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US payment policy for medications to treat opioid use disorder: landscape and opportunities

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Abstract

Offering patients medications for opioid use disorder (MOUD) is the standard of care for opioid use disorder (OUD), but an estimated 75%–90% of people with OUD who could benefit from MOUD do not receive medication. Payment policy, defined as public and private payers' approaches to covering and reimbursing providers for MOUD, is 1 contributor to this treatment gap. We conducted a policy analysis and qualitative interviews ($n = 21$) and surveys ($n = 31$) with US MOUD payment policy experts to characterize MOUD insurance coverage across major categories of US insurers and identify opportunities for reform and innovation. Traditional Medicare, Medicare Advantage, and Medicaid all provide coverage for at least 1 formulation of buprenorphine, naltrexone, and methadone for OUD. Private insurance coverage varies by carrier and by plan, with methadone most likely to be excluded. The experts interviewed cautioned against rigid reimbursement models that force patients into one-size-fits-all care and endorsed future development and adoption of value-based MOUD payment models. More than 70% of experts surveyed reported that Medicare, Medicaid, and private insurers should increase payment for office- and opioid treatment program–based MOUD. Validation of MOUD performance metrics is needed to support future value-based initiatives.

Key words: reimbursement; buprenorphine; methadone; opioid use disorder; payment policy; Medicare; Medicaid; insurance.

Introduction

Offering patients medications for opioid use disorder (MOUD) is the standard of care for opioid use disorder (OUD).[1] The MOUD approved by the US Food and Drug Administration (FDA) include the partial opioid agonist buprenorphine, the opioid agonist methadone, and the opioid antagonist naltrexone. Buprenorphine and naltrexone can be prescribed or administered (ie, in the case of injectable medication) by office-based clinicians, who historically had to obtain special training and federal permission to prescribe buprenorphine for OUD; this requirement was lifted in January 2023.[2] Under federal law, methadone can only be dispensed by opioid treatment programs (OTPs), which most patients attend daily to receive their dose, although more patients have received take-home doses since the COVID-19 pandemic.[3]

The United States has a major MOUD treatment gap: an estimated 75%–90% of people with OUD who could benefit from MOUD do not receive medication.[4,5] Among those who do receive MOUD, in 2019, 57% received MOUD from an office-based clinician (1% received naltrexone, 56% received buprenorphine) and 43% received MOUD from OTPs, which primarily deliver methadone.[4] Infrequent use of naltrexone is largely driven by unpleasant side effects and the requirement for a 7- to 10-day period of abstinence from opioids prior to the first dose, which is not feasible for many people experiencing OUD.[6] Current guidelines recommend that MOUD be offered without requiring counseling.[1,7] Many patients also benefit from accompanying counseling, care management and coordination, and social services like employment assistance.[1]

The MOUD treatment gap is driven by stigma,[8] MOUD provider shortages,[9] fragmentation of specialty substance use disorder care outside the general medical system,[10] and—the focus of this report—payment policy, defined as public and private payers' approaches to covering and reimbursing providers for MOUD. Historically, most MOUD were financed by federal grants and delivered in OTPs.[1,11] Limited insurance coverage of MOUD, low insurer payment rates to providers delivering MOUD, and insurance barriers such as high cost-sharing and prior authorization requirements have impeded broader MOUD care delivery.[1,10,12] Insurance coverage and payment of MOUD have evolved in response to the opioid overdose crisis in the United States, which took over 80 000 lives in 2022.[13]

The study objectives were to (1) describe MOUD payment policy across major categories of US insurers, including policies delineating MOUD coverage, reimbursement models, prior authorization, and cost-sharing requirements, and (2) characterize experts' perceptions of MOUD payment policy barriers to expanded use of MOUD and considerations for reform. To achieve these objectives, we conducted policy analysis, qualitative interviews, and surveys with US MOUD payment policy experts.

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Data and methods

Policy analysis

Our policy analysis characterized 4 domains of MOUD payment policy—coverage, provider reimbursement model (eg, fee-for-service, capitated payment), prior authorization, and cost-sharing requirements—across traditional Medicare, Medicare Advantage, Medicaid, and private insurance, the 4 largest insurer categories in the United States. No central repository of MOUD (or other health service) payment policies exists. These policies are, in some cases, proprietary, as is the case for many private insurance plans, or, when publicly available, are often dispersed across documents such as member handbooks, provider manuals, and prescription drug formularies, requiring extensive and systematic review to characterize policy presence and content. Our policy analysis reviewed and synthesized existing MOUD payment policy scans. These existing scans have focused on limited groups of insurers and policies (eg, prior authorization requirements in Medicaid managed care). No prior work has comprehensively summarized what is known about payment policies across major categories of US insurers. Our analysis filled this gap.

