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Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder

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Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder

Why OIG Did This Review

As the United States continues to struggle with the opioid crisis, access to medications for opioid use disorder (known as MOUD) is essential to address the high rates of opioid use disorder and overdose mortality. Medicare and Medicaid play important roles in providing access to MOUD. Nonetheless, recent OIG work found that many enrollees with opioid use disorder did not receive MOUD through these programs. CMS has taken several steps in recent years to increase MOUD access, but if providers are unable or unwilling to treat Medicare and Medicaid enrollees, these actions will have limited success in expanding access to treatment.

What OIG Found

- In 2022, hundreds of counties in high need of MOUD services **lacked office-based buprenorphine providers and opioid treatment programs** (i.e., MOUD providers).
- Even in counties where MOUD providers did practice, they often **did not treat any Medicare or Medicaid enrollees**.
- Factors that may influence MOUD providers' ability and willingness to treat Medicare and Medicaid enrollees include **Medicare Advantage prior authorization requirements, low Medicaid reimbursement rates, and inadequate public information** about MOUD provider locations.

See our companion product for interactive maps and more details from our report.

What OIG Recommends

OIG recommends that CMS:

1. Geographically target efforts to increase the number of MOUD providers that treat Medicare enrollees in high-need counties.
2. Geographically target efforts to increase the number of MOUD providers that treat Medicaid enrollees in high-need counties.
3. Work with States to assess whether their Medicaid reimbursement rates for treatment with MOUD are sufficient to recruit and retain enough MOUD providers.
4. Work with SAMHSA to develop and maintain a list of active office-based buprenorphine providers.

CMS stated that it supports the spirit of our recommendations and did not state whether it concurred with our recommendations. CMS described HHS-wide efforts to increase access to MOUD providers, both generally and for Medicare and Medicaid enrollees.

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BACKGROUND

OBJECTIVES

1. Determine the extent to which providers of medications for opioid use disorder (MOUD) were in areas of high need in 2022.
2. Determine the extent to which providers prescribed or administered MOUD to Medicare and Medicaid enrollees in 2022.
3. Identify factors that supported or impeded providers' ability and willingness to prescribe or administer MOUD to Medicare and Medicaid enrollees.

As the United States continues to struggle with the opioid crisis, access to medications that treat opioid use disorder (known as MOUD) is essential to address the high rates of opioid use disorder and overdose mortality.[1] Medicare and Medicaid play important roles in providing MOUD, but access concerns persist in both programs. For example, OIG previously found that more than three-quarters of Medicare enrollees and one-third of Medicaid enrollees with opioid use disorder did not receive MOUD through their respective programs.[2, 3]

In 2020, the Federal government implemented the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act by adding opioid treatment program coverage to Medicare and by requiring State Medicaid programs to cover all forms of MOUD.[4, 5, 6] However, if providers are unable or unwilling to treat Medicare and Medicaid enrollees, these actions will have limited success in expanding access to treatment.

Medications Used to Treat Opioid Use Disorder

Opioid use disorder is a problematic pattern of opioid use that leads to clinically significant impairment or distress.[7] It is a chronic disease that can be treated with certain medications proven to decrease the risk of overdose mortality and improve quality of life.[8] Experts recommend that patients also have access to mental health, counseling, and other supportive services that they may need to supplement treatment with medication. The two medications most commonly used to treat opioid use disorder are buprenorphine and methadone.[9]

Buprenorphine is a controlled substance that suppresses withdrawal symptoms and relieves cravings by blocking the effects of opioids. Patients can generally obtain buprenorphine through office-based buprenorphine providers (e.g., primary care practices) and opioid treatment programs.[10]

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.[11] Typically, patients must visit opioid treatment programs daily to take their methadone dose under supervision, though, over time, patients can receive up to 28 days of take-home doses.[12]

A third drug, naltrexone, is also approved for treatment of opioid use disorder but is less often prescribed because of poor adherence to it and the requirement of 7 to 14 days of opioid abstinence before initiation.[13] It is not a controlled substance and therefore can be prescribed or administered by any qualified health care provider.[14]

Office-Based Buprenorphine Providers

During 2022—the period of our review—SAMHSA oversaw the enrollment and certification of office-based providers through the Buprenorphine Waiver Program and stored buprenorphine waiver applicant information in the Buprenorphine Waiver Notification System (BWNS).[15] At that time, providers practicing in a broad spectrum of outpatient settings (e.g., primary care practices and community health centers) were required by Federal law to obtain a waiver through SAMHSA to (1) prescribe buprenorphine for a patient to receive at a pharmacy or (2) dispense buprenorphine to patients in a clinical setting.[16] (Opioid treatment programs were exempt from this requirement.) Waivered providers were also limited in the number of patients they could treat.[17] Nationwide, 137,744 office-based providers were authorized by SAMHSA to prescribe or administer buprenorphine at the end of 2022.

The Consolidated Appropriations Act, 2023, repealed the buprenorphine waiver requirement on December 29, 2022. All providers with a standard Drug Enforcement Agency (DEA) registration may now prescribe or administer buprenorphine for opioid use disorder (in accordance with State law).[18]

Opioid Treatment Programs

Opioid treatment programs provide services to treat patients diagnosed with opioid use disorder, including administering methadone on a daily basis (typically in person) and dispensing buprenorphine.[19] Under Federal law, opioid treatment programs must also provide adequate medical, counseling, vocational, educational, and other screening, assessment, and treatment service to meet patient needs.[20]

To administer or dispense MOUD, opioid treatment programs are required to obtain (1) certification from SAMHSA that the provider is qualified under the agency's Federal Guidelines for Opioid Treatment Programs, (2) accreditation from a SAMHSA-approved accreditation body, and (3) DEA registration.[21, 22, 23, 24] Nationwide, 1,995 opioid treatment programs were certified to dispense MOUD at the end of 2022.[25]

Medicare Coverage of MOUD

The Federal government expanded Medicare coverage, beginning January 1, 2020, to include opioid use disorder treatment services (including MOUD) furnished by opioid treatment programs and waived cost sharing (after the annual deductible) for these services.[26, 27, 28] Previously, Medicare did not cover MOUD provided by opioid treatment programs because they were not a recognized provider type in Medicare.[29]

Medicare Advantage plans (comprehensive managed care plans offered by private companies that contract with the Centers for Medicare & Medicaid Services (CMS)) are required to provide all Medicare-covered services, including opioid use disorder treatment. However, Medicare Advantage plans are permitted to apply utilization management controls such as prior authorization. Prior authorization requires that health care providers must first obtain approval from the patient's health plan before care is delivered.

Medicare beneficiaries may have prescription drug coverage for MOUD through standalone Medicare Part D plans (which solely offer prescription drug coverage) or through Medicare Advantage prescription drug plans (which cover prescription drugs as part of the comprehensive managed care benefit). Both types of plans are required to include MOUD on their formularies and are permitted to apply utilization management controls to MOUD coverage.[30] However, CMS reported that current plans generally do not apply prior authorization to MOUD prescriptions, with a few exceptions for certain forms of buprenorphine.

Medicaid Coverage of MOUD

The SUPPORT for Patients and Communities Act expanded Medicaid coverage requirements in late 2020 by generally requiring State Medicaid programs to cover all forms of MOUD.[31] Prior to this, many States voluntarily provided some level of MOUD coverage, but policies varied widely. Medicaid reimbursement rates to providers for opioid use disorder treatment are generally low relative to Medicare, though rates vary greatly across States.[32, 33] State Medicaid programs are permitted to apply utilization management controls, including prior authorization requirements, to their MOUD coverage.

Concerns About Access to MOUD

Individuals seeking treatment—including those enrolled in Medicare or Medicaid—often face challenges finding providers permitted to prescribe or dispense MOUD, as well as widespread stigma and discrimination that also affects access to care.[34, 35] Prior OIG work highlighted geographic disparities in access, with 40 percent of counties lacking any office-based buprenorphine providers in 2018.[36] Prior OIG work also found that more than three-quarters of the 1.1 million Medicare enrollees with opioid use disorder and one-third of the 1.5 million Medicaid enrollees with opioid

use disorder did not receive MOUD through their respective programs.[37, 38] Data also showed that the most common type of substance use disorder service that people enrolled in Medicaid received was provided in an emergency department—rather than MOUD prescribed by a regular care provider.[39]

Methodology

This mixed-methods review combined HHS and U.S. Census data sources to explore the distribution of office-based buprenorphine providers and opioid treatment programs (hereinafter collectively referred to as MOUD providers) nationally. We also identified counties that may have an insufficient number of MOUD providers to meet the treatment needs of Medicare and Medicaid enrollees.

Specifically, we examined the number and location of MOUD providers in 50 States and the District of Columbia and identified those that treated Medicare and Medicaid enrollees with buprenorphine or methadone during calendar year 2022.[40, 41] (We did not include naltrexone in our review because it has been found to be less effective when used to treat opioid use disorder and is less commonly used than buprenorphine and methadone.)[42, 43] We considered counties with a provider-to-population ratio below the 40th percentile to have disproportionately few MOUD providers.[44] We also identified counties with high need for MOUD services (as indicated by an age-adjusted drug overdose mortality rate above the 60th percentile) and counties that are socially vulnerable (as indicated by a Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index ranking above the 60th percentile).[45, 46, 47] Finally, to identify factors that affect MOUD providers' ability or willingness to treat Medicare and Medicaid enrollees, we interviewed or received written responses from subject matter experts at CMS, SAMHSA, and two MOUD provider professional associations.

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.

