



Policy Brief
September 2026

PROJECT FOR REDUCING INEFFECTIVE MEDICAID EXPENDITURES

Residential Treatment for Opioid Use Disorder Without Follow-Up Medication

Medication for opioid use disorder (MOUD), including methadone, buprenorphine, and naltrexone, is recommended by clinical guidelines as the first-line treatment of opioid use disorder. Despite recommendations, previous studies have identified a lack of follow-up MOUD after discharge from residential treatment as a significant issue, potentially leading to relapse, poor outcomes, and repeated, ineffective use of high-intensity treatment. In an analysis of Medicaid data from 2024, we estimated that approximately half (49.1%) of residential treatment episodes for opioid use disorder had no evidence of MOUD receipt within 30 days after discharge. These episodes amounted to \$353.7 million nationally (state and federal share), with significant state-by-state variation. We found multiple policy approaches to increasing access to MOUD after residential treatment, along with a potential role for increasing oversight of existing policies. From this brief, state Medicaid program administrators can determine if residential treatment without follow-up MOUD is an issue in their state and identify potential policy solutions.

BACKGROUND

Substance use disorder (SUD) treatment in the US was historically focused on residential and inpatient treatment models.¹ Since the 1980s, the SUD treatment landscape has been shifting toward an increased emphasis on outpatient care.¹ Currently, residential treatment is considered part of the continuum of care, most appropriate for patients with more severe impairments.²

One of the historical limitations of residential treatment programs is a lack of access to medication for opioid use disorder (MOUD) during and after treatment.³⁻⁵ This is due to a variety of factors, such as program orientation toward non-medication (i.e., “abstinence-based”) treatment, stigma, lack of qualified MOUD providers, and financing, among other barriers.⁶ Lack of access to MOUD represents a significant gap in care, as MOUD is a well-established first-line treatment with benefits that include reductions in drug use, risk of HIV and hepatitis C virus infection, and overdose mortality.^{7,8} Further, treatment without MOUD is associated with loss of opioid tolerance and high rates of relapse,⁹ which can increase the risk of overdose and lead to repeated use of treatment services without patient improvement.

In 2015, the Centers for Medicare & Medicaid Services created a Section 1115 SUD Demonstration Waiver opportunity to enable state Medicaid programs to develop program improvements in SUD treatment access and quality.¹⁰ Previously, due to the Institutions for Mental Diseases Exclusion, state Medicaid programs were generally prohibited from reimbursing residential treatment programs with more than 16 beds.¹¹ As part of facilitating access to the entire continuum of SUD care, the Section 1115 waiver allows payment for residential treatment in previously excluded programs, with the requirement that medication treatments be available.¹² As of July 2026, 38 states had received approval for Section 1115 SUD waivers and 3 states had waiver applications pending.¹³

In a previous study of Medicaid members in 10 states from 2018 and 2019 (i.e., around the time several states were implementing Section 1115 SUD waivers), 63.8% of episodes of residential treatment did not have evidence of MOUD receipt within 30 days after discharge.⁴ Available evidence suggests that full implementation of Section 1115 SUD waivers has increased access to MOUD in residential treatment settings since that time^{6,14}; however, this has not necessarily translated into increased follow-up MOUD after discharge. For example, in one state, increases in MOUD use after residential treatment appeared to be time-limited.¹⁵ In a national study of Medicaid members, receipt of MOUD 5 months after residential treatment increased by only 4.4 percentage points from 2017 to 2021; however, changes were similar between states with a Section 1115 SUD waiver and states without one.¹⁴ In other words, receipt of evidence-based MOUD after discharge from residential treatment likely remains an issue for Medicaid-insured patients.

Given the limited use of MOUD following residential treatment, and evidence that non-medication treatment is less effective than MOUD,⁹ we selected this service to review in the Project for Reducing Ineffective Medicaid Expenditures (PRIME). The purpose of PRIME is to identify Medicaid-covered

services that may warrant coverage limitation due to limited or no demonstrated benefit relative to harms. For this topic, we estimated the occurrence of residential treatment without follow-up MOUD and quantified the expenditures associated with such treatment.

MEDICAID DATA ANALYSIS

To estimate the use of follow-up MOUD after residential opioid use disorder (OUD) treatment, we analyzed Transformed Medicaid Statistical Information System (T-MSIS) data for 50 states and the District of Columbia for 2024, the most recent year available from the Centers for Medicare & Medicaid Services.

For each state, we used fully adjudicated paid fee-for-service (FFS) claims and managed care encounters to identify episodes of residential OUD treatment among members age 18 years old or older. We defined an episode of residential OUD treatment as at least 3 days of SUD treatment at any level of residential (non-hospital) care, with a primary or secondary diagnosis code of OUD (F11.*). We included multiple episodes per member if they were separated by at least 30 days. Because claims submission for residential SUD treatment can vary significantly by state, we manually reviewed state behavioral health provider manuals, fee schedules, and other publicly available policy documents to determine state-specific coding policies.

