to Medications to Treat Opioid Use Disorders," *Journal of Addiction Medicine*, Volume 17, Issue 3, May/June 2023. SAMHSA, *The Opioid Crisis and the Black/African American Population: An Urgent Issue*, April 2020.

<sup>27</sup> All States collect self-reported applicant race and ethnicity data as part of the Medicaid application process; however, the race and ethnicity data that States submit to CMS are often incomplete or inconsistent. Because information about applicants' race and ethnicity is not necessary to determine eligibility, States must mark related questions as optional (see 42 CFR § 435.907(e)(1)). Further, question details such as the number of race/ethnicity categories from which applicants can choose differ by State. We therefore limited our race/ethnicity analysis to the following 15 States that CMS's DQ (Data Quality) Atlas rated as having enrollee race/ethnicity data that are of "low concern" for 2020 (i.e., the most recent assessment available at the time of our analysis): Alaska, California, Delaware, Michigan, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Virginia, and Washington. The DQ Atlas assesses race/ethnicity data on the basis of (1) the completeness of a State's race and ethnicity data and (2) the extent to which the distribution of a State's non-missing race and ethnicity data aligns with an external benchmark, the American Community Survey. See the DQ Atlas race and ethnicity page for more information: <https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g3m16&tafVersionId=25>.

<sup>28</sup> CDC, Media Statement, "Overdose death rates increased significantly for Black, American Indian/Alaska Native people in 2020," July 19, 2022. Accessed at <https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html> on April 18, 2023.

<sup>29</sup> Ethnicity was populated for 544,022 enrollees with opioid use disorder in the 15 States rated as having "low concern" enrollee race/ethnicity data. Sixty-seven percent of the enrollees who self-identified as Hispanic or Latino received MOUD compared to 68 percent of enrollees who identified as not Hispanic or Latino.

<sup>30</sup> CDC, *Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices*, 2022.

<sup>31</sup> Gaither, J., et al., "US National Trends in Pediatric Deaths From Prescription and Illicit Opioids, 1999-2016," *JAMA Network Open*, Volume 1, Issue 8, December 2018.

<sup>32</sup> Methadone and naltrexone are not explicitly approved by FDA for patients under the age of 18, and buprenorphine is only approved for patients 16 years of age and older.

<sup>33</sup> According to FDA, once it has approved a drug, providers generally may prescribe the drug for unapproved use when they judge that it is medically appropriate for their patient. See FDA, "Understanding Unapproved Use of Approved Drugs 'Off Label,'" last updated February 5, 2018. Accessed at <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label> on July 26, 2023.

<sup>34</sup> See 42 CFR § 8.12(e)(2).

<sup>35</sup> King, C., Beetham, T., Smith, N., et al., "Treatments Used Among Adolescent Residential Addiction Treatment Facilities in the US, 2022," *JAMA*, Volume 329, Number 22, June 2023.

<sup>36</sup> Han, B., and Moore, A., "Prevention and Screening of Unhealthy Substance Use by Older Adults," *Clinics in Geriatric Medicine*, Volume 34, Issue 1, February 2018. Joshi, P., et al., "Medication-Assisted Treatment for Opioid Use Disorder in Older Adults: An Emerging Role for the Geriatric Psychiatrist," *The American Journal of Geriatric Psychiatry*, Volume 27, Issue 4, April 2019. Bond, A., "Nursing homes routinely refuse people on addiction treatment — which some experts say is illegal," *STAT News*, April 17, 2018. Accessed at <https://www.statnews.com/2018/04/17/nursing-homes-addiction-treatment/> on July 20, 2023.

<sup>37</sup> Medicare began reimbursing opioid treatment programs for opioid use disorder treatment services in January 2020. See Section 2005 of the SUPPORT for Patients and Communities Act (P.L. 115-271).

<sup>38</sup> SAMHSA, *Advisory: Mental and Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities*, 2019.

<sup>39</sup> CMS, "Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment (SHO# 20-005)." Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf> on March 16, 2022.

<sup>40</sup> Orgera, K., and Tolbert, J., "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment," Kaiser Family Foundation, May 24, 2019. Accessed at <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/> on April 19, 2023.

<sup>41</sup> CMS's Behavioral Health Strategy can be accessed at <https://www.cms.gov/cms-behavioral-health-strategy>. Last updated May 5, 2022.

<sup>42</sup> Brooks-LaSure, C., and Tsai, D., "A Strategic Vision for Medicaid And The Children's Health Insurance Program (CHIP)," *Health Affairs Forefront*, November 16, 2021. Accessed at <https://www.healthaffairs.org/doi/10.1377/forefront.20211115.537685/> on May 22, 2023.

<sup>43</sup> From July 2014 through September 2020, CMS administered the Medicaid Innovation Accelerator Program. The goal of the Innovation Accelerator Program was to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting States' ongoing payment and delivery system reforms. CMS, "Medicaid Innovation Accelerator Program." Accessed at <https://www.medicaid.gov/resources-for-states/medicaid-innovation-accelerator-program/index.html> on March 16, 2023. CMS, "Reducing Substance Use Disorders." Accessed at <https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html> on March 16, 2023.