We conducted web searches to identify policy summaries (eg, Centers for Medicare and Medicaid Services [CMS] billing and payment guidance) and PubMed and Google Scholar searches to identify peer-reviewed literature delineating insurer coverage, prior authorization, and cost-sharing requirements for MOUD. Search terms are included in Appendix S1. Documents and articles were independently reviewed by 2 team members to identify the most recently available data for each type of insurance. Initial data extraction detailing each policy was performed using a standard abstraction tool (Appendix S2) by 1 study team member and verified by a second member. Data were summarized separately for office-based and OTP-based MOUD.

Interviews

We identified and recruited experts whose professional roles involved developing, implementing, or evaluating MOUD payment policy, including representatives from federal agencies, state agencies, national professional societies, advocacy groups, insurance companies, academic institutions, and health care delivery organizations. An initial list of 42 experts (see Appendix S3 for an overview of expert affiliations) was created based on recommendations from individuals involved in the NIDA Helping to End Addiction Long-term Initiative Data2Action network. Of these, 16 experts agreed to an interview (17 declined and 9 did not respond). This initial group of interviewees recommended another 5 experts who agreed to participate, for a total of 21 experts interviewed. The 21 interviewees (Table 1) included experts affiliated with federal agencies ($n = 3$); state agencies ($n = 6$); national professional societies ($n = 3$); advocacy groups ($n = 3$); a private insurer with plan options in the Medicaid managed care, Medicare Advantage, and individual and family and employer-sponsored health insurance markets ($n = 1$); academic institutions ($n = 4$); and a health care delivery organization ($n = 1$).

Interview recruitment was done via email. After obtaining oral consent, a single team member conducted interviews using a semi-structured guide designed to elicit experts' perceptions of MOUD coverage and payment (Appendix S4). The interview guide included 8 questions aiming to elicit experts' perceptions of MOUD payment policy barriers and solutions in 3 domains: insurance coverage, provider reimbursement, and other insurance payment policy issues experts viewed as influencing access to MOUD (eg, cost-sharing requirements).

Table 1. Professional affiliation of the 21 interviewees.

Interviewee professional affiliation	No. ($n = 21$)
Federal agency	3
State agency[a]	6
National professional societies	3
Advocacy groups	3
Insurance companies	1
Academic institutions	4
Health care delivery organization	1

[a]Interviewees from state agencies represented 6 different agencies (eg, Medicaid, Single State Agency [SSA]) in 4 different states from the Northeast, mid-Atlantic, South, and Southwest regions of the United States.

Interviews were conducted from April through July 2023 and median length was 45 minutes (22–68 minutes). Interview recruitment continued until at least 2 experts representing each of the groups above had completed an interview and no new themes emerged from interviews (ie, saturation). Interviews were audio-recorded, transcribed, and analyzed for key themes using a content analysis approach.[14]

Survey

The survey was designed to further assess experts' opinions on key themes identified in the qualitative analysis, a sequential type of mixed-method analysis (QUAL -> quan).[15] Specifically, the survey focused on quantifying experts' preferences for different MOUD reimbursement models discussed in the qualitative interviews. Policy experts recruited for the surveys included the 21 interview participants and 25 additional experts who were the lead authors of published reports, opinion pieces, scholarly articles, or other products (eg, blog posts) on MOUD coverage and payment policy between 2018 and 2022 (Appendix S3). The 17-item survey instrument (Appendix S5) was fielded online. Experts received 3 emails, each 1 week apart, inviting them to participate in the anonymous survey. A total of 31 MOUD policy experts responded to the survey, for a response rate of 67%. The survey was analyzed using descriptive statistics. The study was approved by the Weill Cornell Medical College Institutional Review Board.

Results

Policy analysis

Traditional Medicare, Medicare Advantage, and Medicaid all provide coverage for at least 1 formulation of buprenorphine, naltrexone, and methadone for OUD (Table 2).[16,17] Private insurance coverage varies by carrier and by plan, with methadone most likely to be excluded.[18] Medicare, Medicaid, and private insurers predominantly pay clinicians delivering MOUD using standard fee-for-service payment or a bundled payment that pays providers a monthly fee for delivering a "bundle" of services accompanying MOUD, such as treatment plan development, care coordination (eg, coordination of social services to address needs such as housing), and counseling.[17,19,20] Some state Medicaid programs use capitated payments where clinicians receive a per-patient monthly payment to deliver MOUD care—for example, in hub-and-spoke models where OTPs or other specialized addiction treatment clinics (hubs) and provider offices (spokes) receive capitated,

Table 2. Summary of medication for opioid use disorder (MOUD) coverage and payment design by insurance type.

