Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections

DATA BRIEF

February 2025 | OEI-02-23-00360

Not All Medicare Enrollees Are Continuing Treatment for Opioid Use Disorder

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Why OIG Did This Review

- Combatting the overdose crisis continues to be an important National priority, with almost 82,000 opioid-related overdose deaths in 2023.[1]
- Buprenorphine—the most common medication used to treat opioid use disorder in Medicare—can decrease both opioid use and overdose deaths. People who continue treatment with buprenorphine have improved outcomes.
- In alignment with the mission of the Department of Health and Human Services to enhance the health and well-being of all Americans, CMS plays an important role in supporting Medicare enrollees continuing treatment with buprenorphine for as long as appropriate. CMS determines Medicare coverage and payment for buprenorphine and other services related to treatment; it also informs enrollees and providers about the medications and services that Medicare covers.
- Information about the extent to which Medicare enrollees continue treatment can be used by CMS and other interested parties to help address the overdose crisis.

What OIG Found

- About 40 percent of Medicare enrollees who started treatment with buprenorphine continued; fewer enrollees who continued treatment died compared to those who did not continue treatment.
- Just one-third of enrollees who started buprenorphine received at least one behavioral therapy service; those who did not receive any of these services were less likely to continue treatment.
- Few enrollees received services billed to Medicare under payments aimed, in part, at helping enrollees stay in treatment.

What OIG Recommends

OIG recommends that CMS:

1. Educate Medicare **providers** about Medicare services that help enrollees continue treatment for opioid use disorder;
2. Educate Medicare **enrollees** about Medicare services that help enrollees continue treatment for opioid use disorder;
3. Assess and make changes, as appropriate, to the **bundled payment codes** for office-based treatment to ensure they meet provider and enrollee needs; and
4. Inform providers of emergency department services about the **Medicare payment for the initiation of medication** for the treatment of opioid use disorder and connecting patients to ongoing care.

CMS concurred with all four of these recommendations.

Primer—Buprenorphine for the Treatment of Opioid Use Disorder

- Opioid use disorder is a problematic pattern of opioid use that leads to clinically significant impairment or distress. About 1.1 million people enrolled in Medicare had a diagnosis of opioid use disorder in 2022.[2]
- **Buprenorphine is the most common medication used to treat opioid use disorder in Medicare**.[3] It reduces withdrawal symptoms and relieves cravings.
- **It is critical for people who start treatment with buprenorphine to continue treatment.** Longer retention in treatment for opioid use disorder is associated with improved outcomes, including reduced risk of both overdose-related and overall mortality.[4]
- The Substance Abuse and Mental Health Services Administration (SAMHSA) advises that **patients should remain in treatment for as long as they benefit and wish to continue**. For some, this could mean years, decades, or even lifelong treatment.[5]
- **Ensuring access to buprenorphine**—and other medications for opioid use disorder—**is also important** to addressing the overdose crisis. Due to concerns that buprenorphine has the potential for misuse and is at risk for diversion, this medication had been restricted.
    - Until late 2022, providers were required to obtain a waiver from SAMHSA to prescribe or administer buprenorphine in office-based settings and were limited in the number of patients whom they were allowed to treat.[6]
    - With recent legislative changes, buprenorphine can now be prescribed or administered by any provider who is able to order Schedule III controlled substances (in accordance with State law) and prescriptions can be filled at pharmacies.[7] Schedule III controlled substances include drugs with a moderate or low potential for physical dependence or high potential for psychological dependence.[8]
- **The Centers for Medicare & Medicaid Services has recently taken steps to increase access** to services to support treatment for opioid use disorder in Medicare, including:
    - creating office-based substance use disorder bundled payments, which include care coordination and psychotherapy in 2020; and
    - establishing an add-on payment for emergency departments that initiate medication for opioid use disorder. This payment is for assessing the patient and referring the patient to ongoing care outside of emergency department settings in 2021.[9]
- **Prior Office of Inspector General (OIG) reports** have assessed the extent to which Medicare enrollees receive buprenorphine and the risk of misuse and diversion of buprenorphine. OIG found:
    - Fewer than 1 in 5 Medicare enrollees with opioid use disorder received medication—including buprenorphine—to treat their opioid use disorder.[10] Certain groups of Medicare enrollees were less likely than others to receive medication to treat their opioid use disorder.
    - The risk of misuse and diversion of buprenorphine in Medicare Part D appears to be low.[11] Almost all Medicare Part D enrollees who received buprenorphine for the treatment of opioid use disorder received the recommended amounts.

FINDINGS

This data brief provides information about the extent to which Medicare enrollees in traditional Medicare and Medicare Advantage continue treatment with buprenorphine. This information can help the Centers for Medicare & Medicaid Services (CMS) and other interested parties target policies to improve treatment for those with opioid use disorder.

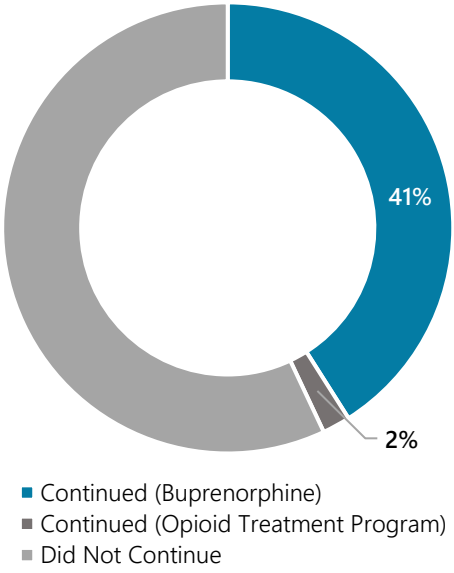
We based this analysis on Medicare enrollees who started treatment with buprenorphine indicated for the treatment of opioid use disorder in office-based settings in 2021 or 2022. We included enrollees who either started treatment with buprenorphine for the first time or restarted buprenorphine after a gap in treatment that lasted more than a month. We considered enrollees to have continued treatment with buprenorphine if they received buprenorphine continuously for at least 6 months. These criteria are aligned with the CMS quality measure related to continuity of care for treatment of opioid use disorder.[12]

Less than half of Medicare enrollees—41 percent—continued treatment with buprenorphine for opioid use disorder

A total of 143,383 Medicare enrollees started treatment with buprenorphine in office-based settings in 2021 or 2022. These enrollees were prescribed buprenorphine by a provider and either filled these prescriptions at pharmacies or received buprenorphine directly administered by their providers, for example through an injection in the provider's office.[13]

Of those who started buprenorphine, just 41 percent continued treatment for at least 6 months in office-based settings. They represent 59,235 of the 143,383 enrollees. See Exhibit 1. On average, these enrollees continuously received treatment with buprenorphine for 14.2 months. They most often received buprenorphine from general care, addiction medicine, and behavioral health providers.