From this manual review and through T-MSIS data, we were able to identify residential OUD treatment episodes in 35 states and the District of Columbia. For the other 15 states, we could not reliably identify residential OUD treatment episodes due to one or more of the following factors: 1) an inability to accurately identify state-specific residential SUD treatment coding methodology, potentially due to lack of coverage; 2) lack of access to residential SUD treatment claims data in the long-term care file of T-MSIS; or 3) missing data elements in the T-MSIS data that prevented us from properly identifying residential SUD treatment claims. Even for states for which we could identify residential OUD treatment episodes, we may not have identified all episodes covered by Medicaid due to coding or data availability issues.

To determine whether members received follow-up MOUD, we identified claims for methadone (medical claims only for methadone received through an opioid treatment program), buprenorphine (medical or pharmacy claims), and naltrexone (medical or pharmacy claims) within 30 days after the last day of residential OUD treatment. We estimated expenditures for residential treatment using state fee schedule amounts, where available.

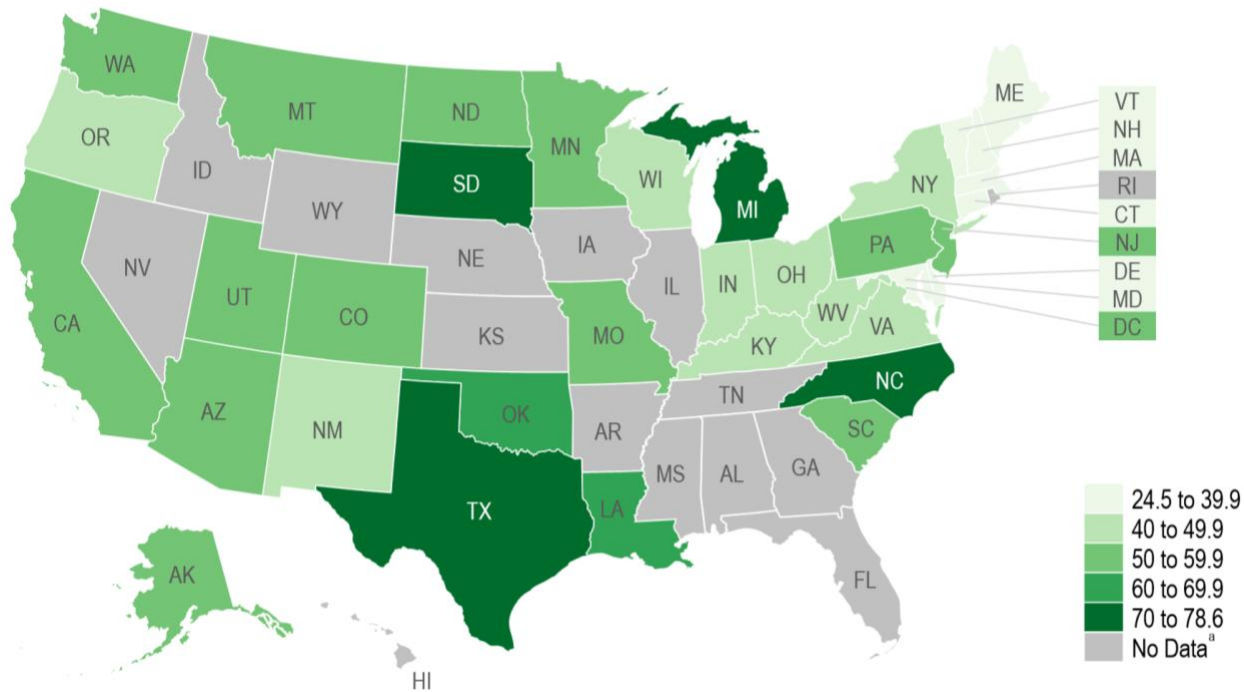
Results

Across the 35 states and the District of Columbia where analysis was possible, we identified 125,207 episodes of residential OUD treatment among 106,956 members. Of those episodes, 49.1% did not have follow-up MOUD within 30 days after discharge, ranging from 24.5% to 78.6% by state

(Figure 1). We estimated expenditures on residential treatment without follow-up MOUD to be \$353.7 million, with significant state-by-state variation. Full results are available in Appendix Table A1.

FIGURE 1

Percentage of Residential OUD Treatment Episodes Without Follow-Up MOUD Within 30 Days, by State, 2024



Note. ^a Data not available.

Abbreviations. MOUD: medication for opioid use disorder; OUD: opioid use disorder.