<sup>44</sup> States vary in how they obtain race/ethnicity data from Medicaid applicants, and questions about applicants' race and ethnicity must be marked as optional (see 42 § CFR 435.907(e)(1)). Consequently, the race and ethnicity data that States submit to CMS are often incomplete or inconsistent. CMS's DQ Atlas rated only 15 States as having enrollee race/ethnicity data that are of "low concern" for 2020 (i.e., the most recent assessment available at the time of our analysis). The DQ Atlas assesses race/ethnicity data on the basis of (1) the completeness of a State's race and ethnicity data and (2) the extent to which the distribution of a State's non-missing race and ethnicity data aligns with an external benchmark, the American Community Survey. See the DQ Atlas race and ethnicity page for more information: <https://www.medicaid.gov/dq-atlas/landing/topics/single/map?topic=g3m16&tafVersionId=25>.

<sup>45</sup> CMS, *CMS Framework for Health Equity 2022–2032*, April 2022.

<sup>46</sup> Section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) generally requires States to cover MOUD until September 2025. Three States are exempt from coverage: Hawaii, South Dakota, and Wyoming.

<sup>47</sup> Section 5022 of the SUPPORT for Patients and Communities Act (P.L. 115-271).

<sup>48</sup> Office of Management and Budget, *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, 62 FR 58782-58790 (October 30, 1997). U.S. Department of Health and Human Services, *Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status*, October 2011.

<sup>49</sup> Guam, American Samoa, and the Northern Mariana Islands did not report 2021 Medicaid data to T-MSIS. Puerto Rico and the U.S. Virgin Islands reported 2021 data to T-MSIS but were not included in this review due to the unavailability of Medicaid enrollment data.

<sup>50</sup> We searched Medicaid claims for the following opioid abuse and opioid dependence diagnosis codes: F11.1, F11.2, 304.0, 304.7, and 305.5.

<sup>51</sup> Methadone is used to treat pain in addition to opioid use disorder. To avoid including methadone claims for the treatment of pain, we excluded methadone pharmacy claims from this review because methadone for the treatment of opioid use disorder can only be dispensed by opioid treatment programs. Buprenorphine is also used to treat pain in addition to opioid use disorder. We excluded buprenorphine products that are not explicitly indicated for the treatment of opioid use disorder from this review.

<sup>52</sup> For example, an enrollee may not have disclosed symptoms to a provider due to the stigma surrounding opioid use disorder and therefore may not have had a Medicaid claim with an opioid use disorder diagnosis code. As a result, the enrollee would not have been included in our review.

<sup>53</sup> CMS's DQ Atlas rated the completeness of several States' 2021 T-MSIS claims, encounter records, and/or eligibility data as "high concern." See the DQ Atlas website for more information: <https://www.medicaid.gov/dq-atlas/welcome>.

<sup>54</sup> Section 6008 of the Families First Coronavirus Response Act, as amended by the Consolidated Appropriations Act, 2023, P.L. No. 117-328 (Dec. 29, 2022), provides a temporary increase to each qualifying State's Federal Medical Assistance Percentage (FMAP), effective January 1, 2020, through December 31, 2023. Among other conditions, to receive the increased FMAP, States must provide and continue benefits through March 31, 2023, to individuals who were enrolled in Medicaid as of March 18, 2020, or became enrolled in Medicaid between March 18, 2020, and March 31, 2023, unless the individual requested a voluntary termination of eligibility, or the individual ceased to be a resident of the State.

<sup>55</sup> The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) extended Medicaid eligibility to all adults under the age 65 with incomes below 133 percent of the Federal poverty level. The Supreme Court ruling in *National Federation of Independent Business (NFIB) v. Sebelius* effectively made the expansion optional for States.

<sup>56</sup> Figures summarizing enrollees with opioid use disorder do not include the small proportion for whom the relevant characteristics were missing. Less than .1 percent of enrollees were associated with both urban and rural zip codes. We used eligibility data to identify enrollees who were eligible for Medicaid due to (1) pregnancy; (2) disability and/or blindness; or (3) Medicaid expansion for adults. Some enrollees were eligible for multiple reasons (including reasons other than the three we analyzed). Eligibility records may not have accurately captured the actual status of all enrollees in 2021 (i.e., 2021 eligibility redeterminations may not have been conducted if a State was offering continuous coverage).

<sup>57</sup> The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) extended Medicaid eligibility to all adults under the age 65 with incomes below 133 percent of the Federal poverty level. The Supreme Court ruling in *National Federation of Independent Business (NFIB) v. Sebelius* effectively made the expansion optional for States.

<sup>58</sup> Summaries of MOUD utilization are limited to enrollees for whom the relevant characteristics were populated. We used eligibility data to identify enrollees who were eligible for Medicaid due to (1) pregnancy; (2) disability and/or blindness; or (3) Medicaid expansion for adults. Some enrollees were eligible for multiple reasons (including reasons other than the three we analyzed). Eligibility records may not have accurately captured the actual status of all enrollees in 2021 (i.e., 2021 eligibility redeterminations may not have been conducted if a State was offering continuous coverage). We used T-MSIS claims data to determine if the enrollees in our study were associated with (1) fee-for-service claims; (2) managed care claims; or (3) both fee-for-service and managed care claims during the period of review. Under fee-for-service, States pay providers directly for covered services received by enrollees. Under managed care, States pay fees to managed care plans, and the plans pay providers for services received by enrollees in accordance with the plan's contract with the State.