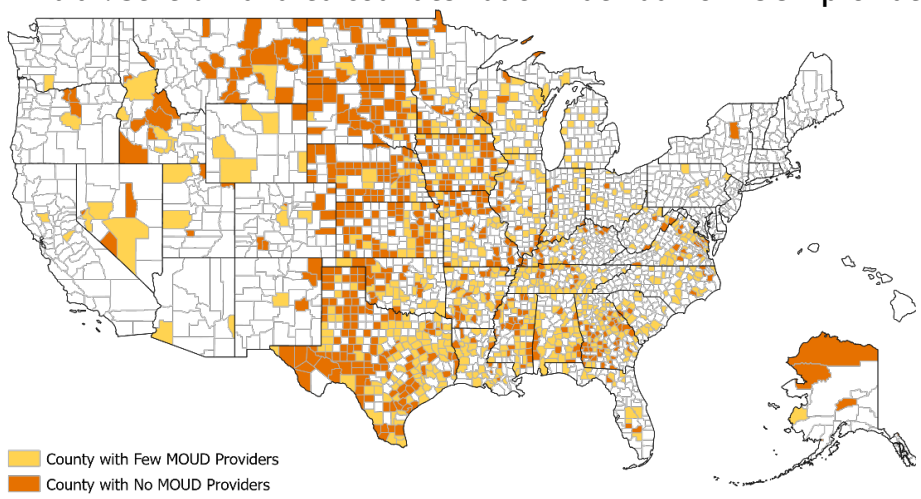
FINDINGS

Nineteen percent of U.S. counties did not have a single MOUD provider, including more than one hundred counties with a high need for MOUD services

In 2022, 597 of the 3,143 U.S. counties nationwide (19 percent) did not have any office-based buprenorphine providers or opioid treatment programs (i.e., MOUD providers). An additional 660 counties (21 percent) had disproportionately few MOUD providers in comparison to other counties of a similar population size (see Exhibit 1).[48] We note that during the time of our review, office-based providers were required to obtain a waiver from SAMHSA to prescribe buprenorphine; that requirement is no longer in place. However, other barriers to MOUD prescribing—including stigma and regulatory restrictions—remain.[49] The broader patterns we observed in 2022 therefore remain relevant to understanding gaps in access to MOUD.

See our companion product for interactive maps and more details from our report.

Exhibit 1: Several hundred counties nationwide had no MOUD providers

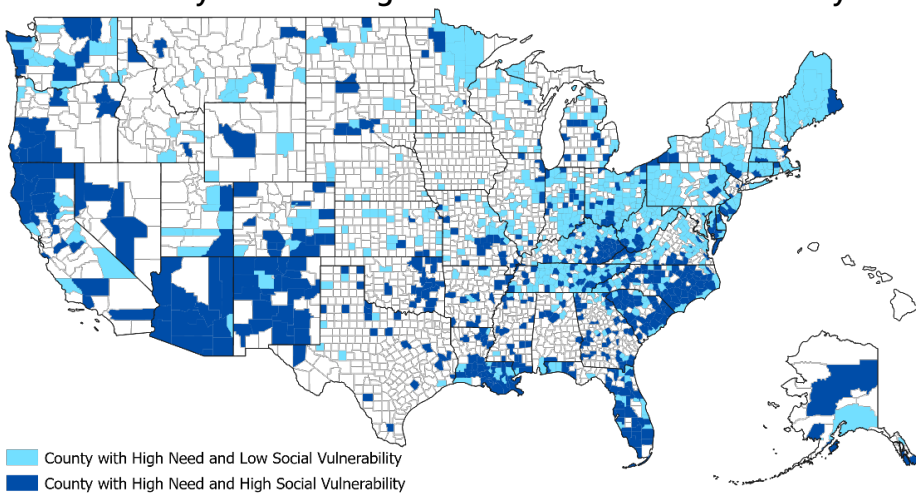


Source: OIG analysis of SAMHSA data.
Note: See our companion product for an interactive version of this map.

More than one-quarter of high-need counties had few or no MOUD providers

Nationwide, 1,258 counties were in high need of MOUD services as indicated by their disproportionately high drug overdose mortality rates (see Exhibit 2).[50] Of these high-need counties, 586 were also socially vulnerable and therefore at greater risk during public health emergencies, such as the opioid crisis, because of factors such as socioeconomic status and household demographic characteristics.[51]

Exhibit 2: Nearly half of all high-need counties were also socially vulnerable



Source: OIG analysis of CDC county-level mortality data and the CDC/ATSDR Social Vulnerability Index.
Note: See our companion product for an interactive version of this map.

Despite their high drug overdose mortality rates, 330 high-need counties (26 percent) had few or no MOUD providers. Consequently, many of these counties may be unable to meet opioid use disorder treatment needs for their area. Moreover, nearly half of these counties (144 counties) were also socially vulnerable and likely need additional State and Federal support to increase the number of MOUD providers available (see Exhibit 3).[52]

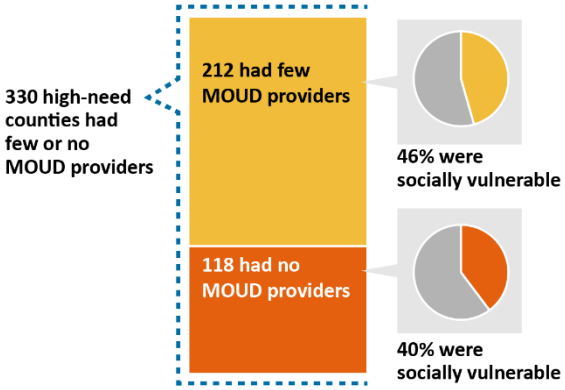
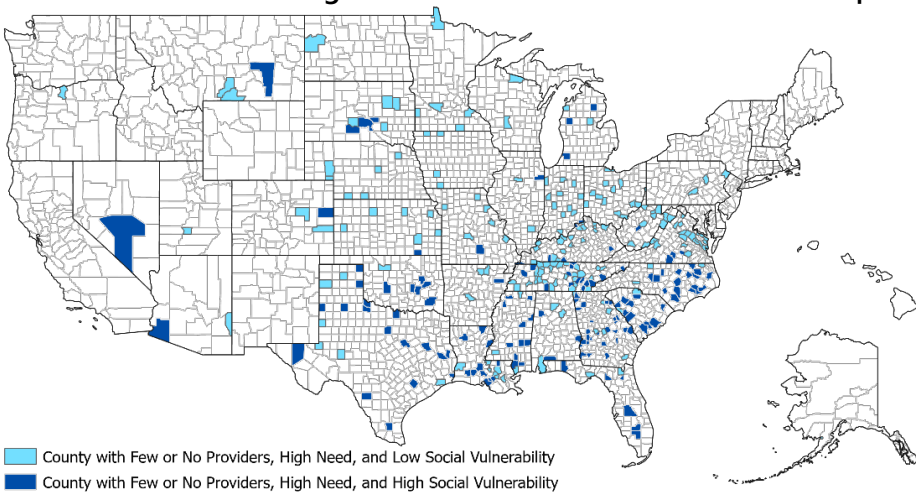


Exhibit 3: Hundreds of high-need counties had few or no MOUD providers



Source: OIG analysis of CDC and SAMHSA data.
Note: See our companion product for an interactive version of this map.

Nearly one-third of U.S. counties did not have a single MOUD provider that treated any Medicare or Medicaid enrollees

In 2022, 32 percent of all U.S. counties and 19 percent of all high-need counties (excluding Florida[53]) did not have any MOUD providers that treated either Medicare or Medicaid enrollees. There was substantial overlap; of counties with no MOUD providers treating Medicaid enrollees, 95 percent also had no providers treating Medicare enrollees.

One-quarter of high-need counties had few or no MOUD providers that treated Medicare enrollees

Nationwide, 1,147 counties (36 percent) did not have any MOUD providers that prescribed or administered buprenorphine or methadone to at least one Medicare enrollee in 2022. For 52 percent of these counties, there were no MOUD providers located in the county. The remaining counties did have MOUD providers, but none that treated any Medicare enrollees. Another 110 counties had disproportionately few providers that treated Medicare enrollees.[54]

Hundreds of these counties were also in high need of MOUD services and, therefore, may not be able to meet opioid use disorder treatment needs for Medicare enrollees. In total, 316 high-need counties (25 percent) had few or no MOUD providers serving Medicare enrollees. More than one-third of these counties (123 counties) were also socially vulnerable. (See Exhibit 4.)

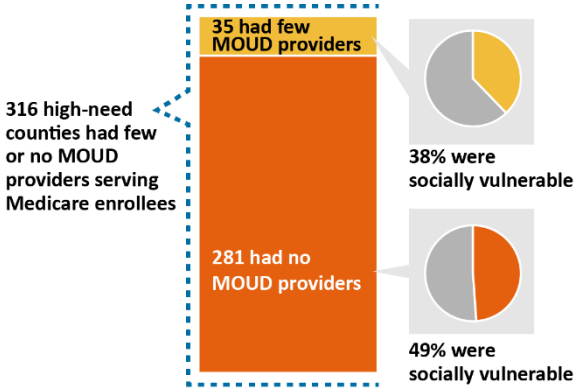
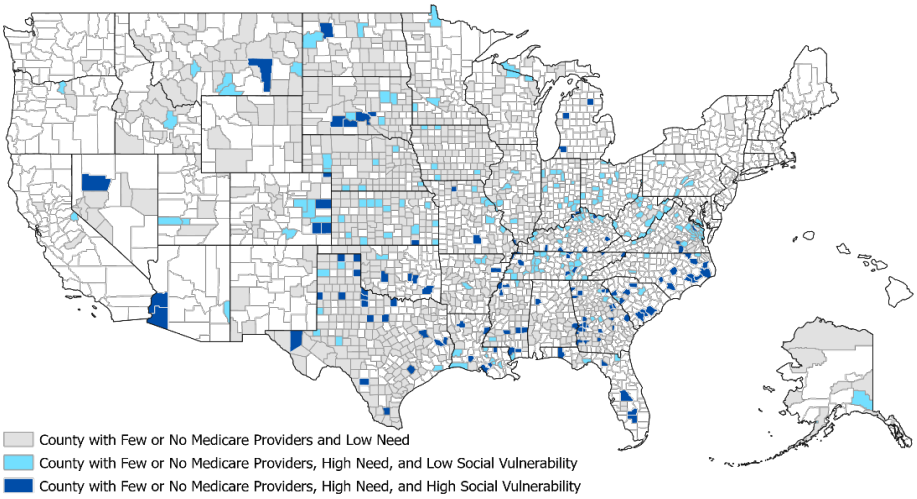


Exhibit 4: Many counties had few or no MOUD providers that treated Medicare enrollees



Source: OIG analysis of CDC, CMS, and SAMHSA data.
Note: See our companion product for an interactive version of this map.

Nearly one-quarter of high-need counties had few or no MOUD providers that treated Medicaid enrollees

Similar to the case with the Medicare program, 1,035 counties (34 percent) nationwide (excluding Florida) did not have any MOUD providers that prescribed or administered buprenorphine or methadone to at least one Medicaid enrollee in 2022. For 57 percent of those counties, there were no MOUD providers located in the county. The remaining counties did have MOUD providers, but none that treated any Medicaid enrollees. Another 195 counties had disproportionately few providers that treated Medicaid enrollees.[55]

As with Medicare, a concerning number of high-need counties may not be able to meet opioid use disorder treatment needs for Medicaid enrollees. In total, 297 high-need counties (24 percent) had few or no MOUD providers serving Medicaid enrollees. More than one-third of these counties (119 counties) were also socially vulnerable.

