

Strategies for Expanding Access to Treatment for Opioid Use Disorder in High-Need Areas

This fact sheet provides background information and potential strategies to help states expand opioid use disorder (OUD) provider capacity for Medicaid beneficiaries and increase access to medications for opioid use disorder (MOUD) services in high-need areas.¹

Current Landscape

According to Centers for Disease Control and Prevention (CDC) data, approximately [79,000 deaths](#) in 2023 were attributed to opioid use. [Expanding access to MOUD](#), including methadone, buprenorphine, and naltrexone, can reduce the overdose mortality rate and support recovery. Despite [mandatory coverage](#), states face challenges in meeting the needs of all Medicaid beneficiaries with OUD.

[Many Medicaid beneficiaries with OUD still face limited access to treatment for OUD](#) due to provider shortages, geographical and transportational barriers to treatment centers, and patient- and provider-based stigma around OUD and its treatment. The following findings, based on [2022 data](#) from the U.S. Department of Health and Human Services, Office of Inspector General (OIG), highlight gaps in Medicaid access to treatment for OUD and MOUD:



Quick Start Checklist

Five key strategies that states can implement to help expand access to treatment for opioid use disorder (OUD) include:

- Leveraging managed care approaches;
- Supporting medications for opioid use disorder (MOUD) provider recruitment and workforce development initiatives;
- Supporting increased access to MOUD via telehealth;
- Increasing reimbursement rates; and
- Addressing provider-based stigma.

297

high-need counties had few or no MOUD providers serving Medicaid beneficiaries.²

38%

of office-based buprenorphine providers nationwide prescribed or administered buprenorphine to at least one Medicaid beneficiary.

1,035

counties nationwide (34%) did not have any MOUD providers that prescribed or administered buprenorphine or methadone to at least one Medicaid beneficiary.

As detailed below, states can use various strategies to increase access to treatment for OUD in high-need areas. For additional information and resources, see the “Additional Resources” box at the end of the document.

¹ For the purpose of this fact sheet, we use the definition of counties with high need for MOUD services used by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) in their report, which defines counties with a high need for MOUD services as those with an age-adjusted drug overdose mortality rate above the 60th percentile.

² OIG considered counties with a provider-to-population ratio below the 40th percentile to have disproportionately few MOUD providers.

Strategies and Innovations

States can use various Medicaid authorities and policy levers to increase access to treatment for OUD in high-need areas. Key strategies, such as leveraging managed care approaches, supporting MOUD provider recruitment and workforce development, expanding access to MOUD through telehealth, improving reimbursement rates, and addressing provider-based stigma, can be implemented through Medicaid authorities including state plan amendments (SPA) and section 1115 demonstrations, as well as state, local, and/or foundation-based grants and appropriations.



Leverage Managed Care Approaches

Under [42 Code of Federal Regulations \(CFR\) 438.68](#), states must ensure that managed care plans maintain provider networks sufficient to meet the needs of enrollees, including those requiring behavioral health services. States can [strengthen network adequacy](#) by incorporating metrics focused on access to treatment for OUD, such as geographic proximity to opioid treatment programs (OTP), wait time standards for MOUD initiation, or provider-to-enrollee ratios, into contracts and oversight processes. Additionally, [states can remove prior authorization \(PA\) requirements](#) and limit the ability of managed care plans to require PA for MOUD, which can help reduce administrative barriers to OUD treatment for providers and beneficiaries.

New Hampshire's managed care plan contracts stipulate SUD-specific network adequacy service access requirements, including requiring specific geographic access standards for mental health providers and enforcing additional provider network standards for OTPs and buprenorphine providers.



Support MOUD Provider Recruitment and Workforce Development Initiatives

States can expand MOUD provider capacity by using data to identify high-need areas and develop training initiatives. States can draw on Centers for Disease Control and Prevention ([CDC overdose mortality data](#)) and [CDC Agency for Toxic Substances and Disease Registry \(ATSDR\) Social Vulnerability Index data](#) to identify and prioritize counties with high OUD prevalence and limited provider availability.

States can leverage non-Medicaid grant funding and state appropriations to [train, recruit, and provide ongoing support to MOUD providers](#). Workforce development initiatives to help expand the MOUD workforce can include increased focus on behavioral health in medical schools, training stipends for students pursuing MOUD-related medical and nursing degrees, scholarships to train providers who prescribe MOUD, job-based provider training, continuing education on MOUD and SUD, and flexible practice models. [Incentives](#) targeting MOUD providers working in high-need

areas can include loan repayment (including state-based and federal loan repayment programs), student loan forgiveness programs, and tax credit programs.

States can use managed care contract language and Medicaid authorities like section 1115 demonstrations as well as state-level efforts like [legislative action and state agency policy changes](#) to encourage community-based providers to support MOUD initiation and treatment and expand the role of different types of providers, such as peers, in the MOUD workforce. States have also expanded access under section 1115 demonstrations by credentialing SUD provider networks.