	Traditional Medicare	Medicare Advantage (MA)	Medicaid	Private insurers
Covers all FDA-approved MOUD?[a]	Yes[17]	Yes[17]	Yes, but federal requirement to cover MOUD expires in September 2025[16]	Varies by plan; methadone is least likely to be covered[18]
Office-based MOUD				
Reimbursement model?	Bundled payment or unbundled fee-for-service.[17,19] Value-based payment is being tested through the Value in Opioid Use Disorder Treatment Demonstration.[24]	Bundled payment or unbundled fee-for-service[17,19]	Mostly unbundled fee-for-service. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) use prospective payment. Bundled, capitated, and value-based payment models are being used in some state Medicaid fee-for-service programs and managed care plans.[19]	Mostly unbundled fee-for-service.[19,20] Some insurers may be testing other models.
Prior authorization (PA) required?	Varies by Part D plan, product, and formulation. In 2019, 2% of formularies required PA for generic buprenorphine-naloxone and 37% required PA for generic buprenorphine.[26] Data not available for naltrexone.	Varies by plan, product, and formulation. In 2021, 15% of MA formularies required PA for any immediate-release buprenorphine product and 17% required PA for any extended-release buprenorphine. Data not available for naltrexone.[27]	Varies by state Medicaid fee-for-service program and managed care plans, product, and formulation. In 2022–2023, 37% of Medicaid fee-for-service programs in the 50 US states and Washington, D.C., with available data (see SAMHSA report for details on state data availability[28]) required PA for immediate-release buprenorphine; 24% required PA for extended-release injectable buprenorphine; 32% required PA for buprenorphine-naloxone; 11% required PA for oral naltrexone; and 15% required PA for extended-release injectable naltrexone.[28] Among Medicaid MCOs with available data in 39 states and D.C. in 2022–2023, 30% of MCOs required PA for immediate-release buprenorphine; 21% required PA for extended-release injectable buprenorphine; 15% required PA for buprenorphine-naloxone; 18% required PA for oral naltrexone; and 7% required PA for extended-release injectable naltrexone.[28] Fifteen states have laws prohibiting PA for MOUD in Medicaid.[29]	Varies by plan, product, and formulation. In 2021, 5% of small group and individual Marketplace plans and midsize and large-group non-Marketplace plan formularies required PA for any immediate-release buprenorphine product and 17% required PA for any extended-release buprenorphine product.[27] Data not available for naltrexone. Eleven states have laws that limit state-regulated commercial plans from imposing prior authorization on MOUD.[29]
Cost-sharing?	Medicare deductible applies; maximum of $505 in 2023.[30] Copayment and co-insurance requirements vary by Part D plan, product, and formulation.[31]	Medicare deductible applies; maximum of $505 in 2023.[30] Copayment and coinsurance requirements vary by plan, product, and formulation.[32,33]	Deductible, coinsurance, and copayment requirements vary by state.[34] Copayment requirements vary across Medicaid fee-for-service program and managed care plans, product, and formulation. In 2021 32% of state Medicaid fee-for-service programs required a co-pay for buprenorphine, 33% required a co-pay for oral naltrexone, and 32% required a co-pay for injectable naltrexone.[35] Estimates of the proportion of managed care plans requiring a co-pay are not available.	Deductibles, coinsurance, and copayment are all used, with variation by plan, product, and formulation.[36,37]

(*continued*)

Table 2. Continued

	Traditional Medicare	Medicare Advantage (MA)	Medicaid	Private insurers
Opioid treatment program (OTP)–based MOUD				
Reimbursement model?	Bundled payment.[17,19] Value-based payment is being tested through the Value in Opioid Use Disorder Treatment Demonstration.[24]	Bundled payment[17,19]	Mostly unbundled fee-for-service. Bundled, capitated, and value-based payment models are being used in some state Medicaid fee-for-service programs and managed care plans[19,38]	Mostly unbundled fee-for-service[18,39]
Prior authorization (PA) required?	No.	Varies by plan.[40] In 2022, 85% of MA beneficiaries were in plans requiring PA for OTP-based MOUD.[41]	Varies by state Medicaid fee-for-service program and managed care plans. In 2022–2023, 61% of Medicaid fee-for-service programs in the 50 U.S. states and D.C. with available data (see SAMHSA report for details on state data availability[28]) required PA for methadone.[28] Among Medicaid MCOs with available data in 39 states and D.C. in 2022–2023, 68% of Medicaid MCOs required PA for methadone.[28] Fifteen states have laws prohibiting PA for MOUD in Medicaid.[29]	Varies by plan.[39] Estimates of the proportion of private plans requiring PA are not available.
Cost-sharing?	Medicare Part B deductible applies for supplies and medications obtained through an OTP[42]; maximum of $226 in 2023.[43] No copayment or coinsurance.	Deductible, copayment, and coinsurance requirements vary by plan.[33] In 2022, 57% of MA beneficiaries were in plans requiring a co-pay for OTP-based MOUD.[41]	Varies by state Medicaid fee-for-service program and managed care plans. In 2021, 19% of state Medicaid fee-for-service programs required a co-pay for methadone.[35] Estimates of the proportion of managed care plans requiring a co-pay are not available.	Varies by plan.[18,39] Estimates of the proportion of private plans requiring a co-pay are not available.