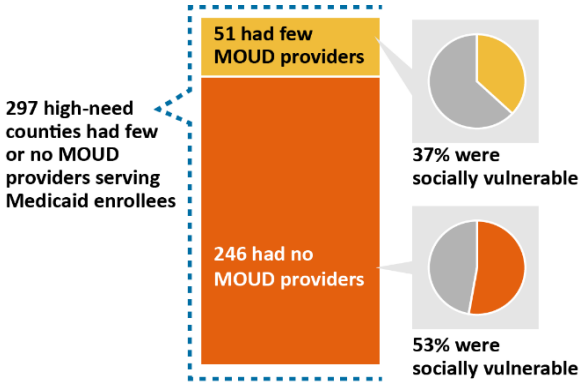
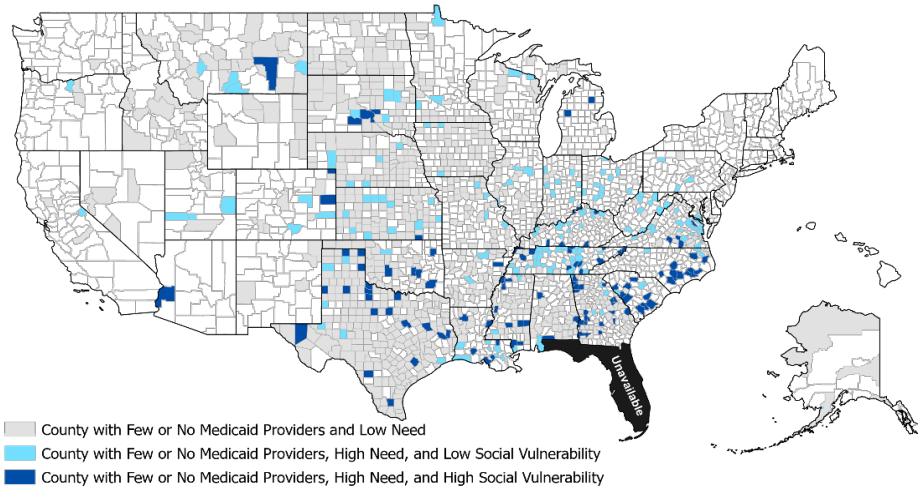


Exhibit 5: Many counties had few or no MOUD providers that treated Medicaid enrollees



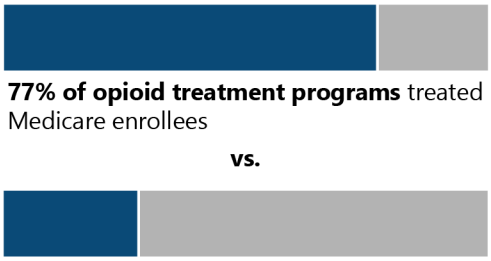
Source: OIG analysis of CDC, CMS, and SAMHSA data.
Note: See our companion product for an interactive version of this map.

The vast majority of opioid treatment programs treated Medicare and Medicaid enrollees; in contrast, most office-based buprenorphine providers did not

Opioid treatment programs—the only provider type able to offer treatment with methadone—were much more likely to treat Medicare and Medicaid enrollees than office-based buprenorphine providers. However, there are far fewer opioid treatment programs, and they are much less widespread across the Nation.[56] Therefore, high rates of Medicare and Medicaid participation from both opioid treatment programs and office-based buprenorphine providers are critical to ensure sufficient enrollee access.

Less than one-third of office-based buprenorphine providers treated Medicare enrollees

Nationwide, 77 percent of opioid treatment programs prescribed or administered buprenorphine or methadone to at least one Medicare enrollee in 2022.[57, 58] In contrast, just 28 percent of office-based buprenorphine providers nationwide prescribed or administered buprenorphine to at least one Medicare enrollee.[59]



77% of opioid treatment programs treated Medicare enrollees

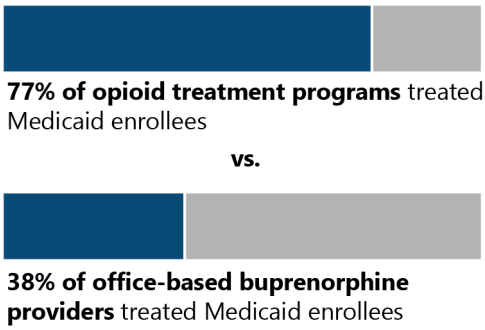
vs.

28% of office-based buprenorphine providers treated Medicare enrollees

In some States, the percentage of opioid treatment programs that treated at least one Medicare enrollee was far lower than that for the Nation. For example, South Dakota did not have any opioid treatment programs that treated at least one Medicare enrollee, and in three additional States, less than half of the opioid treatment programs treated any Medicare enrollees. Conversely, in seven States, every opioid treatment program treated Medicare enrollees.

The percentage of office-based providers that treated at least one Medicare enrollee with MOUD also varied by State, although the proportion was below 50 percent in all States. Delaware, Iowa, and the District of Columbia had the lowest percentage of office-based providers that treated Medicare enrollees (19.0, 19.9, and 20.3 percent, respectively). Maine and Louisiana had the highest percentage at 44.6 and 39.3 percent, respectively. See Appendix A for details.

Less than half of office-based buprenorphine providers treated Medicaid enrollees



Similar to the case with the Medicare program, most opioid treatment programs treated Medicaid enrollees while most office-based buprenorphine providers did not. Nationwide (excluding Florida), 77 percent of opioid treatment programs prescribed or administered buprenorphine or methadone to at least one Medicaid enrollee in 2022. In contrast, just 38 percent of office-based providers nationwide (excluding Florida) prescribed or administered buprenorphine to at least one Medicaid enrollee.

As with Medicare, there was also substantial variation across States. For example, opioid treatment programs operated in South Dakota and Montana but did not treat any Medicaid enrollees in 2022. In three additional States, less than half of the opioid treatment programs treated any Medicaid enrollees. Conversely, in six States, every opioid treatment program treated Medicaid enrollees.

The percentage of office-based buprenorphine providers that treated Medicaid enrollees also varied by State. Texas, Georgia, and Kansas had the lowest percentage of office-based buprenorphine providers that treated Medicaid enrollees (19.1, 24.1, and 27.5 percent, respectively). Conversely, in five States, more than half of office-based buprenorphine providers treated Medicaid enrollees. See Appendix A for details.

Stakeholders described administrative, financial, and other challenges that may prevent MOUD providers from treating Medicare and Medicaid enrollees

To better understand factors that either help or hinder MOUD providers in treating Medicare and Medicaid enrollees, OIG interviewed subject matter experts from CMS and two professional organizations that represent opioid treatment programs and office-based buprenorphine providers. We also submitted written questions to, and received written responses from, SAMHSA. Collectively, these stakeholders described an array of barriers that impede MOUD providers' ability and willingness to treat Medicare and Medicaid enrollees. Stakeholders also identified a variety of HHS actions that have supported MOUD providers' ability to treat Medicare and Medicaid enrollees.

Medicare Advantage administrative burden and prior authorization requirements pose challenges for MOUD providers

Both professional associations stated that the large number of Medicare Advantage plans with different administrative requirements may hinder providers' ability and willingness to treat Medicare enrollees. One of the associations further noted that some of their members limit the number of Medicare Advantage plans that they will accept, and that some have questioned continuing to treat Medicare Advantage patients at all, given the many different administrative hurdles the providers experience. CMS officials agreed that Medicare Advantage rules and requirements for paying claims may impede providers' treatment of Medicare patients, noting that there are sometimes lags between claim submission and payment to the provider.

CMS officials and one of the professional associations also noted that Medicare Advantage prior authorization requirements sometimes impede providers' provision of MOUD to Medicare enrollees. According to an analysis of 2022 data, 85 percent of Medicare Advantage enrollees were required to obtain prior authorization for opioid treatment program services, and 83 percent were required to obtain prior authorization for outpatient substance abuse services.[60] CMS officials reiterated that prior authorization requirements are permitted by law but stated that it "is definitely the thing [hindrance] we hear most often." These statements are consistent with prior research that has found that prior authorization requirements are one of the most frequently cited barriers to providers prescribing or administering MOUD.[61, 62, 63, 64, 65]

Low reimbursement rates may discourage MOUD providers from treating Medicaid enrollees

Both professional associations stated that low reimbursement rates are the primary factor that discourages providers from treating Medicaid enrollees. One association emphasized that most State Medicaid programs reimburse MOUD providers at much lower rates than the Medicare program and stated that this disparity is codified in some State statutes. The other association stated that State reimbursement rates vary widely and that in some States, the rate has not increased for a long time. These statements are consistent with prior research that has found wide variation across States in Medicaid reimbursement and low rates relative to Medicare.[66, 67]

Inadequate information about provider location may hinder MOUD providers' ability to serve Medicare and Medicaid enrollees

SAMHSA's public website currently provides the contact information and locations for all opioid treatment programs[68] and most office-based providers that previously received a buprenorphine-waiver prior to the repeal of the Buprenorphine Waiver Program.[69] However, SAMHSA stated that as a result of the repeal, it no longer has responsibility for tracking and verifying the qualifications of office-based buprenorphine providers. Therefore, the agency only updates its BWNS database

when previously listed providers request changes and would have no insight into new providers that offer buprenorphine treatment. Moreover, the agency is currently in the process of archiving the BWNS database. Consequently, SAMHSA's public website no longer maintains an up-to-date list of office-based buprenorphine providers.

For the same reason, CMS recently decided to not require Medicare Advantage organizations to identify office-based buprenorphine providers in their own provider directories.[70] The lack of an up-to-date public directory may hinder Medicare and Medicaid enrollees' efforts to find treatment for OUD.

HHS has taken actions to increase the number of MOUD providers accessible to Medicare and Medicaid enrollees

CMS stated that the agency has taken several actions that support MOUD providers' ability and willingness to prescribe or administer MOUD to Medicare enrollees, including:

- establishing Medicare payment codes for a wide variety of MOUD services;[71, 72]
- setting reasonable reimbursement rates under Medicare for those services;[73]
- enabling opioid treatment programs to bill Medicare for opioid use disorder treatment services furnished by mobile units;[74]
- increasing regulatory flexibility for providing certain treatment services, such as telehealth and telemedicine;[75]
- reducing Medicare Advantage prior authorization requirements;[76]
- establishing Medicare Advantage plan network adequacy standards for outpatient behavioral health, which includes provider types that offer treatment with MOUD (e.g., opioid treatment programs, addiction medicine physicians);[77] and
- developing an outreach campaign to educate providers and Medicare enrollees on the opioid use disorder treatment services provided by opioid treatment programs.