Exhibit 1. Just 4 in 10 Medicare enrollees continued treatment with buprenorphine for at least 6 months



Source: OIG analysis of Medicare data, 2024.

An additional 2 percent of enrollees continued treatment for opioid use disorder at opioid treatment programs.[14] These enrollees most often switched from buprenorphine to methadone. Opioid treatment programs are the only settings in which people can receive methadone to treat their opioid use disorder; it is not available in office-based settings.[15]

The remaining 57 percent of enrollees did not continue treatment. These enrollees' average length of treatment was only 2 months. Like enrollees who continued treatment, these enrollees most often received buprenorphine from general care, addiction medicine, and behavioral health providers. See Appendix A for more information.

Enrollees may have not continued treatment for a variety of reasons. For instance, some enrollees may have had trouble accessing providers who prescribe buprenorphine or pharmacies able to fill these prescriptions. Provider stigma around both opioid use disorder and medications for opioid use disorder may be contributing to these challenges.[16] In other instances, providers or enrollees may have determined that treatment be discontinued.

Fewer enrollees who continued treatment with buprenorphine died compared to those who did not continue treatment

In total, 3 percent of enrollees who continued treatment with buprenorphine for at least 6 months died during the study period.[17] This includes all causes of death. By comparison, 11 percent of enrollees who did not continue treatment with buprenorphine died over the study period.[18] In total, 11,248 of the 143,383 enrollees who started treatment with buprenorphine died over the study period.

About 1 in 10
Medicare enrollees who
did not continue treatment
with buprenorphine **died** over
the study period.

The differences in death rates between enrollees who continued treatment and those who did not are consistent with research showing that treatment with buprenorphine is associated with reducing both overdose-related and overall mortality.[19]

Enrollees living in urban areas were less likely to continue treatment with buprenorphine than enrollees living in rural areas

In total, 40 percent of enrollees in urban areas who started buprenorphine continued treatment, compared to 47 percent of enrollees in rural areas.[20] See Exhibit 2.

Exhibit 2. Enrollees living in urban areas were less likely than those in rural areas to continue treatment with buprenorphine

Source: OIG analysis of Medicare data, 2024.

The lower percentage of enrollees continuing treatment in urban areas is of particular concern, as urban counties continue to have higher rates of overdose deaths than rural counties.[21]

The percentages of enrollees who continued treatment were similar for other key factors, including age, sex, and dual eligibility status. For example, 42 percent of enrollees under the age of 65 continued treatment with buprenorphine, while 40 percent of enrollees aged 65 and over continued treatment. See Appendix B for more information.

Just one-third of enrollees who started treatment with buprenorphine received at least one behavioral therapy service; those who did not receive any of these services were less likely to continue treatment

Behavioral therapy—such as individual and group therapy—can increase patient engagement, modify patient behavior, and address any co-occurring mental health disorders of people with opioid use disorder.[22] Therefore, these services are recommended—but not required—for patients receiving medication for opioid use disorder in office-based settings.[23]

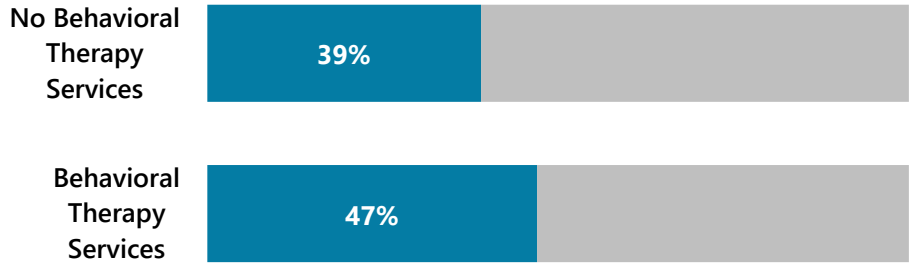
Yet, among the enrollees who started buprenorphine, about one-third (34 percent) received at least one behavioral therapy service over the study period.[24] The low proportion of enrollees receiving behavioral therapy services raises concern, as enrollees with opioid use disorder often have co-occurring mental health disorders.[25] It may also indicate that enrollees are having difficulty accessing behavioral health care services. A recent OIG study found that a lack of behavioral health providers impedes Medicare enrollees' access to care.[26]

When enrollees did receive behavioral therapy, they most commonly received individual psychotherapy. It was less common for enrollees to receive group psychotherapy or therapy as part of Medicare's bundled services for the treatment of

substance use disorder.[27] On average, enrollees who received individual psychotherapy received 13 sessions over the study period while those with group psychotherapy received 15 sessions.[28]

Enrollees who did not receive any behavioral therapy services were less likely to continue treatment than enrollees who received at least one service. A total of 39 percent of enrollees who did not receive any behavioral therapy services continued treatment with buprenorphine, compared to 47 percent of enrollees who received at least one behavioral therapy service.[29] See Exhibit 3.

Exhibit 3. A lower percentage of enrollees who did not receive any behavioral therapy services continued treatment with buprenorphine compared to enrollees who received at least one behavioral therapy service



Source: OIG analysis of Medicare data, 2024.

Few enrollees received services billed to Medicare under the payments aimed, in part, at helping enrollees stay in treatment

CMS has added new Medicare payments aimed, in part, at helping enrollees stay in treatment for opioid use disorder, as appropriate. Namely, in 2020, CMS added bundled provider payment codes to incentivize the provision of counseling and care coordination for patients with opioid use disorder in office settings.[30] In addition, in 2021, CMS introduced an add-on payment for emergency departments that allows them to be paid for helping connect enrollees to ongoing care when they initiate medication for opioid use disorder.[31] However, few Medicare enrollees who started treatment with buprenorphine received services billed to Medicare using these payment codes during the study period.