Nebraska has supported the development of [MOUD-specific professional development opportunities and trainings](#) through the [Behavioral Health Education Center of Nebraska \(BHECN\)](#). These opportunities and trainings included a course on OUD treatment that resulted in the certification of 21 professionals who can prescribe buprenorphine. The initiative was authorized by state legislation and funded through a variety of state, federal, and foundation-based grants.



Support Increased Access to MOUD via Telehealth

Research shows that [at-home initiation of MOUD such as buprenorphine can be as effective as in-person care](#), telehealth can improve [abstinence and retention rates](#) compared to in-person treatment, and patients using telehealth for MOUD are [significantly more likely to continue treatment](#) compared to those using in-person treatment. Telehealth also serves as a [valuable way to deliver MOUD](#) due to its [opportunities to overcome the shortage of MOUD prescribers, stigma, and geographical barriers](#). States may consider reviewing available [Medicaid.gov resources](#) on telehealth to understand potential strategies to extend telehealth flexibilities for MOUD services under Medicaid, especially in counties with few or no in-person providers.

New Mexico encourages MOUD telehealth delivery through its section 1115 demonstration. The state disseminates U.S. Department of Health & Human Services guidance on MOUD prescribing via telehealth to all OTPs and incorporates telehealth-specific guidance into state-developed provider trainings.



Improve Payment and Reimbursement Rates

States can increase Medicaid reimbursement rates for MOUD services through Medicaid fee-for-service (FFS) payment rate adjustments and leveraging value-based payments. To ensure rates are sufficient to recruit and retain MOUD providers, states can consider [benchmarking Medicaid FFS payments against Medicare](#), conducting payment rate analyses and publishing findings, and establishing advisory groups to gather input from providers and stakeholders. States can also

leverage [value-based payment models](#) to incentivize MOUD administration and prescribing through the development of provider incentives for meeting benchmarks, following guidelines, and monitoring quality measures related to prescribing MOUD.



Address Stigma

[Provider-based stigma](#), including [prejudicial attitudes](#) towards MOUD and negative perceptions of patients with OUD, can lead to [lower willingness](#) among providers to prescribe MOUD and a higher likelihood among patients of [discontinuing MOUD](#). States can [develop initiatives](#) like education campaigns, trainings, and opportunities for provider champions to share their experiences to address provider-based stigma, encourage more primary care providers to offer MOUD treatment, and expand the Medicaid population's access to MOUD care.

Alabama developed trainings and printable resources to educate providers on the stigma around SUD. Alabama continues to offer provider trainings (i.e., [Stigma Summits](#)), in collaboration with the University of Alabama, to address SUD and OUD-based stigma. In 2024, Alabama hosted [seven Stigma Summits attended by more than 600 participants](#).

Additional Resources

The following resources include federal guidance, reports, and policy documents that provide information to support states in expanding OUD provider capacity and treatment for OUD for Medicaid beneficiaries.

- [Guidance on Provider Directory Requirements](#) (SHO #24-003): Details changes to provider directory data requirements and how states can remain in compliance with CMS regulations.
- [Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit](#) (2021 CMCS Toolkit): Offers actionable guidance for states and managed care plans to assess and strengthen behavioral health provider networks and network adequacy.
- [State Medicaid and CHIP Telehealth Toolkit](#) (2024 CMCS Toolkit): Provides information and details to help state Medicaid and CHIP agencies in their adoption and implementation of telehealth policies, including offering details on strategies for delivering behavioral health services via telehealth.
- [Parity Compliance Toolkit](#) (2017 CMCS Toolkit): Includes detailed technical guidance and tools to help states understand and perform the parity analysis for each of the requirements of the final parity rules.
- [Parity Implementation Roadmap](#) (2017 CMCS Toolkit): Provides recommendations on how to approach parity implementation and compliance from a planning and operational perspective.

- [Mandatory Medicaid State Plan Coverage of Medication Assisted Treatment](#) (SHO #20-005): Describes available opportunities for increasing treatment options for substance use disorders (SUD) generally.
- [Extension of Medicaid Coverage of Substance Use Disorder Treatment and Managed Care Medical Loss Ratio Provisions in the Consolidated Appropriations Act](#) (SMD #24-004): Outlines state responsibilities for extending Medicaid coverage of substance use disorder treatment and complying with managed care medical loss ratio provisions.
- [Medicaid Enterprise Systems Compliance and Reapproval Process for State Systems with Operational Costs Claimed at the 75 Percent Federal Match Rate](#) (May 24, 2023, CMCS Informational Bulletin): Clarifies requirements for states claiming enhanced federal financial participation for Medicaid Enterprise System (MES) operations, including CMS reapproval and compliance expectations.
- [Impacts on SUD Service Access in 17 Demonstration States](#) (May 2025): Shares early findings and insights about section 1115 SUD demonstrations.