Both professional associations noted that Medicare's payment codes have supported providers' ability and willingness to treat Medicare enrollees, with one specifying that CMS has been very responsive and worked closely with providers to determine Medicare's reimbursement rates for MOUD. One of the associations also stated that the recent regulatory changes to increase flexibility in access through services, such as telemedicine, and the educational information made available by both CMS and SAMHSA have supported this goal.

Regarding Medicaid, CMS described several initiatives that may facilitate MOUD providers' ability and willingness to treat Medicaid enrollees. These include:

- increasing regulatory flexibility for providing certain services;
- publishing a toolkit to help State Medicaid agencies and managed care plans meet network adequacy requirements for behavioral health care providers, including those that prescribe MOUD;
- providing guidance on general options related to Medicaid coverage of MOUD services;[78, 79, 80] and
- requiring States, by July 2026, to publish all fee-for-service Medicaid fee schedule payment rates and conduct a review of how rates for certain services, including substance use disorder services, compare with Medicare rates.[81]

CMS does not conduct provider outreach to increase the number of MOUD providers treating Medicaid enrollees. CMS stated that it defers to States for provider outreach efforts because Medicaid is structured as a Federal-State partnership and CMS has a limited role in provider enrollment at the state level.

One professional association was not aware of any factors that supported its members' ability or willingness to treat Medicaid enrollees. The other association noted that certain States have fewer restrictions on treatment options and better Medicaid reimbursement rates than others, which could improve access.

SAMHSA does not specifically take any actions to increase the number of MOUD providers that are treating Medicare and Medicaid enrollees, but rather takes actions to increase the number of MOUD providers available in general. These actions include (1) providing information about MOUD to providers through publications and on SAMHSA's website; (2) performing outreach to professional associations to encourage the use of MOUD; and (3) providing funding for provider training that integrates the use of MOUD to treat opioid use disorder.

Additionally, in April 2021, HHS issued revised Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder that eased requirements for obtaining a waiver to prescribe buprenorphine for OUD.[82] Specifically, the revised guidelines removed a training requirement and a requirement that otherwise eligible clinicians certify their ability to provide or refer for counseling or other ancillary services.

CONCLUSION AND RECOMMENDATIONS

Access to MOUD is crucial to reduce overdose mortality and improve the quality of life of people with opioid use disorder. Medicare and Medicaid play important roles in providing such access, and the Federal government has taken several steps in recent years to increase available treatment options through both programs. However, our findings demonstrate that a substantial number of counties in high need of MOUD services—including many that are socially vulnerable—lack office-based buprenorphine providers and opioid treatment programs. Although office-based providers are no longer required to obtain a waiver from SAMHSA to prescribe buprenorphine, other barriers remain, and the patterns we observed in 2022 therefore remain relevant to understanding gaps in access to MOUD. Further, Medicare and Medicaid enrollees in need of MOUD will remain underserved if MOUD providers are unwilling or unable to treat these individuals—a serious concern, given our finding that most office-based buprenorphine providers did not treat a single Medicare or Medicaid enrollee in 2022.

Stakeholders identified administrative, financial, and regulatory challenges that—in combination with widespread stigma about opioid use disorder and treatment—impede MOUD providers' ability and willingness to treat Medicare and Medicaid enrollees. Additionally, neither CMS nor SAMSHA maintains an up-to-date list of office-based buprenorphine providers to enable the public to locate nearby MOUD providers or to accurately monitor access to MOUD treatment.

Given the findings in this review, we recommend that CMS:

Geographically target efforts to increase the number of MOUD providers that treat Medicare enrollees in high-need counties

Building on previous OIG recommendations to increase the number of MOUD providers, CMS should work with SAMHSA to increase the proportion of office-based buprenorphine providers and opioid treatment programs that treat Medicare enrollees.[83, 84] These efforts should target high-need counties identified in this report that have few or no MOUD providers treating enrollees, especially counties that also are socially vulnerable.

Geographically target efforts to increase the number of MOUD providers that treat Medicaid enrollees in high-need counties

CMS should work with States and SAMHSA to increase the proportion of office-based buprenorphine providers and opioid treatment programs that treat Medicaid enrollees. As with Medicare, these efforts should target the high-need counties identified in this report that have few or no MOUD providers treating enrollees.

Work with States to assess whether their Medicaid reimbursement rates for treatment with MOUD are sufficient to recruit and retain enough MOUD providers

Consistent with prior research on this issue, the stakeholders we interviewed identified low Medicaid reimbursement rates for MOUD providers as an important factor that impedes these providers' ability and willingness to prescribe or administer MOUD to Medicaid enrollees. CMS should work with States with disproportionately low Medicaid reimbursement rates to assess whether their rates are (1) consistent with efficiency, economy, and quality of care and (2) sufficient to recruit and retain enough MOUD providers to ensure that MOUD treatment services are available for enrollees.[85] As States publish their Medicaid fee-for-service payment rates and conduct comparisons of how their rates for MOUD compare to Medicare rates, no later than July 2026, CMS may use this information to assist them in addressing this recommendation.[86]

Work with SAMHSA to develop and maintain a list of active office-based buprenorphine providers

The lack of a comprehensive, up-to-date public directory of office-based buprenorphine providers may prevent patients with opioid use disorder, including Medicare and Medicaid enrollees, from locating MOUD providers that would otherwise be willing and able to provide care. Building on OIG's previous recommendations for CMS to monitor and share data on office-based buprenorphine providers and enrollees receiving buprenorphine, CMS should work with SAMHSA and DEA to develop and maintain an up-to-date directory of active office-based buprenorphine providers.[87, 88] For example, SAMHSA could regularly update its current BWNS database using new and renewing DEA registrant application data that indicates whether an applicant satisfied training requirements to treat and manage patients with opioid use disorder. CMS could then supplement this database with Medicare and Medicaid claims data to determine which providers are actively prescribing or administering MOUD to Medicare and Medicaid enrollees. CMS could also require Medicare Advantage organizations to identify providers in their provider directories that are able and willing to prescribe or administer MOUD. Collecting and maintaining data on active office-based buprenorphine providers will enable both SAMHSA and CMS to provide public directories that identify nearby providers and improve the Federal government's ability to monitor access to MOUD.

CMS recently published a Request for Information indicating that it is considering whether to develop a national directory of health care providers; if CMS moves forward with this directory, it should include information about whether providers prescribe or administer buprenorphine to treat opioid use disorder.

AGENCY COMMENTS AND OIG RESPONSE

CMS stated that it supports the spirit of our recommendations and did not state whether it concurred with our recommendations. CMS described HHS-wide efforts to increase access to MOUD providers, both generally and for Medicare and Medicaid enrollees.

In response to our recommendation that CMS geographically target its efforts toward increasing the number of MOUD providers that treat Medicare enrollees in high-need counties, the agency stated that it is continuously targeting its efforts toward removing barriers to accessing MOUD treatment in Medicare. CMS stated that these efforts are undertaken both through a focus on equity in underserved and rural communities and through payment policy changes. These include allowing opioid treatment programs to provide treatment from mobile units and providing telecommunication flexibilities. CMS also noted that the repeal of the buprenorphine waiver requirement (effective December 29, 2022) may increase the number of MOUD providers.

OIG recognizes CMS for its efforts. However, additional action is warranted given our findings. Although the repeal of the buprenorphine waiver requirement aims to increase the number of MOUD providers, Medicare (and Medicaid) enrollees do not benefit from this change if providers are unable or unwilling to treat them. CMS should take steps to increase the proportion of MOUD providers that treat Medicare enrollees within these underserved, high-need counties. For example, CMS could use our Medicare analyses in addition to its own Mapping Medicare Disparities tool to identify where further actions are necessary to meet the MOUD treatment needs of Medicare enrollees.

In response to our recommendation that CMS geographically target its efforts toward increasing the number of MOUD providers that treat Medicaid enrollees in high-need counties, the agency stated that States retain primary responsibility for administering their Medicaid programs, including provider outreach and payment structures. However, CMS noted that States can apply for waivers to test new programs in limited geographic areas, which allows States to target different approaches toward care in high-need counties. The agency also stated that it recently issued guidance regarding the provision of non-emergency medical transportation that may help certain Medicaid enrollees located in counties with few or no MOUD providers to travel to areas where there are available MOUD providers.

OIG recognizes CMS's limited authority over State Medicaid programs and appreciates its efforts to increase MOUD access for Medicaid enrollees. However, additional action is warranted given our findings. CMS should take steps to increase the proportion of MOUD providers that treat Medicaid enrollees within these underserved, high-need counties. For example, CMS could use our Medicaid analyses to assist States in identifying where further efforts are most needed.

In response to our recommendation that CMS work with States to assess whether their Medicaid reimbursement rates for treatment with MOUD are sufficient to recruit and retain enough MOUD providers, the agency stated that States have broad discretion to set Medicaid reimbursement rates. However, CMS also noted that States must set Medicaid payment rates that are consistent with efficiency, economy, and quality of care, and that are sufficient to enlist enough providers to ensure that Medicaid services are available to enrollees. CMS described efforts underway to improve price transparency by requiring States, by July 2026, to publish all fee-for-service Medicaid payment rates and to conduct a review of how rates for certain services, including substance use disorder services, compare with Medicare rates. CMS also stated that it is working with States to implement legislative requirements that include rules aimed at ensuring comparable reimbursement rates for mental health and substance use disorder treatment providers.

OIG appreciates the initial steps CMS has taken toward improving Medicaid reimbursement rates. As States begin to comply with the new requirement to publish their Medicaid fee-for-service payment rates and conduct rate comparisons, CMS should use this information to assist in addressing our recommendation. For example, CMS could use this information to identify States with reimbursement rates for MOUD services that may be insufficient to enlist enough providers to ensure that MOUD services are available to Medicaid enrollees.

In response to our recommendation that CMS work with SAMHSA to develop and maintain a list of active office-based buprenorphine providers, the agency stated that it encourages Medicare Advantage plans to incorporate information about provider expertise into their personal provider directories and has provided guidance for Medicaid agencies on complying with requirements to publish accurate, updated, and searchable provider directories. In addition, CMS stated that it currently has an effort underway to study the potential for establishing a national directory of health care providers to assist consumers in identifying providers.

OIG recognizes CMS's efforts; however, further action is needed. CMS's effort to study the potential for establishing a national provider directory is a welcome first step; if CMS moves forward with this directory, it should include information about whether providers prescribe or administer buprenorphine to treat opioid use disorder and whether those providers are willing to treat Medicare and Medicaid enrollees.