Less than 5 percent of enrollees who started treatment with buprenorphine received care under the bundled payment codes for office-based treatment during the study period. In total, 6,655 of the approximately 143,000 enrollees had at least one claim for these bundled payment codes over the study period. Under the bundled payments, enrollees can receive care coordination, individual psychotherapy, group psychotherapy, and counseling. These payments do not include the cost of the medication or medication management.

The relatively low percentage of enrollees receiving services under these payment codes may suggest that providers are unaware of them or that they may need to be re-evaluated. For example, these codes may not reflect the optimal number or types of services.

Cost-sharing may also be a factor, in that it may be a barrier for some enrollees receiving this care.[32] On average, enrollees in Medicare Fee-For-Service had approximately $66 a month of cost-sharing for these bundles. Although CMS has waived cost-sharing for a similar set of services when they are provided in opioid treatment programs, it does not have the statutory authority to waive coinsurance for the office-based treatment bundled payments.

Few enrollees received treatment under the payment to emergency departments for initiating medication for opioid use disorder and connecting patients to ongoing care. Just 355 of the approximately 143,000 enrollees who started buprenorphine had a claim from an emergency department for initiating medication for opioid use disorder and arranging for ongoing care outside of emergency departments. The payment covers costs associated with assessing the patient, referring the patient to ongoing care, follow-up, and arranging access to supportive services. It is intended to link enrollees to care—therefore improving outcomes.

Although this billing code was introduced fairly recently, its low utilization may indicate that providers are not aware of it.

RECOMMENDATIONS

Buprenorphine is an important tool in addressing the overdose crisis, which continues to claim tens of thousands of lives a year. When used to treat opioid use disorder, it can help lead to lasting recovery. Further, continuing treatment for opioid use disorder is associated with improved outcomes, including reduced risk of both overdose-related and overall mortality.

However, we found that less than half of Medicare enrollees who started buprenorphine continued treatment for at least 6 months and that fewer enrollees who continued treatment died compared to those who did not continue treatment. Further, enrollees who did not receive at least one behavioral therapy service were less likely to continue treatment. Finally, few enrollees received services billed to Medicare under payments aimed, in part, at helping enrollees stay in treatment.

These findings can be used by CMS, its Departmental partners, and other researchers to identify strategies to help enrollees continue with treatment, as appropriate.

In addition, we recommend that CMS:

Educate Medicare providers about Medicare services that help enrollees continue treatment for opioid use disorder

In addition to educating Medicare enrollees, CMS should add information to its provider educational materials emphasizing that Medicare covers treatment for opioid use disorder for as long as reasonable and necessary—i.e., that there are no limits on the amount of time an enrollee can receive treatment under Medicare. Adding this information is important, as continuing treatment with buprenorphine is associated with better health outcomes, including decreased risk of overdose death.

In addition, CMS should share the findings of this report and other data it deems appropriate with its Departmental partners—such as those on the Behavioral Health Coordinating Council and the Harm Reduction Interagency Workgroup—to help inform their efforts to educate providers and patients about continuing treatment for opioid use disorder.

Educate Medicare enrollees about Medicare services that help enrollees continue treatment for opioid use disorder

In recent years, CMS has educated Medicare enrollees and providers about the services that Medicare covers to treat opioid use disorder. CMS should add information to its educational materials for enrollees, emphasizing that Medicare

covers treatment for opioid use disorder for as long as reasonable and necessary—i.e., that there are no limits on the amount of time an enrollee can receive treatment under Medicare. Adding this information is important, as continuing treatment with buprenorphine is associated with better health outcomes, including decreased risk of overdose death.

Assess and make changes, as appropriate, to the bundled payment codes for office-based treatment to ensure they meet provider and enrollee needs

CMS should conduct an assessment of whether its bundled payment codes for office-based substance use disorder treatment services are meeting the needs of providers and enrollees.[33] Under the bundled payments, enrollees can receive care coordination, individual psychotherapy, group psychotherapy, and counseling. However, less than 5 percent of enrollees received care billed under these bundled payments.

CMS should explore whether these codes are meeting the needs of Medicare enrollees and determine whether any modifications to these codes should be made. These steps should be in addition to CMS's routine assessments of the reimbursement rates of payment codes. As a part of this effort, CMS should determine whether additional bundled payment codes are needed—such as codes focused on the management of medications for opioid use disorder. CMS should also consider seeking statutory authority to set Medicare Fee-For-Service coinsurance at $0 for opioid use disorder treatment in office-based settings.

Taking these steps may help encourage providers to treat more enrollees with substance use disorders.

Inform providers of emergency department services about the Medicare payment for the initiation of medication for the treatment of opioid use disorder and connecting patients to ongoing care

Emergency departments are often an entry point into the healthcare system for patients with opioid use disorder. Connecting patients to care after initiating medication in emergency departments may help to improve patient health outcomes.[34] As such, in 2021 CMS created a new procedure code that allows providers to bill Medicare for the initiation of medication for the treatment of opioid use disorder in emergency department settings and connecting patients to ongoing care. Yet, OIG found that this procedure code is rarely billed to Medicare.

CMS should conduct outreach to providers of emergency department services to ensure they are aware of this procedure code, what it covers, and when they can bill

Medicare using this procedure code.[35] As part of this effort, CMS should consider incorporating some of the rationale for the creation of this payment code from the Contract Year 2021 Physician Fee Schedule Final Rule.[36]

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all four of our recommendations. CMS stated that it is committed to ensuring that Medicare enrollees who have an opioid use disorder have access to appropriate treatment, including medications for opioid use disorder.

CMS concurred with our recommendation to educate Medicare providers about Medicare services that help enrollees continue treatment for opioid use disorder. CMS reiterated that, as required by statute, Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). CMS noted that it references this standard in its Physician Fee Schedule 2025 education related to opioid treatment programs, and that it will further clarify that these services are covered for as long as they are reasonable and necessary.

CMS concurred with our recommendation to educate Medicare enrollees about Medicare services that help enrollees continue treatment for opioid use disorder. CMS stated that it will add information to its enrollee education materials clarifying that Medicare covers treatment for opioid use disorder for as long as reasonable and necessary. Further, CMS stated that it will share findings from this report, future data, educational materials, and outreach opportunities with partner agencies to encourage both Department and Agency-wide collaboration and partnership.