Abbreviations: FDA, Food and Drug Administration; MCO, managed care organization; SAMHSA, Substance Abuse and Mental Health Services Administration.
The information in this table was summarized in October 2023 using the most recently available published data points.
[a]Indicates that at least 1 formulation of buprenorphine, naltrexone, and methadone for opioid use disorder is covered.

per-patient payments for coordinating MOUD treatment.[19,21-23] Medicare and some state Medicaid programs are testing value-based payment models tying clinician payment for MOUD care to performance metrics indicating high-quality care.[19,24,25]

Medicare, Medicaid, and private insurers all require cost-sharing and prior authorization for some types of MOUD. Cost-sharing includes deductibles, co-payments, and coinsurance. A deductible is the amount paid by a patient before insurance coverage begins. Co-payment is the set rate (eg, $10 per prescription or visit) that a patient pays after the deductible has been met. Coinsurance is similar, but instead of a set rate, patients pay a percentage of costs. Opioid treatment program–based MOUD in traditional Medicare have the fewest insurance barriers across the insurance types examined. In traditional Medicare, OTP-based MOUD are subject to the Part B deductible ($226 in 2023[43]) but have no prior authorization or co-payment requirements. Office-based MOUD are subject to the Part D deductible ($505 in 2023[30]) and may also have co-payment, coinsurance, and prior authorization requirements, with variation across Part D plans, products, and formulations. Medicare Advantage, Medicaid, and private insurance all use deductible, co-payment, coinsurance, and prior authorization requirements for office-based and OTP-based MOUD, with variation across carriers, plans, and MOUD products and formulations (and, in the case of Medicaid, states). In Medicaid, co-payment is the most common form of cost-sharing used, although many states use nominal co-payment amounts.[44,45] Under federal rules, the total amount of premiums and cost-sharing incurred by all individuals in a Medicaid household cannot exceed 5% of the family's monthly or quarterly income.[45,46] Across insurers, prior authorization requirements were more common for extended-release, relative to immediate-release, buprenorphine.[26,27,47,48] Extended-release buprenorphine comes in an injectable formulation requiring medical administration and is therefore more expensive than prescription immediate-release buprenorphine.[49]

The presence and timing of enactment of MOUD payment policies vary within categories of insurers. For example, prior authorization requirements for buprenorphine vary across the more than 280 Medicaid managed care organizations (MCOs) in the 41 states that use MCOs to provide Medicaid benefits.[47,50] While it was outside of the study scope to longitudinally track dates of MOUD payment policy enactment and repeal across insurance plans, our analysis suggests an overall trend toward greater MOUD coverage with fewer insurance restrictions. Beginning in 2020—but expiring in 2025—federal law requires state Medicaid programs to cover at least 1 formulation of each of the 3 FDA-approved MOUD.[16] Prior to this federal requirement, Medicaid programs in the 50 US states and Washington, D.C., covered buprenorphine and naltrexone, but 6 states did not cover methadone for OUD.[51]

In response to guidance issued by the US FDA in 2017[52] and the CMS in 2018,[53] the proportion of Medicare Part D prescription drug plans requiring prior authorization for generic buprenorphine-naloxone dropped from 71% in 2017 to 2% in 2019.[26] The proportion of prescription drug plan formularies covering at least 1 immediate-release buprenorphine product without prior authorization increased from 2017 to 2021 in Medicare Advantage (43% in 2017 to 85% in 2021), Medicaid (including both fee-for-service and managed care: 81% to 2021), and commercial plans including individual and small-group Marketplace and midsize and large-group plans (84% to 95%).[27] From 2015 to 2019, the number of US states with laws restricting the use of prior authorization for some or all classes and formulations of MOUD for insurers in the state increased from zero to 14 states and Washington, D.C.; of these, all 15 jurisdictions prohibited prior authorization in Medicaid and 11 also prohibited prior authorization for MOUD by other types of insurers in the state.[29]

Expert interviews and surveys

Box 1 integrates interview and survey findings.