We ask that, in its final management decision, CMS clarify whether it concurs with our recommendations and what steps it will take to implement them.

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

DETAILED METHODOLOGY

Scope

We examined the number and location of office-based buprenorphine providers and opioid treatment programs in 50 States and the District of Columbia and identified those that treated Medicare and Medicaid enrollees with buprenorphine or methadone during calendar year 2022.[89] We did not include naltrexone in our review because it has been found to be less effective when used to treat opioid use disorder and is less commonly used than buprenorphine and methadone.[90, 91] We also identified counties with high drug overdose mortality rates and those with high indices of social vulnerability. We combined these analyses to identify counties that may have an insufficient number of office-based buprenorphine providers and opioid treatment programs to meet the treatment needs of Medicare and Medicaid enrollees.

Data Sources

This review combined data from administrative and management systems maintained by SAMHSA, the Centers for Medicare and Medicaid Services (CMS), the U.S. Census, and the Centers for Disease Control and Prevention (CDC). Specifically:

- We used SAMHSA's BWNS Waivered Practitioner Table dataset and Opioid Treatment Program Directory to identify all office-based buprenorphine providers and opioid treatment programs at the end of calendar year 2022.
- We used 2022 Medicare and Medicaid claims data, including both fee-for-service and managed care, to identify providers that prescribed or dispensed buprenorphine or methadone to at least one Medicare or Medicaid enrollee.
- We used provider identifier information from CMS's Master Data Management system and DEA registration file to match Medicare and Medicaid claims to our list of office-based buprenorphine providers and opioid treatment programs.
- We used 2021 U.S. Census County Population with Characteristics data to identify the population of each county.
- We used CDC's 2021 detailed mortality data to identify counties with high rates of drug overdose mortality.
- We used the 2020 CDC/ATSDR Social Vulnerability Index (SVI) to identify counties with high indices of social vulnerability.
- We interviewed subject matter experts from CMS and two professional associations that represent MOUD providers. We also submitted written questions to, and received written responses from, SAMHSA.

Data Analysis

To determine whether a county had disproportionately few MOUD providers, few Medicare MOUD providers, or few Medicaid MOUD providers, we calculated the total number of MOUD providers, MOUD providers with Medicare claims, and MOUD providers with Medicaid claims per 100,000 people in each county. We considered counties with a provider-to-population ratio below the 40th percentile to have disproportionately few MOUD providers.[92]

To identify counties in high need of MOUD services, we compared rates of drug overdose mortality across counties. We considered counties with an age-adjusted drug overdose mortality rate above the 60th percentile to be in high need of MOUD services.[93]

To identify counties that are socially vulnerable, we compared the CDC/ATSDR SVI across counties. This index uses 16 U.S. census variables (including socioeconomic status, household characteristics, housing and transportation availability, and other factors) to identify communities that are especially vulnerable to the negative impact of external stresses on human health, such as the opioid crisis. We considered counties with an SVI ranking above the 60th percentile to be socially vulnerable.[94]

To identify factors that support or impede MOUD providers' ability or willingness to prescribe or administer MOUD to Medicare and Medicaid enrollees, we reviewed interview and written responses from stakeholders to identify key points and common themes.

Limitations

We did not independently verify the completeness or accuracy of Medicare or Medicaid claims data. Also, Florida Medicaid pharmacy claims data did not have prescriber identifiers in 2022; therefore, we excluded Florida from the Medicaid portion of our nationwide analyses.

We also did not independently verify the completeness or accuracy of SAMHSA's BWNS database or Opioid Treatment Directory and were not able to identify provider identifier information for 2 percent of the providers in these databases. Therefore, our analyses may not fully account for every MOUD provider that prescribed or administered buprenorphine or methadone to Medicare and Medicaid enrollees in 2022.

We were not able to measure county-level Medicare and Medicaid enrollee demand for OUD treatment. Therefore, our analysis identifying counties with few or no MOUD providers that treated enrollees may, in some cases, reflect low demand for treatment. Additionally, an enrollee living in a county with few or no MOUD providers may be able to access treatment in a neighboring county.

APPENDICES

Appendix A: Percentage of MOUD Providers with Medicare and Medicaid Claims

State	Opioid Treatment Programs	Office-Based Buprenorphine Providers	Percentage with Medicare Claims		Percentage with Medicaid Claims	
			Opioid Treatment Programs	Office-Based Buprenorphine Providers	Opioid Treatment Programs	Office-Based Buprenorphine Providers
AK	7	847	86%	25%	86%	49%
AL	22	1,084	91%	38%	73%	30%
AR	5	655	40%	34%	20%	35%
AZ	59	3,268	81%	21%	73%	31%
CA	160	17,317	91%	21%	96%	34%
CO	34	3,329	53%	24%	68%	41%
CT	42	2,161	69%	33%	74%	42%
DC	4	556	50%	20%	75%	28%
DE	19	594	79%	19%	79%	28%
FL	98	5,473	44%	27%	**Unavailable**	**Unavailable**
GA	64	1,850	73%	28%	58%	24%
HI	4	450	75%	27%	75%	33%
IA	8	592	100%	20%	100%	36%
ID	4	720	75%	37%	75%	51%
IL	81	3,768	78%	25%	40%	36%
IN	19	2,368	89%	32%	95%	52%
KS	8	710	63%	23%	50%	27%
KY	30	2,228	97%	35%	93%	44%
LA	10	1,246	100%	39%	100%	48%
MA	61	7,896	48%	28%	48%	34%
MD	88	3,717	76%	28%	91%	38%
ME	12	1,560	92%	45%	100%	55%
MI	44	4,497	84%	28%	82%	37%
MN	15	2,738	93%	29%	93%	50%
MO	17	1,651	82%	31%	88%	45%
MS	4	501	100%	34%	75%	30%
MT	3	544	100%	33%	0%	45%
NC	82	4,008	83%	33%	89%	37%
ND	4	278	50%	24%	75%	37%
NE	3	372	100%	25%	100%	33%
NH	10	1,176	90%	31%	100%	38%
NJ	59	3,648	66%	27%	73%	40%
NM	16	1,631	88%	33%	88%	47%
NV	15	919	73%	25%	73%	35%
NY	92	10,536	73%	25%	53%	34%

OH	107	6,093	87%	26%	90%	41%
OK	21	1,118	62%	31%	62%	30%
OR	23	2,610	83%	37%	96%	51%
PA	91	6,692	69%	30%	74%	41%
RI	20	938	85%	36%	85%	42%
SC	27	1,669	93%	26%	96%	29%
SD	1	280	0%	30%	0%	37%
TN	23	1,919	96%	34%	91%	30%
TX	85	4,240	66%	24%	54%	19%
UT	15	1,565	93%	33%	93%	47%
VA	44	2,664	84%	25%	91%	35%
VT	6	777	100%	35%	83%	50%
WA	35	6,097	91%	30%	94%	43%
WI	22	2,170	86%	28%	86%	41%
WV	9	1,021	100%	35%	100%	42%
WY*	**0**	238	**N/A**	26%	N/A	32%
Total	**1,732**	**134,979**	**77%**	**28%**	**77%**	**38%**

Source: OIG analysis of CMS and SAMHSA data.
Note*: Wyoming does not have any opioid treatment programs operating within the State.
Note: See our companion product for interactive maps of this data.

Appendix B: 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: September 3, 2024

TO: Ann Maxwell
Deputy Inspector General
for Evaluation and Inspections

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare and Medicaid Enrollees in Many High Need Areas May Lack Access to Medications for Opioid Use Disorder (OEI-BL-23-00160)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. Substance use disorders (SUD) impact the lives of millions of Americans, including individuals enrolled in the Medicare and Medicaid programs. CMS is committed to ensuring that Medicaid and Medicare beneficiaries who have an opioid use disorder (OUD) have access to appropriate treatment, including through Opioid Treatment Programs (OTPs) and office-based treatment. Ensuring access to these benefits and addressing disparities in access is an important part of combatting the nation's overdose crisis, and CMS has been actively engaged in the work necessary to help people enrolled in our programs access the care they need, when they need it.

In both Medicare and Medicaid, CMS continues to work within its authority to improve access to SUD treatment. To accomplish these goals, CMS has begun implementation of 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 includes focusing on effectively addressing disparities in access to mental health, SUD, and pain care in Medicare and Medicaid. 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. The Agency's vision is for all beneficiaries and consumers to receive access to person-centered, timely, and affordable

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

care.[2] Outlined in CMS's strategic 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] CMS's investment in behavioral health spans across Medicare, Medicare Advantage, Medicaid and the Children's Health Insurance Program, and the Health Insurance Marketplace.

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 providers that is sufficient to provide adequate access to covered services, including any covered SUD treatment, to meet the needs of the population serviced. In addition, regulations at 42 CFR 422.116 establishes specific time and distance and minimum number of provider requirements for many specialty provider and facility types for the provider networks of MA coordinated care plans. CMS evaluates MA provider networks at the contract level against these regulatory standards at the time of application and at least every three years.

For Contract Year (CY) 2024, CMS added Clinical Psychologists and Licensed Social Workers as specialty types under regulations at 42 CFR 422.116 for which CMS sets network standards, and made these types eligible for a 10-percentage point telehealth credit. CMS also amended general access standards to include explicitly behavioral health services and codified standards for appointment wait times for behavioral health services, among other behavioral health policies. For CY 2025, CMS finalized regulations to add a facility-specialty type under these network adequacy standards called "Outpatient Behavioral Health," which will also be eligible toward at 10-percentage point telehealth credit. This new facility-specialty type includes a range of behavioral health providers under one category, including specialists such as OTPs, Community Mental Health Centers, addiction medicine physicians, and other providers who furnish addiction medicine and behavioral health counseling and/or therapy services in Medicare today. CMS will evaluate whether each contract-level network is sufficient to provide access to covered services for the Outpatient Behavioral Health specialty type against these minimum regulatory number and time and distance standards. Specifically, MA plans must independently verify that the 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 provider, such as the MA plan's claims data, prescription drug claims data, electronic health records or similar data in order to make this determination.