CMS concurred with our recommendation to assess and make changes, as appropriate, to the bundled payment codes for office-based treatment to ensure they meet provider and enrollee needs. CMS stated that it will do so as part of its annual rulemaking process. CMS also noted that certain healthcare providers, such as general practitioners, may not be able to provide all of the services comprised in the bundled payments for office-based treatment of substance use disorders, and may therefore choose to bill for individual services instead. Further, CMS stated that, when developing proposals for the Fiscal Year 2026 President's Budget, it will consider seeking statutory authority to set Medicare Fee-For-Service coinsurance at $0 for the treatment of opioid use disorder in office-based settings.

Lastly, CMS concurred with our recommendation to inform providers of emergency department services about the Medicare payment for the initiation of medication for the treatment of opioid use disorder and connecting patients to ongoing care. CMS stated that will further educate healthcare providers regarding this procedure code.

For the full text of CMS's response, see Appendix C.

METHODOLOGY

This study was based primarily on an analysis of Medicare Part D Prescription Drug Event (PDE) records, Medicare Part B claims from the National Claims History File, and Medicare Advantage encounters from Part C Encounter data.

To obtain descriptive information about the medications, enrollees, and providers, we also used data from the First Databank; the National Plan & Provider Enumeration System (NPPES); the Provider Enrollment, Chain, and Ownership System (PECOS); the Master Beneficiary Summary File; and the Medicare Enrollment Database.

The study period included January 1, 2021, to June 30, 2023.

Identifying Enrollees Who Started Buprenorphine and Continued Treatment

We first identified Medicare enrollees who received buprenorphine indicated for the treatment of opioid use disorder in office-based settings.[37] OIG has previously found that the vast majority of enrollees who receive buprenorphine to treat their opioid use disorder receive it in office-based settings.[38] Medications received in office-based settings include medications dispensed at pharmacies or administered in a provider's office. Opioid treatment programs are not considered to be office-based settings.

We then identified the enrollees who started buprenorphine in 2021 or 2022. We considered an enrollee to have "started" buprenorphine if they had no prior prescriptions for buprenorphine or if more than 30 days had passed since any prior prescriptions for buprenorphine had ended.[39] To identify prior prescriptions, we also included data from the last 6 months of 2020.

Next, we identified the enrollees who continued treatment with buprenorphine for at least 6 months in the study period. We considered enrollees to have continued treatment if they received at least 180 days of buprenorphine—without significant gaps—after they started treatment. We considered a significant gap to be more than 7 days. These criteria are aligned with the Merit-Based Incentive Payment System (MIPS) quality measure related to continuity of care for treatment of opioid use disorder.[40]

We then determined whether any of the remaining enrollees continued their treatment at opioid treatment programs. To identify these enrollees, we took into account any claims or encounters they had from opioid treatment programs for any medication for opioid use disorder (i.e., buprenorphine, methadone, or naltrexone). We also determined, when taking into account any naltrexone they received in office-based settings, whether any of these enrollees continued their treatment.[41]

We considered the rest of the enrollees to have not continued treatment. We then determined the proportion of enrollees who received buprenorphine by provider type using data from NPPES and PECOS.

Enrollee Characteristics

Next, we used the Master Beneficiary Summary File to identify which enrollees had a death date during the study period. We calculated the percentage of enrollees who continued treatment with buprenorphine and died and the percentage of enrollees who did not continue treatment and died.

We then used the Medicare Enrollment Database to identify enrollees' demographic characteristics and geographic locations. Using these data, we determined the proportion of enrollees who continued treatment with buprenorphine by age group; disability status; dual-eligibility status; low-income subsidy status; Medicare enrollment type (i.e., fee-for-service or Medicare Advantage); sex; and urban and rural location.[42] We then determined differences in these characteristics between enrollees who continued treatment for at least 6 months and those who did not.

Behavioral Therapy Services

We then determined the extent to which the enrollees who started treatment in 2021 or 2022 received at least one behavioral therapy service through Medicare during the study period.[43] Using the Medicare Part B claims and Part C encounter data, we determined if enrollees had received individual psychotherapy or group psychotherapy as standalone services or behavioral therapy services covered by bundled payments for substance use disorder in office-based settings. We then counted the unique number of enrollees who received each of these categories of behavioral therapy and the average number of services or months of services received. In addition, we calculated the percentage of enrollees who continued treatment with buprenorphine who received behavioral therapy and the percentage of enrollees who did not continue treatment who received behavioral therapy.

Billing for Opioid Use Disorder Services

Lastly, we determined how many of the enrollees who started buprenorphine in 2021 or 2022 for whom providers billed either the office-based substance use disorder bundled payments or for the initiation of medication for the treatment of opioid use disorder in the emergency department during the study period.[44]

Limitations

This analysis is based on Medicare data. We did not review medical records or independently verify the accuracy of the Medicare data for this study. The analysis does not include data on buprenorphine or other medications for opioid use disorder that enrollees may have received from sources other than Medicare. The analysis of

enrollee death data does not take into account the cause of death; enrollee deaths may be due to factors not associated with opioid use disorder.

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

Most enrollees received buprenorphine for opioid use disorder from general care providers*

Provider Type	Enrollees Who Continued Treatment with Buprenorphine	Percent**	Enrollees Who Did Not Continue Treatment	Percent**
General*	43,985	74%	49,870	61%
Addiction	19,174	32%	19,112	24%
Behavioral Health	14,495	24%	13,672	17%
Emergency	7,801	13%	8,149	10%
Pain	8,179	14%	13,486	17%
Other	4,253	7%	3,476	4%

Source: OIG analysis of Medicare data, 2024.
Note: This analysis is based on enrollees who started treatment with buprenorphine in 2021 and 2022.
* General care providers include general practitioners, internists, and family medicine providers, among others.
** Percentages in these tables sum to greater than 100 due to enrollees receiving buprenorphine from multiple types of providers.

APPENDIX B

Percentage of Enrollees Who Continued Treatment with Buprenorphine by Key Characteristic

Enrollee Group		Total Number of Enrollees	Percentage Who Continued Treatment with Buprenorphine
Age	<65	81,849	42%
	65+	61,534	40%
Disability Status	Yes	91,855	42%
	No	51,528	40%
Dual-Eligible	Yes	92,644	41%
	No	50,739	42%
Low-Income Subsidy	Yes	99,742	41%
	No	43,641	41%
Medicare Advantage	Yes	99,746	42%
	No	43,637	40%
Sex	Female	69,603	41%
	Male	73,780	42%

Source: OIG analysis of Medicare data, 2024.
Note: This analysis is based on enrollees who started treatment with buprenorphine in 2021 and 2022.