MOUD coverage

Experts expressed concern that Medicaid coverage of MOUD may decrease when the federal SUPPORT Act provision[16] requiring state Medicaid programs to cover all 3 types of FDA-approved MOUD expires in 2025; 94% ($n = 29$ of 31 total) of experts surveyed agreed that the US Congress should make this requirement permanent. Expert interviewees highlighted the importance of MOUD care management, coordination of medical and social services, and peer support and viewed coverage of these services across insurers as inadequate. Of experts completing the survey, 67%, 67%, and 77% agreed that Medicare, Medicaid, and private insurers need to improve coverage of care management and coordination. Eighty percent of experts endorsed coverage of care management and coordination services delivered by peer support specialists.

MOUD reimbursement model

The experts interviewed noted that standard unbundled fee-for-service and bundled payments are the most common MOUD reimbursement models and discussed the pros and cons of MOUD reimbursement models for different settings. Experts discussed standard fee-for-service payments as working well for some practices and patients, particularly smaller practices and patients responding well to MOUD without accompanying services like counseling, care management, and coordinated social services. However, they also noted that the fee-for-service reimbursement model incentivizes delivery of a greater volume of services as opposed to high-value care and flagged that a fee-for-service model may incentivize providers to avoid sicker patients if the fees paid for time-intensive induction and stabilization phases of MOUD treatment—which can last longer for sicker patients—are not meaningfully higher than payments for the MOUD maintenance phase.

Experts viewed bundled payments as being most useful for large office-based practices and OTPs serving a high-volume of patients with OUD in need of comprehensive services. Experts cautioned against inflexible bundles requiring a rigid set of services not appropriate for every patient and noted that small practices may not have the necessary provider team (MOUD prescribers, care managers, counselors, etc) to deliver a full array of bundled services. Experts perceived capitated payments as the most flexible reimbursement model. Some interviewees mentioned hub-and-spoke models, described above, as a promising approach. While the flexibility of capitated payments may support innovation, experts noted that that, unless capitated payments are tied to performance, they create an incentive to skimp on care. Experts expressed enthusiasm for value-based payment models that tie payment to performance, consistently highlighting value-based models as a priority for future MOUD payment policy reform. However,

Box 1. Medication for opioid use disorder (MOUD) payment policy experts' perceptions of MOUD coverage and payment in the United States.

Theme 1: MOUD coverage

Interviews

The experts interviewed noted that most insurers now cover at least 1 formulation of all FDA-approved MOUD but perceived continued coverage barriers to comprehensive MOUD access by patients with opioid use disorder:

Incomplete MOUD coverage: Interviewees discussed that some private health insurers do not cover methadone for opioid use disorder and that Medicare, Medicaid, and private insurers typically do not cover all formulations of MOUD. Interviewees noted that more insurers cover immediate-release, relative to extended-release, buprenorphine. Interviewees also expressed concern that state Medicaid programs might reduce MOUD coverage when the federal SUPPORT Act provision requiring them to cover at least 1 formulation of FDA-approved MOUD expires in September 2025.

Care management, coordination, and peer support: Across insurers, the experts interviewed noted inadequate coverage of care management and coordination services as a barrier to MOUD delivery in both office-based and opioid treatment program settings. Interviewees highlighted the importance of covering coordination services to address social needs—for example, related to housing. Interviewees also highlighted a need for better coverage of peer support services, which might include care coordination or navigation delivered by peers as well as other services like health education and emotional support.

> *Illustrative quotes* "…in the Medicaid program, there is coverage of some buprenorphine products. Failure to cover all the buprenorphine products and formulations. You have some states that impose prior authorization requirements on one or more of the buprenorphine products. Again, that has been, as we all know, one of the primary barriers to accessing those medications." "So a lot of, for example, patient navigation, care management, peer support services, a lot of the other pieces that go into providing kind of holistic care and helping patients navigate the system that are not reimbursable by insurance or are not always reimbursable by insurance."

Survey

Permanent Medicaid MOUD coverage: 94% of experts surveyed agreed that the US Congress should make the federal SUPPORT Act requirement for state Medicaid programs to cover at least 1 formulation of all FDA-approved MOUD permanent.