To ensure access to these benefits, CMS has engaged in annual rulemaking to continue to remove barriers to OTPs and other providers in billing Medicare for medications for opioid use disorder (MOUD) treatment. Examples of policy changes that CMS implemented to increase access in high-need areas include expanding access for OTPs to furnish OUD treatment services from mobile vans and telecommunication flexibilities. Payment rates are also re-analyzed annually to ensure they accurately reflect services provided. In the Contract Year 2023 Policy

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

and Technical Changes to the Medicare Advantage Program final rule, CMS clarified that emergency behavioral health services must not be subject to prior authorization.[5] CMS has also continued outreach to educate both beneficiaries and providers about covered treatments for SUDs. In addition, CMS works to ensure that Medicare beneficiaries are aware of these treatment options and has published information about coverage of office-based treatment in the Medicare & You Handbook[6]. In addition, CMS also finalized a rule that sets the maximum appointment wait time for routine behavioral health care at 30 business days in MA.[7]

Because addressing disparities is also an important part of increasing access, CMS has established a Framework for Health Equity.[8] This publication provides a framework for measurable, actionable goals to achieve health equity. It reflects CMS's overall strategic plans as well as needs identified by interested parties to expand an equity framework for the coming years. CMS is following the process established in the Framework to help address these disparities.

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.[9] CMS understands that access to providers who are willing to provide behavioral health care to beneficiaries is essential to combatting the overdose crisis. During the OIG's audit period, through calendar year 2022, office-based providers were required by federal law to obtain a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) in order 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 provider could treat with buprenorphine. As of December 29, 2022, all practitioners who have a current DEA registration that includes Schedule III authority were permitted to prescribe buprenorphine for opioid use disorder, subject to state law. These changes decrease barriers to access and increase the number of providers who may be available to treat Medicare and Medicaid enrollees. While CMS had previously proposed to require MA organizations to include in their provider directories notations for MOUD-waivered providers who are listed on SAMHSA's Buprenorphine Practitioner Locator, CMS decided to not finalize this proposal due to the elimination of the waiver requirement, and SAMHSA's subsequent decision not to maintain the Buprenorphine Practitioner Locator. Currently, any licensed provider can treat patients with MOUD without a waiver. However, CMS continues to encourage plans, through the Provider Directory Model, to incorporate information about providers into the provider directory including provider's expertise in treating patients with OUDs (e.g., prescribers of medications for OUDs, addiction specialists, and OTPs.

CMS has taken a number of steps to increase access to behavioral health services in Medicaid specifically. For example, CMS published a toolkit to guide states and managed care plans in meeting network adequacy requirements for behavioral health care providers. CMS also finalized

[5] 88 FR 22171
[6] https://www.medicare.gov/medicare-and-you
[7] 42 CFR 422.112(a)(6)(i)
[8] https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework
[9] https://www.cms.gov/files/document/cms-cross-cutting-initiatives-infographic.pdf

a rule that sets the maximum appointment wait time for routine behavioral health care at 10 business days in Medicaid managed care.[10] While these rules do not specifically address MOUDs, they are designed to assist in meeting the need for behavioral health care services in general. In addition, the Consolidated Appropriations Act, 2024 (P.L. 118-42) made MOUD a mandatory state plan benefit in Medicaid permanently.

Authorized under the American Rescue Plan of 2021 (P.L. 117-2), states also have the option to support community-based mobile crisis intervention services for people with Medicaid by temporarily receiving an enhanced federal Medicaid match. Mobile crisis intervention services are essential tools to meet people in crisis where they are and rapidly provide critical services to people experiencing mental health or substance use crises by connecting then to a behavioral health specialist 24 hours per day, 365 days a year. This option helps states integrate these services into their Medicaid programs, a critical component in establishing a sustainable and public health-focused support network. Currently, 19 states and DC have implemented mobile crisis units.

Regarding Medicaid payment rates, Medicaid is a state/federal partnership, administered by states according to federal requirements. States retain responsibility for administration of their Medicaid programs, including provider outreach and payment structures, within certain federal parameters. Federal law requires that states set Medicaid payment rates that are consistent with efficiency, economy and quality of care, and are sufficient to enlist enough providers to ensure that Medicaid services are available to beneficiaries at least to the extent that the services are available to the general population in the same geographic area. To increase transparency and awareness of rates across states and payers, CMS finalized a rule [11]to ensure clear and easy access to all fee-for-service (FFS) payment rates, which would include payment rates for MOUD services. In addition, the rule requires states to conduct and publish a comparative payment rate analysis to specifically examine outpatient mental health and substance use disorder service payment rates in comparison to Medicare. Through these mechanisms, CMS and the public can readily identify where rates may be low when compared to other states or between or other payers.

The nation’s overdose crisis is a top priority for CMS, and the Agency remains committed to ongoing examination of its payment and coverage policies to ensure healthcare providers can execute best practices in providing care and services to people with substance use disorders, and other behavioral health needs.

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

OIG Recommendation

CMS should geographically target efforts to increase the number of MOUD providers that treat Medicare enrollees in high-need counties.

[10] 42 CFR 438.68(e)(1)(i)

[11] Ensuring Access to Medicaid Services Final Rule, 89 FR 40542, available at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf

CMS Response

CMS supports the spirit of this recommendation and is continuously targeting efforts to remove barriers to access to MOUD treatment from OTPs and other providers billing Medicare.

CMS engages in annual rulemaking to continue to remove barriers to OTPs and other providers in billing Medicare for MOUD treatment. Examples of policy changes that we implemented to increase access in high-need areas include expanding access to OUD treatment services by allowing OTPs to furnish medically reasonable and necessary services from mobile units and telecommunication flexibilities when authorized by SAMHSA and DEA for certain services. CMS also continues to consider refinements and expansions to the Medicare OTP benefit, in coordination with SAMHSA, to ensure Medicare beneficiaries have access to high quality OUD treatment to meet their diverse needs. CMS is already undertaking efforts to reduce barriers to MOUD treatment in Medicare, both through focus on equity in underserved and rural communities and through payment policy changes, and will remain focused on these priorities.

CMS is already working within the Framework for Health Equity and as part of the Department-wide Behavioral Health Coordinating Council. This work includes examining disparities experienced by underserved communities, including people living in rural areas, and prioritizes building the capacity of health care organizations and the workforce to reduce health and health care disparities. Our Mapping Medicare Disparities[12] tool also supports this work.

In addition, 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 providers who may be available to treat Medicare and Medicaid enrollees.

OIG Recommendation

CMS should geographically target efforts to increase the number of MOUD providers that treat Medicaid enrollees in high-need counties.

CMS Response

While CMS supports the spirit of this recommendation, as stated above, Medicaid is a state/federal partnership, administered by states according to federal requirements. States retain responsibility for administration of their Medicaid programs, including provider outreach and payment structures, and have broad discretion to set Medicaid reimbursement rates in accordance with general federal requirements. While states generally cannot exclude enrollees or providers because of where they live or work in the state, states can apply for waivers to test new programs in limited geographic areas of the state. This option allows states to target different approaches to care in high-need counties. Further, CMS recently issued guidance on the requirement that state Medicaid agencies provide assurance of non-emergency medical transportation, which can help improve access for individuals living in counties without MOUD providers by providing coverage for travel to areas where there are providers of MOUD.[13] In addition, the Consolidated Appropriations Act, 2024, made MOUD a mandatory state plan benefit in Medicaid

[12] https://data.cms.gov/tools/mapping-medicare-disparities-by-population

[13] https://www.cms.gov/medicare/medicaid-coordination/states/non-emergency-medical-transportation

permanently. As allowable under existing authorities and resource constraints, CMS will continue taking actions to support state efforts to increase the number of MOUD providers treating Medicaid enrollees.

OIG Recommendation

CMS should work with States to assess whether their Medicaid reimbursement rates for treatment with MOUD are sufficient to recruit and retain enough MOUD providers.

CMS Response

As stated above, states have broad discretion to set Medicaid reimbursement rates in accordance with general federal requirements. In accordance with section 1902(a)(30)(A) of the Act, states must set Medicaid payment rates that are consistent with efficiency, economy and quality of care, and are sufficient to enlist enough providers to ensure that Medicaid services are available to beneficiaries at least to the extent that the services are available to the general population in the same geographic area. CMS finalized a rule[14] to improve transparency in Medicaid fee-for-service payment rates, which will provide further information and context to state partners. This rule's payment rate transparency provision covers payment rates for MOUD services, and further requires a comparative payment rate analysis that will compare Medicaid and Medicare outpatient mental health and substance use disorder service payment rates. Through these mechanisms, CMS and the public will be better able to identify where rates may be low when compared to other states or payers. In addition, CMS works with states to implement Mental Health Parity and Addiction Equity Act (MHPAEA) requirements that include rules aimed at ensuring comparable reimbursement rates for mental health and substance use disorder treatment providers. CMS is currently developing new tools to improve processes for working with states to ensure compliance with parity requirements. As allowable under existing authorities and resource constraints, CMS will continue working with our state Medicaid agency partners to improve their reimbursement rates for MOUD providers.

OIG Recommendation

CMS should work with SAMHSA to develop and maintain a list of active office-based buprenorphine providers.

CMS Response

As stated above, providers are no longer required to obtain a federal waiver to prescribe buprenorphine for OUDs, nor are there federal limits on the number of patients they can treat. Therefore, after considering interested party feedback, CMS decided to not finalize a proposal to require MA plans to include in their provider directories notations for MOUD-waivered providers. However, CMS continues to encourage plans, through the Provider Directory Model, to incorporate information about providers into the provider directory including providers' expertise in treating people with OUDs (e.g., prescribers of medications for OUDs, addiction specialists, and OTPs). In addition, CMS currently has an effort underway to study the potential for establishing a national directory of healthcare providers to assist consumers in identifying providers. CMS released a Request for Information in October 2022 which further details this

[14] Ensuring Access to Medicaid Services Final Rule, 89 FR 40542, available at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf

effort and will continue to evaluate responses received.[15] In addition, CMS issued a state health official letter on July 16, 2024, providing guidance for state Medicaid agencies on complying with requirements to publish accurate, updated, and searchable provider directories and availability of enhanced federal match for Medicaid fee-for-service Provider Directory development and operations.[16] CMS will continue working with our state Medicaid agency partners and others to improve availability of information regarding providers, including office-based buprenorphine providers for Medicare and Medicaid enrollees.

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

[15] 87 FR 61018
[16] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24003.pdf

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ENDNOTES

[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) currently recommends using the term "medication 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 Fed. Reg. 77330, 77338 (Dec. 16, 2022). As of March 2023, the U.S. Food and Drug Administration (FDA) has approved three medications for opioid use disorder: buprenorphine, methadone, and naltrexone.

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

[3] OIG, *Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns* (OEI-BL-22-00260) September 25, 2023.

[4] "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.