APPENDIX C

Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: January 10, 2025

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Data Brief: *Not All Medicare Enrollees Are Continuing Treatment for Opioid Use Disorder*, OEI-02-23-00360

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 Medicare enrollees who have an opioid use disorder (OUD) have access to appropriate treatment, including medications for opioid use disorder (MOUD). Ensuring access to these benefits, addressing equity and removing barriers to continuing treatment is an important part of addressing the nation's overdose crisis, and CMS has been actively engaged in the work necessary to meet these goals.

CMS continues to work within its authority to improve access to Substance Use Disorder (SUD) treatment, including OUD treatment, which includes the ability of enrollees to engage with medically necessary treatment as long as they benefit and choose to continue. To accomplish these goals, CMS has been implementing the CMS Behavioral Health Strategy, which advances priorities in the Department of Health and Human Services (HHS) Roadmap for Behavioral Health Integration, the HHS Overdose Prevention Strategy, and the HHS Pain Management Task Force Report.[1]

CMS's Behavioral Health Strategy focuses on three key areas: SUD prevention, treatment and recovery services, ensuring effective pain treatment and management, and improving mental health care and services. This work includes focusing on effectively addressing disparities in access to mental health, SUD, and pain care. These areas are aligned with CMS's overall strategic focus on four health outcomes-based domains: coverage and access to care, quality of care, equity and engagement, and data and analytics. CMS' vision is for all beneficiaries to receive access to person-centered, timely, and affordable care.[2] Outlined in CMS's strategic

[1] https://www.cms.gov/cms-behavioral-health-strategy#:~:text=The%20CMS%20Behavioral%20Health%20Strategy,mental%20health%20care%20and%20services.
[2] https://www.cms.gov/cms-behavioral-health-strategy#:~:text=The%20CMS%20Behavioral%20Health%20Strategy,mental%20health%20care%20and%20services.

plan[3] are 12 cross-cutting initiatives, including a behavioral health initiative that aims to increase and enhance access to equitable and high-quality behavioral health services and improve outcomes for people with behavioral health care needs.[4]

In Medicare Advantage (MA), CMS has worked to improve access to SUD treatment, including office-based treatment, by strengthening network adequacy requirements. Regulations at 42 CFR 422.112 require that MA coordinated care plans maintain a network of appropriate healthcare providers that is sufficient to provide adequate access to covered services, including any covered SUD treatment, to meet the needs of the population served. In addition, regulations at 42 CFR 422.116 establish network standards for MA coordinated care plans. This includes specific time and distance and minimum number requirements for healthcare provider and facility types, including those that provide SUD treatment. CMS evaluates MA healthcare provider networks against these regulatory standards at the time of application and at least every three years.

Access to behavioral healthcare providers is an important component of SUD treatment. Recently, CMS added clinical psychologists and licensed social workers as specialty types for which CMS sets network standards under regulations at 42 CFR 422.116 and made these healthcare provider types eligible for a 10-percentage point telehealth credit. CMS also amended general access standards for MA to explicitly include behavioral health services and codified standards for appointment wait times for behavioral health services, among other related policies, and finalized a rule that sets the maximum appointment wait time for routine behavioral health care at 30 business days in MA.[5]

For CY 2025, CMS finalized regulations to add a facility-specialty type under these network adequacy standards called "Outpatient Behavioral Health." This facility specialty type is also eligible for the 10-percentage point telehealth credit. This new facility-specialty type includes a range of behavioral healthcare providers under one category, including specialists such as Opioid Treatment Programs (OTPs), community mental health centers, addiction medicine physicians, and other healthcare providers who furnish addiction medicine and behavioral health counseling and/or therapy services in Traditional Medicare. CMS includes these healthcare providers as part of its network adequacy evaluation. In addition, for this particular facility specialty-type, MA plans must independently verify that the healthcare provider they are adding to their network has furnished or will furnish such services to at least 20 patients within a 12-month period, using reliable information about services furnished by the healthcare provider, such as the MA plan's claims data, prescription drug claims data, electronic health records or similar data. Additionally, in the Contract Year 2023 Policy and Technical Changes to the Medicare Advantage Program final rule, CMS clarified that emergency behavioral health services must not be subject to prior authorization.[6] Finally, CMS encourages MA plans to include information in their directories regarding a healthcare provider's expertise in treating patients and clients with OUDs (e.g., prescribers of medications for OUDs, addiction specialists, and OTPs).

[3] https://www.cms.gov/about-cms/what-we-do/cms-strategic-plan
[4] https://www.cms.gov/files/document/cms-cross-cutting-initiatives-infographic.pdf
[5] 88 FR 22174; 42 CFR 422.112(a)(6)(i)
[6] 88 FR 22171

CMS has engaged in annual rulemaking to continue to remove barriers to healthcare providers in billing Medicare for MOUD treatment. Examples of policy changes that CMS implemented to increase access include introducing an office-based bundled payment code for SUD treatment in the CY 2020 PFS final rule[7] that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling. Healthcare providers who cannot furnish all services in the bundle, such as general practitioners, are still able provide MOUD and bill for individual services. Payment rates are also re-analyzed annually to ensure they accurately reflect services provided. In the CY 2021 PFS final rule,[8] CMS also created an add-on payment for initiation of MOUD treatment in the emergency department, including referral to ongoing care. In the CY 2023 PFS final rule[9], CMS added an exception to the direct supervision requirement under the "incident to" regulation at 42 CFR 410.26. This change allows behavioral health and SUD services to be provided under the general, rather than direct, supervision of a physician or non-physician practitioner (NPP). CMS believes that these changes facilitate access and extend the reach of behavioral health services. Beginning in 2025, Medicare will pay for safety planning interventions for beneficiaries in crisis, including people with suicidal ideation or at risk of suicide or overdose, and for post-discharge telephonic follow-up contacts intervention, after discharge from the emergency department for a crisis encounter.[10]

CMS has also continued outreach to educate both beneficiaries and healthcare providers about covered treatments for SUDs. These efforts include updating webpages and messaging to healthcare providers around changes to OUD coverage in 2024 and 2025. In addition, CMS works to ensure that Medicare beneficiaries are aware of these treatment options and annually publishes information about coverage of office-based treatment and other services in the Medicare & You Handbook,[11] which is available in print, and electronically.