Care management: 67%, 67%, and 77% of experts reported that Medicare, Medicaid, and private insurers need to improve coverage of care management related to office-based treatment with MOUD; 75%, 71%, and 64% of experts reported that these same types of insurers need to improve coverage of care management related to MOUD in opioid treatment programs. Eighty percent of experts agreed that care management and coordination services delivered by peer support specialists should be covered.

Theme 2: MOUD reimbursement model

Interviews

Interviewees discussed the need for flexible approaches to MOUD payment design rather than a one-size-fits-all approach given heterogeneity in MOUD delivery settings and patient populations.

Bundled payments: Experts viewed bundled payments, which pay providers a weekly or monthly fee or delivering a "bundle" of services, as a potentially promising approach to support a coordinated set of MOUD services. However, several experts interviewed cautioned against inflexible bundles that may not be appropriate for a given patient. Interviewees discussed unbundled fee-for-service payments as working well for some practices and patients, particularly smaller practices and patients responding well to MOUD medication without accompanying wraparound services like therapy and care management.

Capitated payments: Some interviewees mentioned capitated approaches, such as hub-and-spoke models where OTPs (hubs) and provider offices (spokes) both receive capitated per-patient payments for coordinated delivery of MOUD treatment, as a promising approach. Interviewees noted that capitation can give providers more flexibility than bundled payment or traditional unbundled fee-for-service models. However, interviewees expressed caution that capitated payments, if not tied to quality-of-care metrics, may create a financial incentive to skimp on care.

Value-based payment: Expert interviewees perceived value-based payment models tying payment to quality of care as important for MOUD in general and particularly for capitated payment models. However, experts noted that value-based payment is hampered by the limited number of validated MOUD performance metrics and limited capacity of many MOUD providers, particularly OTPs, to track and report performance data. Interviewees recommended starting small, for example with pay-for-reporting mechanisms to incentivize quality metric tracking and reporting and upside-risk-only models that reward providers for high performance but do not penalize them if metrics are not met.

Payment rates: The experts interviewed perceived payment rates for treatment with MOUD to be too low to adequately cover the cost of delivering services. Experts flagged this issue across types of insurers but highlighted it for Medicaid in particular.

> ***Illustrative quotes*** "So I think there are a couple of things. One is actual reimbursement rates for buprenorphine administration and for methadone dispensing, but then also reimbursing providers for delivering, case management, potentially thinking about bundled payments for all services related to MOUD, making sure that reimbursement rates are adequate." "When you're asking about financing, are you just talking about the medication when you're asking about medication for treatment of opioid use disorder or are you talking about comprehensive care that comes with the medications… it's kind of impossible to separate [MOUD from other wraparound services, like care management or therapy], especially as we're thinking of bundled payments or value-based care payments and those kind of models."

Survey

Reimbursement model: Relative to traditional unbundled fee-for-service payments, 61% of experts viewed bundled payment as preferable and 52% viewed capitated payment as preferable for large practices with a high-volume of patients with OUD; 55% and 45% viewed bundled or capitated payment as preferable for small practices. For OTPs, 67% of experts viewed bundled payment as preferable to unbundled fee-for-service and 48% viewed capitated payment as preferable. Seventy-one percent of experts reported that bundled payment and capitated models should incorporate pay-for-performance (ie, be value-based).

Payment rates: 90%, 83%, and 83% of experts reported that Medicare, Medicaid, and private insurers should increase payment for office-based MOUD, relative to current rates; 79%, 72%, and 90% reported that these insurers need to increase payment rates for delivery of MOUD in OTPs.

Theme 3: MOUD insurance restrictions[a]

The experts interviewed discussed insurance restrictions on coverage and payment, with a focus on prior authorization and cost-sharing, as a barrier to MOUD treatment access. Interviewees viewed buprenorphine prior authorization requirements tied to dose thresholds—in which prior authorization is required for prescriptions above a certain dose or is required more frequently at higher doses—as a problematic restriction on clinically appropriate dosing for some patients with opioid use disorder. Experts perceived co-payments for MOUD as impediments to MOUD for some patients. Experts highlighted that some Medicare Advantage and private plans require co-payment for each MOUD visit to an OTP, which could occur daily. Experts also discussed inadequate inclusion of MOUD providers in Medicare Advantage, Medicaid managed care, and private insurance plan networks as an impediment to MOUD access.