[5] Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act, Pub. L. 115-271, enacted October 24, 2018) amended the Social Security Act (SSA) by adding Sections 1861(s)(2)(HH), 1861(s)(jjj), 1833(a)(1)(CC), and 1834(w) to establish a new benefit for opioid use disorder treatment services furnished by an opioid treatment program beginning on or after January 1, 2020. See also 42 CFR § 410.67. An opioid treatment program must be enrolled in Medicare to receive reimbursement for services provided to Medicare enrollees.

[6] See Section 1006(b) of the 2018 SUPPORT for Patients and Communities Act (P.L. 115-271). Hawaii, South Dakota, and Wyoming were granted an exception from the requirement to cover all FDA-approved MOUDs. However, each of the three States covered or reimbursed some form of buprenorphine or methadone in 2022.

[7] A diagnosis of opioid use disorder is based on specific criteria such as unsuccessful efforts to cut down or control use or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria. "Opioid use disorder" is preferred over other terms with similar definitions, "opioid abuse or dependence" or "opioid addiction." Accessed at https://www.cdc.gov/opioids/basics/terms.html#print on March 29, 2023.

[8] SAMHSA, *Treatment Improvement Protocol 63: Medications for Opioid Use Disorder*, updated 2021. Accessed at https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf on January 22, 2024.

[9] Ibid.

[10] SAMHSA, *Buprenorphine*, March 2023. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine on March 21, 2023.

[11] SAMHSA, *Methadone*, March 2023. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone on March 21, 2023.

[12] 42 CFR Part 8 was amended on February 2, 2024, with an effective date of April 2, 2024. See 89 Fed. Reg. 7528. Under the revised Section 8.12(i), patients can receive up to 28 days of take-home doses.

[13] SAMHSA, "Chapter 3C: Naltrexone," *Medications for opioid use disorder: for healthcare and addiction professionals, policymakers, patients, and families: Updated 2021, Treatment Improvement Protocol (TIP) Series, No. 63*, 2018. Accessed at https://www.ncbi.nlm.nih.gov/books/NBK574910/pdf/Bookshelf_NBK574910.pdf on January 23, 2024.

[14] SAMHSA, *Naltrexone*, November 2022. Accessed at https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone on November 22, 2022.

[15] BWNS includes data on each applicant's address, Drug Enforcement Agency (DEA) registration number, patient-limit level, provider specialty, and year of waiver approval. The database only contains contact information for office-based providers that consent to release their practice information.

[16] 70 Fed. Reg. 36338, 36339 (June 23, 2005).

[17] Waivered providers were limited to treating no more than 30 patients in the first year of prescribing, but could then apply for an increase to a 100-patient maximum after one year. See 21 U.S.C. § 823(g)(2)(B)(iii)(I)-(II). In subsequent years, a practitioner could treat up to 275 patients. See 42 CFR § 8.610.

[18] Section 1262 of the Consolidated Appropriations Act, 2023. Separately, the Act also introduced a requirement for all new and renewing DEA registrants to satisfy a one-time 8-hour training requirement related to treating and managing patients with opioid or other substance use disorders. Practitioners are required to check a box on their online DEA registration form—regardless of whether a registrant is completing their initial registration application or renewing their registration—affirming that they have completed the new training requirement. Section 1263 of the Consolidated Appropriations Act, 2023.

[19] See Endnote 12.

[20] 42 CFR § 8.12(f)(1), *Federal opioid treatment standards*.

[21] 42 CFR §§ 8.11-8.12. See also SAMHSA, *Certification of Opioid Treatment Programs (OTPs)*. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program# on April 04, 2024.

[22] Accreditation is a peer-review process that evaluates an opioid treatment program (OTP) against SAMHSA's opioid treatment standards and the accreditation standards of SAMHSA-approved accrediting bodies. The accreditation process includes onsite visits by specialists with experience in opioid treatment medications and related treatment activities. The purpose of site visits is to ensure that OTPs meet specific, nationally accepted standards for OTPs. SAMHSA, *Certification of Opioid Treatment Programs, OTP Accreditation*, March 2023. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program on March 29, 2023.

[23] The accreditation bodies for OTPs are the Commission on Accreditation of Rehabilitation Facilities, the Joint Commission, the National Commission on Correctional Health, the Council on Accreditation, the Missouri Department of Mental Health, and the Washington State Department of Health.

[24] An OTP may hold a provisional certification for up to one year as it is working toward becoming accredited. See SAMHSA, *Certification of Opioid Treatment Programs, OTP Accreditation*, March 2023. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/become-accredited-opioid-treatment-program on May 15, 2024. See also 42 CFR § 8.11(d).

[25] SAMHSA, "Opioid treatment programs in All: 1,995," *Opioid Treatment Program Directory*, January 2023. Accessed at https://dpt2.samhsa.gov/treatment/ on January 12, 2023.

[26] Section 2005 of the SUPPORT for Patients and Communities Act (Pub. L. 115-271) amended the SSA by adding Sections 1861(s)(2)(HH), 1861(s)(jjj), 1833(a)(1)(CC), and 1834(w) to establish a new benefit for opioid use disorder treatment services furnished by an opioid treatment program beginning on or after January 1, 2020. See also 42 CFR § 410.67. An opioid treatment program must be enrolled in Medicare to receive reimbursement for services provided to Medicare enrollees.

[27] As of January 1, 2020, under the OTP benefit, Medicare covers dispensing and administration of MOUD; substance use counseling; individual and group therapy; toxicology testing; intake activities; and periodic assessments. CMS, *Letter to OTP Program Sponsors and State Opioid Treatment Authorities*. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Downloads/OTP-Letter.pdf on February 9, 2023.

[28] 42 CFR § 410.67. As of January 1, 2020, CMS pays OTPs through bundled payments for opioid use disorder treatment services in an episode of care provided to patients with Medicare Part B. OTPs must enroll in the Medicare program in order to receive reimbursement when these services are provided to Medicare patients. CMS, *Opioid Treatment Programs*, February 2023. Accessed at https://www.cms.gov/Center/Provider-Type/Opioid-Treatment-Program-Center on February 10, 2023.

[29] Some patients enrolled in Medicare Advantage plans may have had OTP services covered as a supplemental benefit. CMS, *Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, Access to Medication-Assisted Treatment*, April 2016. Accessed at https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/announcement2017.pdf on February 22, 2023.

[30] CMS, *Medicare Prescription Drug Benefit Manual, Chapter 6 – Part D Drugs and Formulary Requirements, 10.8 – Drugs Used to Treat Opioid Dependence*. Accessed at https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf on April 27, 2023.

[31] Section 1006(b) of the 2018 SUPPORT for Patients and Communities Act (P.L. 115-271) expanded Medicaid coverage requirements in late 2020 by generally requiring State Medicaid programs to cover all forms of MOUD from October 2020 to September 2025. Section 201 of the Consolidated Appropriations Act, 2024, removed this sunset provision, making the expanded coverage permanent. Hawaii, South Dakota, and Wyoming were granted an exception from the requirement to cover all FDA-approved MOUDs. However, each of the three States covered or reimbursed some form of buprenorphine or methadone in 2022.

[32] Clemans-Cope, L., Lynch, V., Payton, M., & Aarons, J., "Medicaid professional fees for treatment of opioid use disorder varied widely across states and were substantially below fees paid by Medicare in 2021," *Substance Abuse Treatment, Prevention, and Policy*, 17(1), 2022, 49.

[33] Zuckerman, S., Skopec, L., & Epstein, M., *Medicaid Physician Fees after the ACA Primary Care Fee Bump*, Washington, DC: Urban Institute , 2017.

[34] Madden, E. F., Prevedel, S., Light, T., & Sulzer, S. H., "Intervention stigma toward medications for opioid use disorder: A systematic review," *Substance Use & Misuse*, 56(14), 2021, 2181-2201.

[35] Stone, E. M., Kennedy-Hendricks, A., Barry, C. L., Bachhuber, M. A., & McGinty, E. E., "The role of stigma in U.S. primary care physicians' treatment of opioid use disorder," *Drug and Alcohol Dependence*, 2021, 108627.

[36] OIG, *Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder* (OEI-12-17-00240) January 29, 2020. This review focused on office-based buprenorphine providers and did not assess access to opioid treatment programs.

[37] OIG, *Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries* (OEI-02-22-00390) September 13, 2022.

[38] OIG, *Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns* (OEI-BL-22-00260) September 25, 2023.

[39] HHS, *Report to Congress T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2020*, December 2022. Accessed at https://www.medicaid.gov/medicaid/data-systems/downloads/2020-sud-data-book.pdf on February 28, 2023.

[40] Our data analysis was limited to the 50 U.S. States and the District of Columbia because several of our data sources did not include complete data for any of the U.S. territories. Specifically, Transformed Medicaid Statistical Information System (T-MSIS) data for U.S. territories are limited to Puerto Rico and the U.S Virgin Islands; CDC/ATSDR Social Vulnerability Index (SVI) data are limited to Puerto Rico; and CDC mortality data do not include data for any of the U.S territories.

[41] We used 2022 Medicare and Medicaid claims data, including for both fee-for-service and managed care, to identify providers that prescribed or dispensed buprenorphine or methadone to at least one Medicare or Medicaid enrollee.

[42] Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A., "Oral naltrexone maintenance treatment for opioid dependence," *Cochrane Database of Systematic Reviews* (4), 2011.

[43] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M., "Comparative effectiveness of different treatment pathways for opioid use disorder," *JAMA Network Open*, 3(2), 2020, e1920622.

[44] We based the county descriptor "disproportionately few MOUD providers" on a quintile ranking of all counties' provider per 100,000 population ratio. We considered counties between the 40th and 60th percentiles (percentile ranges which

include the median) of the distribution as having "typical" or "average" rates. Therefore, counties below the 40th percentile (13.5 MOUD providers per 100,000 people) were considered to have disproportionately few MOUD providers.

[45] On the basis of the distribution of the county age-adjusted drug overdose mortality rate, we considered counties between the 40th and 60th percentiles (percentile ranges which include the median) of the distribution as having "typical" or "average" rates. Therefore, any counties with rates greater than those of the 60th percentile were classified as having a high indicator of drug overdose mortality and, subsequently, a high need for MOUD providers.

[46] CDC, Agency for Toxic Substances and Disease Registry (ATSDR), *CDC/ATSDR Social Vulnerability Index*. The CDC/ATSDR SVI uses 16 U.S. census variables (including socioeconomic status; household characteristics; housing and transportation availability; and other factors) to identify communities that are especially vulnerable to the negative impact of external stresses on human health, such as the opioid crisis.