Because addressing the needs of underserved populations is also an important part of increasing access, CMS has established a Framework for Health Equity.[12] This publication provides a framework for measurable, actionable goals to achieve health equity. CMS is following the process established in the Framework to help address access issues. CMS efforts actively inform and support the HHS department-wide Behavioral Health Coordinating Council, the Harm Reduction Interagency Workgroup, and align with the priorities outlined in the CMS Framework for Health Equity. This work includes examining disparities experienced by underserved communities and understanding the drivers of these disparities to tailor outreach and education to support individuals in accessing appropriate and needed behavioral health services. Specifically, the CMS Mapping Medicare Disparities Tool supports this work by providing a user-friendly tool to allows users to explore and better understand disparities, including within behavioral health and access to substance abuse treatment. It contains a behavioral health domain with quality measures related to behavioral health (e.g., drug use disorder) and allows users to see differences, trends, and disparities in cost, hospitalization, and available psychotherapy healthcare providers at a county, state, and national level. It also includes a social determinants

[7] 88 FR 62673-62677
[8] 85 FR 84643-84644
[9] 87 FR 69545-69548
[10] 89 FR 97710
[11] https://www.medicare.gov/medicare-and-you
[12] https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

of health view that allows health care organizations and decision-makers to understand individuals' health-related social needs at the local level to tailor efforts that may help overcome and eliminate barriers community members may experience in accessing behavioral health, substance use, and opioid use disorder treatment, services, and supports.

Moreover, through the CMS Coverage to Care (C2C) initiative, CMS provides educational materials and conducts outreach with trusted partners to share information about navigating health coverage. This includes the C2C Roadmap to Behavioral Health which helps individuals understand how to use their health coverage for behavioral health services including substance use and opioid use disorder assistance. This resource and others help CMS beneficiaries navigate their coverage to obtain preventive, primary, and behavioral health care, which has been translated and available in 9 commonly spoken languages including Arabic, Chinese, Haitian Creole, Korean, Russian, Spanish, Ukrainian, Vietnamese, and English. In addition, CMS's Office of Healthcare Experience and Interoperability has released several illustrations of the challenges faced by people in recovery informed by human-centered design processes.[13]

As stated above, CMS's strategic plan includes a behavioral health initiative that aims to increase and enhance access to equitable and high-quality behavioral health services and improve outcomes for people with behavioral health care needs.[14] CMS understands that access to healthcare providers who are willing to provide behavioral health care to beneficiaries who want care and services, including those furnished on an ongoing basis, is essential to combatting the overdose crisis. During the OIG's audit period, through calendar year 2022, office-based healthcare providers were required by federal law to obtain a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe buprenorphine. The Consolidated Appropriations Act, 2023 (P.L. 117-328) removed that requirement, along with other restrictions, such as limits on the number of patients a healthcare provider could treat with buprenorphine for OUD in their practice. As of December 29, 2022, all practitioners who have a current DEA registration that includes Schedule III authority were permitted to prescribe buprenorphine for OUD, subject to state law. These changes decrease barriers to access and increase the number of healthcare providers who may be available to treat Medicare and Medicaid enrollees.

The nation's overdose crisis is a top priority for CMS, and the Agency remains committed to examination of its payment and coverage policies to ensure healthcare providers can execute best practices and provide prompt care to people living with SUDs and other behavioral health needs and make those available when Medicare beneficiaries want and need them.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should educate Medicare healthcare providers about Medicare services that help enrollees continue treatment for opioid use disorder.

[13] https://www.cms.gov/priorities/key-initiatives/burden-reduction/stakeholder-engagement
[14] https://www.cms.gov/files/document/cms-cross-cutting-initiatives-infographic.pdf

CMS Response
CMS concurs with this recommendation. As required by statute, Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). CMS already references the reasonable and necessary standard as part of our Physician Fee Schedule 2025 education related to OTPs.[15] CMS will further clarify that these services are covered for as long as they are reasonable and necessary.

OIG Recommendation
CMS should educate Medicare enrollees about Medicare services that help enrollees continue treatment for opioid use disorder.

CMS Response
CMS concurs with this recommendation. CMS will add information to our educational materials for enrollees clarifying that Medicare covers treatment for opioid use disorder for as long as reasonable and necessary. Regarding outreach to the groups of enrollees OIG identified as less likely to continue treatment, CMS is already undertaking efforts to reduce barriers to MOUD treatment in Medicare, both through focus on equity in underserved communities and through payment policy changes and will remain focused on these priorities. CMS will also share the findings of this report and future data, outreach opportunities, and educational materials with partner agencies to encourage Department and Agency-wide collaboration and partnership.

OIG Recommendation
CMS should assess and make changes, as appropriate, to the new bundled payment codes for office-based treatment to ensure they meet healthcare provider and enrollee needs.

CMS Response
CMS concurs with this recommendation. CMS engages in annual rulemaking to continue to remove barriers to healthcare providers in billing Medicare for MOUD treatment, and as part of this process, will assess whether the bundled payment codes for office-based SUD treatment services are meeting the needs of healthcare providers and enrollees. It is important to consider that certain healthcare providers, such as general practitioners, may not have the ability to provide all services comprised in the bundle, and may therefore choose to bill for individual services rather than using the bundled payment. CMS is already undertaking efforts to reduce barriers to MOUD treatment in Medicare, both through focus on equity in underserved communities and through payment policy changes and will remain focused on these priorities.

Regarding OIG's suggestion that CMS consider seeking statutory authority to set Medicare Fee-For-Service coinsurance at $0 for opioid use disorder treatment in office-based settings, this policy change was not included in the FY 2025 President's Budget. In the absence of authority under current law, CMS will consider this recommendation when developing proposals for the FY 2026 President's Budget.

[15] https://www.cms.gov/medicare/payment/opioid-treatment-program/billing-payment

OIG Recommendation

CMS should inform healthcare providers of emergency department services about the new Medicare payment for the initiation of MOUD treatment and connecting patients to ongoing care.

CMS Response

CMS concurs with this recommendation and will further educate healthcare providers regarding the new procedure code that allows healthcare providers to bill Medicare for the initiation of MOUD treatment in emergency department settings and connecting patients to ongoing care.

CMS thanks OIG for its efforts on this issue and looks forward to working with OIG on this and other issues that impact behavioral health in the future.