> ***Illustrative quotes*** "It [prior authorization] poses a unique and harmful and quite frankly deadly barrier for individuals who are seeking substance use disorder treatment. Because it delays care at the critical moment when an individual really needs and is willing to engage in treatment. And so it's really important, people who have substance use disorder that the moment when they're able to engage in treatment, they are able to. There's no barriers to care. And there's really no medical reason for prior authorization." "But I will tell you that I think depending on the insurance carrier that they don't always understand OTP services and I know in one instance, particularly– so if you have a co-pay and the private insurance company was interpreting every daily visit for medication…as an outpatient visit. So the patient in order to utilize their insurance would have to pay a $25 co-pay every day but if they paid cash out of pocket, they only had to pay about $15." "I think, in terms of accessing OTP services, you frequently have problems with providers not being included in networks."
> Abbreviations: FDA, Food and Drug Administration: OTP, opioid treatment program.Interviews were conducted with 21 US MOUD payment policy experts. Surveys were conducted with 31 US payment policy experts, including experts who participated in interviews and additional experts not involved in the interview phase of the study. [a]The survey did not include items about MOUD insurance restrictions. All experts interviewed mentioned these restrictions as barriers to care; given high consistency, we opted to not further explore attitudes via the survey.

experts highlighted barriers, including lack of validated performance metrics linked to improved patient outcomes and limited capacity of many MOUD providers to track performance data.

For large office-based practices, small office-based practices, and OTPs, 61%, 55%, and 67%, respectively, of experts surveyed viewed bundled payments as preferable relative to standard fee-for-service. For these same settings, 52%, 45%, and 48% of experts viewed capitated payment as preferable to fee-for-service. In interviews, experts consistently discussed low payment rates as a barrier to MOUD delivery. More than 70% of experts surveyed reported that Medicare, Medicaid, and private insurers should increase payment for office- and OTP-based MOUD. Seventy-one percent of experts surveyed reported that bundled payment and capitated reimbursement models should incorporate pay-for-performance (ie, be value-based). Of these, 55% recommended use of engagement-in-care measures (eg, treatment retention), 13.6% recommended process-of-care measures (eg, medication induction), 9.1% recommended patient-reported outcome measures (eg,

satisfaction with care), and 23% recommended a mix of these. No experts surveyed recommended the use of health outcomes (eg, overdose) measures.

Insurance restrictions

Experts viewed prior authorization, co-payments, and lack of inclusion of MOUD providers in insurance networks as barriers to MOUD treatment access. Multiple experts highlighted that prior authorization for buprenorphine is often tied to clinically meaningless dose thresholds, with higher doses more likely to require authorization. Experts also emphasized that some Medicare Advantage and private insurance plans using traditional, unbundled fee-for-service payment require co-payment for each visit to an OTP, which could occur daily.

Discussion

Experts lacked consensus on a single "best" MOUD reimbursement model and cautioned against rigid approaches that force patients into one-size-fits-all care. When asked about priorities for MOUD payment policy reform and innovation, experts expressed enthusiasm for the idea of value-based MOUD payment models that tie payment to performance indicators of high-value care, defined as care that is safe, timely, effective, efficient, equitable, and patient-centered.[54] They noted that value-based approaches—which can be used in standard fee-for-service, bundled payment, or capitated reimbursement models—can overcome the standard fee-for-service model's incentive to maximize volume of services, facilitate inclusion of high-value services in the payment bundles, and prevent care-skimping in capitated payment models where providers receive a lump sum per patient to deliver MOUD. However, experts did not view value-based MOUD payment models as ready for widespread use due to a dearth of validated performance metrics associated with improved patient outcomes and a lack of provider capacity to track and report data.

These findings highlight the importance of ongoing efforts to develop MOUD performance indicators associated with improved patient outcomes[55-57] and demonstration programs testing value-based MOUD payment models. For example, the Medicare Value in Opioid Use Disorder Treatment Demonstration Program includes performance-based incentives tied to MOUD treatment initiation and retention.[24] To build capacity for value-based payment in MOUD, policymakers should consider starting with pay-to-report and upside-risk-only shared savings models, which can help MOUD providers build the health information technology (IT) infrastructure necessary to monitor and report performance metrics and minimize their financial risk.[58] The majority of experts surveyed endorsed increased payment to providers delivering MOUD across insurers. Payment rates are lowest in Medicaid, which is the single largest insurer of people with OUD in the United States.[38]