[47] On the basis of the distribution of the county SVI rates, we considered counties between the 40th and 60th percentiles (percentile ranges that include the median) of the distribution as having "typical" or "average" rates. Therefore, any county with an SVI greater than the 60th percentile was classified as having high social vulnerability. Note that the CDC/ATSDR SVI denotes an SVI at or above the 90th percentile as "high." However, on the basis of additional analysis, we felt this threshold would underestimate the number of counties at greater risk during the opioid crisis due to higher than typical indicators of social vulnerability (including in regard to socioeconomic status; household characteristics; housing and transportation availability; and other factors). We therefore selected the 60th percentile (i.e., above average) as our threshold for high social vulnerability.

[48] We based the county descriptor "disproportionately few MOUD providers" on a quintile ranking of all counties' provider per 100,000 population ratio. We considered counties between the 40th and 60th percentiles (percentile ranges which include the median) of the distribution as having "typical" or "average" rates. Therefore, counties below the 40th percentile (13.5 MOUD providers per 100,000 people) were considered to have disproportionately few MOUD providers.

[49] Davis, Jeffery, *The X-Waiver is Gone… But There is a Lot More Work to do to Increase Access to Opioid Use Disorder Treatment*, 2023. Accessed at https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggsarticles/regs--eggs---march-23-2023 on June 24, 2024.

[50] We based the county descriptor "high-need" on a quintile ranking of each county's age-adjusted drug overdose mortality rate in 2021. We considered counties between the 40th and 60th percentiles (percentile ranges which include the median) of the distribution as having "typical" or "average" rates. Therefore, any counties with a mortality rate above the 60th percentile (29.76 deaths per 100,000 people) were considered to be in high need of MOUD providers.

[51] See Endnotes 46-47.

[52] See Endnotes 46-47.

[53] 2022 Medicaid prescriber data were not available for the State of Florida. We therefore excluded Florida from all Medicaid analyses in this report.

[54] We based the county descriptor "few Medicare MOUD providers" on a quintile ranking of all counties' provider per 100,000 population ratios. Counties below the 40th percentile (2.66 MOUD providers with Medicare claims for MOUD per 100,000 people) were considered to have few Medicare MOUD providers.

[55] We based the county descriptor "few Medicaid MOUD providers" on a quintile ranking of all counties' provider per 100,000 population ratios. Counties below the 40th percentile (3.38 MOUD providers with Medicaid claims for MOUD per 100,000 people) were considered to have few Medicaid MOUD providers.

[56] There were 1,995 opioid treatment programs at the end of calendar year 2022 compared to 137,744 office-based buprenorphine providers. Additionally, 78 percent of counties nationwide did not have opioid treatment programs compared to only 19 percent of counties that did not have any office-based buprenorphine providers.

[57] For the purposes of our study, we were able to identify a National Provider Identifier (NPI) for 1,732 out of the 1,995 opioid treatment programs (86.8 percent) listed in SAMHSA's OTP Directory.

[58] Less than six percent of the OTPs in our analysis had received only provisional certification from SAMHSA by the end of calendar year 2022 and, therefore, were not permitted to bill either Medicare or Medicaid for MOUD services during that year.

[59] For the purposes of our study, we were able to identify an NPI for 134,979 out of the 137,744 office-based buprenorphine providers (98 percent) listed in SAMHSA's Buprenorphine Waiver Notification System.

[60] Freed, M., Cubanski, J., & Neuman, T., *FAQs on Mental Health and Substance Use Disorder Coverage in Medicare*, KFF, 2023. Accessed at https://www.kff.org/mental-health/issue-brief/faqs-on-mental-health-and-substance-use-disorder-coverage-in-medicare/ on May 22, 2024.

[61] Andrews, C. M., Abraham, A. J., Grogan, C. M., Westlake, M. A., Pollack, H. A., & Friedmann, P. D., "Impact of Medicaid restrictions on availability of buprenorphine in addiction treatment programs," *American Journal of Public Health*, 109(3), 2019, 434-436.

[62] Andraka-Christou, B., & Capone, M. J., "A qualitative study comparing physician-reported barriers to treating addiction using buprenorphine and extended-release naltrexone in US office-based practices," *International Journal of Drug Policy*, 54, 2018, 9-17.

[63] GAO, *Opioid use disorder: barriers to Medicaid beneficiaries' access to treatment medications*, Report to Congressional Committees, 2020.

[64] Haffajee, R. L., Andraka-Christou, B., Attermann, J., Cupito, A., Buche, J., & Beck, A. J., "A mixed-method comparison of physician-reported beliefs about and barriers to treatment with medications for opioid use disorder," *Substance Abuse Treatment, Prevention, and Policy*, 15, 2020, 1-13.

[65] Jones, C. M., & McCance-Katz, E. F., "Characteristics and prescribing practices of clinicians recently waivered to prescribe buprenorphine for the treatment of opioid use disorder," *Addiction*, 114(3), 2019, 471-482.

[66] Clemans-Cope, L., Lynch, V., Payton, M., & Aarons, J., "Medicaid professional fees for treatment of opioid use disorder varied widely across states and were substantially below fees paid by Medicare in 2021," *Substance Abuse Treatment, Prevention, and Policy*, 17(1), 2022, 49.

[67] Zuckerman, S., Skopec, L., & Epstein, M., *Medicaid Physician Fees after the ACA Primary Care Fee Bump*, Washington, DC: Urban Institute, 2017.

[68] SAMHSA, *Opioid Treatment Program Directory*, February 2024. Accessed at https://dpt2.samhsa.gov/Treatment/directory.aspx on February 7, 2024.

[69] SAMHSA, *Buprenorphine Practitioner Locator*. The Consolidated Appropriations Act, 2023, eliminated the Buprenorphine Waiver Program and extended the ability to prescribe buprenorphine for the treatment of opioid use disorder to all practitioners with DEA Schedules II-V on their DEA Registration. Therefore, SAMHSA's Buprenorphine Practitioner Locator does not include all practitioners able to prescribe buprenorphine. In addition, the database only contains the contact information for previously waivered office-based buprenorphine providers that consent to release their practice information. Accessed at https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator on February 7, 2024.

[70] 88 Fed. Reg. 22120, 22158 (April 12, 2023).

[71] 84 Fed. Reg. 62568, 62648-50 (Nov. 15, 2019).

[72] 87 Fed. Reg. 69404, 69774 (Nov. 18, 2022).

[73] 88 Fed. Reg. 78818 (Nov. 16, 2023).

[74] 87 Fed. Reg. 69404, 69774 (Nov. 18, 2022).

[75] 89 Fed. Reg. 7528 (Feb. 2, 2024).

[76] 88 Fed. Reg. at 22330 (adding 42 CFR. § 422.112(b)(8)(i)).

[77] For calendar year 2025, CMS finalized 42 CFR 422.116(b) adding a facility-specialty type under Medicare Advantage plan network adequacy standards called "Outpatient Behavioral Health." This new facility-specialty type includes a range of

behavioral health providers under one category, including specialists such as marriage and family therapists; mental health counselors; opioid treatment programs; community mental health centers; addiction medicine physicians; and other providers that furnish addiction medicine and behavioral health counseling or therapy services in Medicare.

[78] Social Security Act, § 1947. CMS, *SHO# 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services*. Accessed at https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf on May 21, 2024.

[79] CMS, *CMCS Informational Bulletin: Opportunities for Improving Access to Mental Health and Substance Use Disorder Services for Medicaid and CHIP Enrollees Experiencing Homelessness*. Accessed at https://www.medicaid.gov/media/176621 on May 21, 2024.

[80] CMS, *Technical Assistance Resource: Overview of Substance Use Disorder Measures in the 2024 Child, Adult, and Health Home Core Sets*. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/downloads/factsheet-sud-adult-core-set.pdf on May 21, 2024.

[81] 89 Fed. Reg. 40542, 40871-40874 (May 10, 2024). In May 2024, CMS issued a final rule requiring that, by July 2026, States publish all fee-for-service Medicaid fee schedule payment rates; States must also publish a review of how rates for certain services, including substance use disorder services, compare with Medicare rates. CMS reasons that this requirement will provide States and CMS with the necessary information to evaluate if State payment rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available.

[82] 86 Fed. Reg. 22439 (April 28, 2021).

[83] OIG, *Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder* (OEI-02-20-00390) December 15, 2021.

[84] OIG, *Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns* (OEI-BL-22-00260) September 25, 2023.

[85] Section 1902(a)(30)(A) of the SSA provides CMS with the authority to oversee that States assure that Medicaid payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan, at least to the extent that such care and services are available to the general population in the geographic area.

[86] 89 Fed. Reg. 40542, 40871-40874 (May 10, 2024).

[87] OIG, *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.

[88] OIG, *Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder* (OEI-02-20-00390) December 15, 2021.

[89] Our data analysis is limited to the 50 U.S. States and the District of Columbia because complete data are not available for any of the U.S. territories. T-MSIS data for U.S. territories are limited to Puerto Rico and the U.S Virgin Islands; CDC/ATSDR SVI data are limited to Puerto Rico; and CDC mortality data do not include data for any of the U.S territories.

[90] Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A., "Oral naltrexone maintenance treatment for opioid dependence," *Cochrane Database of Systematic Reviews* (4), 2011.

[91] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M., "Comparative effectiveness of different treatment pathways for opioid use disorder," *JAMA Network Open*, 3(2), 2020, e1920622.

[92] On the basis of the distribution of the provider per 100,000 person rates, we considered counties between the 40th and 60th percentiles (percentile ranges which include the median) of the distribution as having "typical" or "average" rates. Therefore, any counties with a rate below the 40th percentile were classified as having few providers for their population.

[93] On the basis of the distribution of the county age-adjusted drug overdose mortality rate, we considered counties between the 40th and 60th percentiles (percentile ranges which include the median) of the distribution as having "typical" or "average"

rates. Therefore, any counties with rates greater than the 60th percentile were classified as having a high indicator of drug overdose mortality and, subsequently, a high need for MOUD providers.

[94] On the basis of the distribution of the county SVI rates, we considered counties between the 40th and 60th percentiles (percentile ranges that include the median) of the distribution as having "typical" or "average" rates. Therefore, any county with an SVI greater than that of the 60th percentile was classified as having high social vulnerability. Note that the CDC/ATSDR SVI denotes an SVI at or above the 90th percentile as "high." However, on the basis of additional analysis, we felt this threshold would underestimate the number of counties at greater risk during the opioid crisis due to higher than typical indicators of social vulnerability (including in regard to socioeconomic status; household characteristics; housing and transportation availability; and other factors). We therefore selected the 60th percentile (i.e., above average) as our threshold for high social vulnerability.