ENDNOTES

[1] NCHS, National Vital Statistics System, *Provisional Drug Overdose Death Counts* (Aug. 2024), Jan. 2025. Estimates for 2023 and 2024 are based on provisional data. Estimates for 2015-2022 are based on final data. Accessed at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm on Aug. 27, 2024.

[2] A total of 1,147,768 people enrolled in Medicare had an opioid use disorder diagnosis in 2022. *The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern* (OEI-02-23-00250) Dec. 11, 2023.

[3] *The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern* (OEI-02-23-00250) Dec. 11, 2023.

[4] Wei-Hsuan Lo-Ciganic, Walid F Gellad, Adam J. Gordon, et al., "Association Between Trajectories of Buprenorphine Treatment and Emergency Department and In-Patient Utilization," *Addiction*, May 2016. Accessed at https://pubmed.ncbi.nlm.nih.gov/26662858/ on Nov. 20, 2024. Also see Recovery Research Institute, *How Important is Suboxone Medication Adherence?* Accessed at https://www.recoveryanswers.org/research-post/links-between-emergency-department-visits-inpatient-treatment-buprenorphine-suboxone/ on Nov. 20, 2024.

[5] SAMHSA, *Treatment Improvement Protocol 63: Medications for Opioid Use Disorder*, 2021. No maximum treatment duration has been established for medications to treat opioid use disorder. Accessed at https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf on Aug. 26, 2024. See CMS, *Quality ID #468: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)* (2024). Accessed at https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_468_MIPSCQM.pdf on Sept. 25, 2024.

[6] The Drug Addiction Treatment Act of 2000 was enacted under Title XXXV of the Children's Health Act of 2000, P.L. No. 106-310. Before late December 2022, with a waiver, practitioners could treat up to 100 patients with buprenorphine in the first year, although most qualified practitioners were limited to treating up to 30. In subsequent years, a practitioner could treat up to 275 patients. See 42 CFR § 8.610 (prior to 89 F.R. 7528 (Feb. 2, 2024)). In December 2022, Congress repealed the need for a waiver. See 21 U.S.C. § 823(g)(2)(B)(iii)(I)-(II), repealed by Consolidated Appropriations Act, 2023, P.L. No. 117-328 § 1262 (Dec. 29, 2022).

[7] For more information about controlled substance scheduling, see DEA, *Drug Scheduling*. Accessed at https://www.dea.gov/drug-information/drug-scheduling on Nov. 1, 2023. Also see P.L. No. 117-328 § 1262. In addition, all providers who apply for or renew their Drug Enforcement Administration (DEA) registration to prescribe controlled substances must take a one-time training on treating and managing patients with substance use disorders. See P.L. No. 117-328 § 1263.

[8] 21 U.S.C. § 812(b)(3).

[9] See 84 F.R. 62568, 62676 (Nov. 15, 2019). In 2021, CMS expanded the office-based bundled payment codes for the treatment of opioid use disorder to include treatment for all substance use disorders. See 85 F.R. 84472, 84643 (Dec. 28, 2020). For information about care in emergency department settings, see 85 F.R. 84643. CMS also began covering services provided at opioid treatment programs in 2020. Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act) (Pub. L. 115-271, enacted October 24, 2018) established a new benefit for opioid use disorder treatment services furnished by an opioid treatment program beginning on or after January 1, 2020. See 84 F.R. 62649.

[10] *The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern* (OEI-02-23-00250) Dec. 11, 2023. *Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries* (OEI-02-22-00390) Sept. 13, 2022. Also see *Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder* (OEI-02-20-00390) Dec. 15, 2021.

[11] *The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder in Medicare Part D Continues to Appear Low: 2022* (OEI-02-24-00130) Nov. 22, 2023. *The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder Appears to Be Low in Medicare Part D* (OEI-02-22-00160) May 16, 2023. Other OIG reports related to buprenorphine include *Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder* (OEI-BL-23-00160) Sept. 18, 2024; and *Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder* (OEI-12-17-00240) Jan. 29, 2020.

[12] See CMS, *Quality ID #468: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)* (2024). Accessed at https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_468_MIPSCQM.pdf on Sept. 25, 2024.

[13] We based the analyses in this report on buprenorphine indicated for the treatment of opioid use disorder that Medicare enrollees received in office-based settings through Medicare Parts B and D and Medicare Advantage. Among the enrollees who started buprenorphine, a total of 143,043 enrollees received buprenorphine that was billed to Part D and a total of 2,154 enrollees received buprenorphine that was administered in a providers' office and billed to Medicare Advantage or Part B.

[14] A small number of enrollees switched to naltrexone from office-based settings. Naltrexone is the only medication for opioid use disorder, other than buprenorphine, that can be used in office-based settings.

[15] Practitioners can also dispense up to a three-day supply of methadone when it is used for the initiation of treatment (or detoxification) while arrangements are being made for referral for treatment. This also applies to buprenorphine. See 21 CFR § 1306.07(b).

[16] National Institute of Drug Abuse, *Stigma and Discrimination*, June 2022. Accessed at https://nida.nih.gov/research-topics/stigma-discrimination on Nov. 7, 2024.

[17] The study period included January 1, 2021, through June 30, 2023. Due to data limitations, we did not analyze enrollees' cause of death.

[18] This includes enrollees who did not continue treatment either with buprenorphine, in opioid treatment programs, or with naltrexone in office-based settings.

[19] Deborah Dowell, Samantha Brown, Shiromani Gyawali, et al., "Treatment for Opioid Use Disorder: Population Estimates—United States, 2022," *Morbidity and Mortality Weekly Report* , Vol. 73, No. 25, June 2024, pp. 567–574. Accessed at http://dx.doi.org/10.15585/mmwr.mm7325a1 on Aug. 14, 2024. Also see Luis Sordo, Gregorio Barrio, Maria J. Bravo, et al., "Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies," *British Medical Journal*, Vol. 357, No. 8103, Apr. 2017, j1550. Accessed at https://www.bmj.com/content/bmj/357/bmj.j1550.full.pdf on Sept. 17, 2024. Also see Thomas Santo, Jr., M.P.H.; Brodie Clark, B.Psych.; Matt Hickman, Ph.D.; et al., "Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis," *JAMA Psychiatry*, Vol. 78, No. 9, June 2021, pp. 979–993. Accessed at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2780655 on Sept. 17, 2024.