Experts consistently viewed MOUD prior authorization, cost-sharing, and narrow MOUD provider networks as impediments to MOUD access by patients. Research demonstrates that prior authorization and cost-sharing are associated with reduced MOUD utilization.[36,59] The presence of these insurance barriers does not necessarily signal stigma toward MOUD; most insurance plans require cost-sharing for most services as a cost-containment strategy, with exceptions such as annual visits and some cancer screenings.[60] Given the scale of the opioid overdose crisis in the United States, proponents of lifting these restrictions assert that the increased MOUD access is worth the heightened health care spending.[61,62] Whether lifting prior authorization requirements improves MOUD access may depend on if other less common insurance restrictions, such as quantity limits, remain in place.[63] Across all insurers, the prevalence of prior authorization requirements for MOUD has declined in recent years.[27] The proportion of state Medicaid programs requiring co-payments for MOUD also declined from 2017 to 2021.[26,35,48] The experts interviewed in this study noted that OTPs and office-based MOUD prescribers are underrepresented in many Medicare Advantage, Medicaid managed care, and private insurance networks. A recent study found that substance use disorder–specific network adequacy criteria for Medicaid managed care plans improved buprenorphine prescriber networks.[64]

In addition to the foundational coverage and reimbursement model issues focused on in this study, insurers and federal regulators are grappling with reimbursement models for telehealth MOUD and take-home methadone. COVID-19 pandemic response policies enhanced telehealth coverage and gave OTPs expanded ability to provide patients with up to 28 take-home doses. For telehealth, ongoing policy debates are focused on whether to continue to allow buprenorphine induction via telehealth without an in-person visit—an allowance supported by many experts and advocates[65-68]—and whether to pay providers the same amount regardless of whether a MOUD-related service is delivered via telehealth or in-person.[69] In Medicare and Medicaid, OTPs receive a lower payment when patients have take-home methadone doses, creating a financial incentive for OTPs to require in-person dosing.[17-19] A growing movement to "free methadone" advocates for office-based or pharmacy-based delivery of methadone to treat OUD, as is done in multiple other countries.[70-72] If US Congress makes this policy proposal a reality, insurers will need to design payment policies for office-based methadone treatment of OUD.

The complexities of the MOUD payment policy landscape, and the fact that we are unable to comprehensively delineate that landscape due to data limitations, are key findings in their own right. MOUD payment policies vary considerably within, as well as across, categories of US insurers, including public insurance programs. MOUD payment policies in Medicare and Medicaid vary within the 800 Medicare Part D plans,[73] nearly 4000 Medicare Advantage plans,[74] and over 280 Medicaid MCOs[75] providing Medicare and Medicaid benefits in 2023. Limited access to MOUD payment policy data impedes comprehensive understanding of this complex landscape. The policy scans summarized in our analysis obtained policy data from a variety of sources, such as member handbooks and formularies, surveys of insurers, and companies that compile insurance data that researchers or other parties can purchase and use under a data use agreement.[26-28,35,47,48]

Our analysis did not include review of MOUD payment rates. With the exception of traditional Medicare, which publishes its physician fee schedule,[76] the negotiated amount that insurers pay physicians to deliver MOUD and other health care services is not transparent. Fee-for-service Medicaid program fee schedules are publicly available but list base payment rates that do not reflect commonly used supplemental payments,[77] and these fee-for-service rates are not relevant for clinicians caring for the 72% of Medicaid beneficiaries

enrolled in Medicaid managed care.[75] As of July 2022, all commercial health insurance plans are required by federal law to publicly disclose in-network negotiated payment rates.[78] These data must be downloaded from the websites of individual insurers or purchased from companies that have compiled the publicly available data into a more usable format; to date, no studies have used these data to examine MOUD payment rates.[79,80] Additional efforts to enhance the transparency of payment data are needed comprehensively characterize the MOUD payment policy landscape and to answer the important questions of whether and how provider reimbursement rates for MOUD services vary across insurers.

Limitations

Interviews and surveys were conducted with a convenience sample of MOUD payment policy experts and may have been subject to response biases due to self-selection of experts willing to participate. The convenience sample included experts with various affiliations, including state and federal agencies, insurers, and academic institutions, in order to capture a range of perspectives. Due to sample-size limitations we could not compare interview and survey results across subgroups. To mitigate researchers' biases in interpretation of results, we used a common interview guide and structured coding process. To encourage survey response, the survey was anonymous, precluding linkage of responses to experts' identities. For the same reason, professional affiliations, which could be identifying, were not captured. As a result, we cannot characterize the affiliations of survey respondents or determine overlap between the survey and interview samples. Survey items did not distinguish between traditional Medicare and Medicare Advantage. The interview and survey samples included MOUD payment policy experts and our study did not capture the perspectives of patients or providers. This study focused on insurance payment policy for MOUD. Analysis of the large federal grant programs[81,82] that MOUD providers use to supplement insurance payments and pay for treatment of the uninsured was outside the scope of this project.

Conclusion

MOUD payment design varies across major US insurers. Flexibility in design is needed to support care across settings and patient populations. Validating performance metrics and building MOUD providers' capacity to track and report performance data are key steps toward implementing value-based payment.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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