[20] Over the study period, 116,341 enrollees lived in urban areas and 27,042 enrollees lived in rural areas.

[21] Merianne Rose Spencer, M.P.H.; Matthew F. Garnett, M.P.H.; and Arialdi M. Miniño, M.P.H., *Urban–Rural Differences in Drug Overdose Death Rates, 2020* (NCHS Data Brief, No. 440), Hyattsville, MD: National Center for Health Statistics, July 2022. DOI: https://dx.doi.org/10.15620/cdc:118601.

[22] Office of the Assistant Secretary for Planning and Evaluation (ASPE), *Psychosocial Supports in Medication-Assisted Treatment: Recent Evidence and Current Practice* (Appendix B), July 2019. Accessed at https://aspe.hhs.gov/sites/default/files/private/pdf/262031/MATPsychLR.pdf on Feb. 8, 2024.

[23] SAMHSA, *Treatment Improvement Protocol 63: Medications for Opioid Use Disorder*, 2021.

[24] Each of these enrollees received individual psychotherapy or group psychotherapy as standalone services or as a part of the bundled payments for substance use disorder in office-based settings. For the purposes of our analysis, we did not include behavioral therapy services received at opioid treatment programs. For more information, see the Methodology.

[25] CMS found that about 56 percent of beneficiaries in Medicare Fee-For-Service with an opioid use disorder also had anxiety and about 52 percent had depressive disorders. See CMS, *Medicare Fee-For-Service Beneficiaries with Opioid Use Disorder in 2018: Disparities in Prevalence by Beneficiary Characteristics*, Dec. 2020. Accessed at https://www.cms.gov/files/document/oud-disparities-prevalence-2018-medicare-ffs-dh-002.pdf on July 5, 2024.

[26] *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050) Mar. 29, 2024.

[27] Specifically, 89 percent of enrollees received individual psychotherapy, 16 percent received group psychotherapy, and 14 percent received psychotherapy through the office-based substance use disorder bundled payments.

[28] In total, 42,875 enrollees received individual psychotherapy and 7,733 enrollees received group psychotherapy. In addition, 6,646 received individual and/or group psychotherapy through the office-based substance use disorder bundled payments. On average, each of these enrollees received about 7 months of psychotherapy; however, we cannot determine if enrollees received individual, group, or both types of psychotherapy. Note that some enrollees received more than one category of psychotherapy.

[29] Among enrollees who did not receive behavioral therapy, 36,730 of 95,349 continued treatment with buprenorphine. Among enrollees who received behavioral therapy, 22,505 of 48,034 continued treatment with buprenorphine.

[30] The Healthcare Common Procedure Coding System (HCPCS) bundled payment codes for office-based substance use disorder treatment are G2086-G2088. When introduced in 2020, these bundled payments were specific to the treatment of opioid use disorder in office-based settings. See 84 F.R. at 62676. In 2021, CMS expanded these payment codes to include treatment for all substance use disorders. See 85 F.R. at 84643.

[31] G2213 is the HCPCS add-on code for the initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services. See 85 F.R. 84644.

[32] In a recent rule related to these bundle services, CMS acknowledged "the potential impact of coinsurance on patient health care decisions." See 84 F.R. at 62676.

[33] The office-based substance use disorder treatment codes are HCPCS codes G2086-G2088. When first introduced, these bundled payment codes were only for the treatment of opioid use disorder. However, in 2021 CMS expanded these codes to be for the treatment of all substance use disorders. See 84 F.R. at 62676 and 85 F.R. at 84643.

[34] SAMHSA, *Use of Medication-Assisted Treatment in Emergency Departments*, Jan. 2021. Accessed at https://store.samhsa.gov/sites/default/files/pep21-pl-guide-5.pdf on June 26, 2024.

[35] This procedure code is HCPCS add-on billing code G2213.

[36] 85 F.R. at 84643.

[37] We identified enrollees receiving office-based buprenorphine using PDE records and Medicare claims and encounter data with HCPCS codes J0570, J0571, J0572, J0573, J0574, J0575, Q9991, and Q9992. To identify PDE records for buprenorphine indicated for the treatment of opioid use disorder, we matched the data to the First Databank. Prescriptions for buprenorphine indicated for pain were not included in this study. We use the term "buprenorphine" to mean buprenorphine indicated for the treatment of opioid use disorder.

[38] *The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern* (OEI-02-23-00250) Dec. 11, 2023.

[39] We use the term "prescription" to refer to any PDE record, Part B claim, or Medicare Advantage encounter. To determine when any prior prescriptions had ended, we looked at the date the buprenorphine was dispensed or administered, and the number of days supplied. For buprenorphine administered in office-based settings, we assigned days supplied on the basis of the drug labels. We did not consider an enrollee to "start" buprenorphine if they had prescriptions for another medication for opioid use disorder—i.e., methadone or naltrexone—that ended within 30 days of the buprenorphine. When identifying prior prescriptions, we looked back at PDE records, Part B claims, and Medicare Advantage encounters for the 6 months prior to 2021.

[40] See CMS, *Quality ID #468: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)* (2024). Accessed at https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_468_MIPSCQM.pdf on Sept. 25, 2024.

[41] We considered these enrollees to have continued treatment at opioid treatment programs or with naltrexone in an office-based setting if a combination of their PDE records, claims, and encounters indicated that they have received at least 180 days of medication for opioid use disorder without any significant gaps in treatment.

[42] For Medicare enrollment type, we considered enrollees who were enrolled in a Medicare Advantage plan for at least 1 day over the study period to be enrolled in Medicare Advantage. We considered enrollees to have resided in an urban area if they had at least 1 day of residence in an urban area over the study period. We used the 2013 National Center for Health Statistics (NCHS) Urban-Rural classification scheme to define urban and rural areas. For more information, see CDC, *NCHS Urban-Rural Classification Scheme for Counties*, Sept. 2024. Accessed at https://www.cdc.gov/nchs/data-analysis-tools/urban-rural.html on Nov. 20, 2024.

[43] As this review is focused on treatment enrollees received in office-based settings, we did not include behavioral therapy services that enrollees may have received through opioid treatment programs or during inpatient stays.

[44] The office-based substance use disorder bundled payment codes are HCPCS G2086-G2088. The initiation of medication for the treatment of opioid use disorder in emergency department settings is billed as the HCPCS add-on code G2213.

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