STATE POLICY ACTIONS

Compared with a study of Medicaid members from 2018 and 2019,⁴ our findings suggest there has been improvement in receipt of MOUD within 30 days after discharge from residential treatment. While there were differences across states, we found 49.1% of residential treatment episodes did not have follow-up MOUD within 30 days after discharge in 2024, compared with 63.8% in the previous study.⁴

One potential contributor to this change is the increased provision of MOUD during residential treatment, which has been a significant focus of state policy making in recent years. A 2022 study reviewed Section 1115 SUD waiver applications and state regulations to identify policy strategies states have used to expand access to MOUD in residential treatment settings¹⁶:

- **18 states** implemented regulations including patient rights to receive MOUD in residential settings (11 states), requiring access to MOUD in the program or at an outside location (8 states), and other situation-specific regulations (12 states)
- At least **25 states** required residential treatment programs to offer MOUD on-site or facilitate access off-site under their Section 1115 SUD waivers
- **40 states** required MOUD in residential treatment settings, either in state regulations, the Section 1115 SUD waiver, or both

In a subsequent 2025 study, researchers analyzed 27 Section 1115 SUD waiver applications and found that states varied in how they enforced the requirement that residential treatment settings provide access to MOUD.¹⁷ They found, “[s]ome states included additional requirements for facilitating off-site MOUD access (e.g., specifying the maximum mileage from the residential facility and providing care coordination)” and “[a] subset of states indicated an enforcement mechanism such as state audits.”¹⁷ An evaluation of Section 1115 SUD waiver implementation commissioned by the Centers for Medicare & Medicaid Services identified several states’ auditing and tracking policies, including¹⁸:

- **New Hampshire** developed an audit tool for managed care organizations to assess compliance
- **New Mexico** implemented site visits to verify provision of MOUD
- **Vermont** used claims data and weekly informal conversations about MOUD held with medical directors of residential programs

STATE CONSIDERATIONS

Even though most states have requirements for MOUD access in residential treatment settings, we found significant gaps in receipt of MOUD after discharge in Medicaid. Our findings, paired with recent state policy actions, provide options for state Medicaid administrators, including:

- For states without a Section 1115 SUD waiver, consider implementing or strengthening state regulations requiring access to MOUD in residential treatment settings
- For states with a Section 1115 SUD waiver or state regulations requiring access to MOUD in residential treatment settings, consider establishing or increasing oversight and enforcement of requirements, where possible
- While we did not identify any states limiting coverage for residential OUD treatment without follow-up MOUD, consider tying payment for residential treatment to receipt of MOUD after discharge (e.g., through performance-based payment arrangements)

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APPENDIX A: RESULTS**TABLE A1****Episodes of Residential Treatment for Opioid Use Disorder Without Follow-Up Medication for Opioid Use Disorder in 35 State Medicaid Programs and the District of Columbia, 2024**

State	Number of Episodes of Residential Opioid Use Disorder Treatment	Episodes Without Follow-Up Medication for Opioid Use Disorder Within 30 Days, %	Estimated Expenditures for Residential Treatment Without Follow Up Medication for Opioid Use Disorder Within 30 Days, \$
US	125,207	49.1%	\$353,742,272
AK	674	57.6%	\$8,719,837
AL	—	—	—
AR	—	—	—
AZ	6,701	50.6%	\$23,030,260
CA	6,921	55.0%	\$38,125,451
CO	1,699	51.5%	\$6,898,669
CT	3,241	36.2%	\$6,470,528
DC	67	50.7%	\$106,396
DE	932	35.7%	\$4,087,687
FL	—	—	—
GA	—	—	—
HI	—	—	—
IA	—	—	—
ID	—	—	—
IL	—	—	—
IN	4,207	42.6%	\$19,359,788
KS	—	—	—
KY	6,940	44.7%	\$19,106,591
LA	5,687	60.8%	\$3,904,929
MA	4,238	34.9%	\$20,195,603
MD	7,792	37.5%	\$21,335,277
ME	1,073	39.3%	\$1,668,033
MI	4,143	78.6%	\$11,306,925
MN	2,129	55.0%	\$3,882,971
MO	1,342	55.2%	\$3,710,247
MS	—	—	—
MT	407	51.1%	\$1,511,013

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State	Number of Episodes of Residential Opioid Use Disorder Treatment	Episodes Without Follow-Up Medication for Opioid Use Disorder Within 30 Days, %	Estimated Expenditures for Residential Treatment Without Follow Up Medication for Opioid Use Disorder Within 30 Days, \$
NC	273	70.3%	\$417,809
ND	74	56.8	\$446,942
NE	—	—	—
NH	1,179	34.8%	\$1,777,709
NJ	6,053	55.6%	\$19,280,029
NM	913	48.5%	\$3,384,359
NV	—	—	—
NY	2,939	40.5%	\$25,127,918
OH	13,988	46.7%	\$33,572,195
OK	1,015	69.9%	\$2,607,898
OR	4,252	41.5%	\$12,490,249
PA	16,686	53.5%	\$60,426
RI	—	—	—
SC	244	53.7%	\$655,931
SD	82	72.0%	\$386,450
TN	—	—	—
TX	218	77.5%	\$237,501
UT	1,407	53.9%	\$7,982,230
VA	4,237	43.5%	\$15,239,569
VT	388	24.5%	\$7,047,653
WA	6,708	50.5%	\$10,400,687
WI	1,064	50.0%	\$3,468,472
WV	5,294	45.5%	\$15,738,043
WY	—	—	—

Source. Center analysis of Medicaid claims and encounter data from the Transformed Medicaid Statistical Information System (T-MSIS) maintained by the Centers for Medicare & Medicaid Services for calendar year 2024.

Note. “—” indicates that we believed we could not reliably identify residential OUD treatment episodes due to one or more of the following factors: 1) an inability to identify state-specific coding methodology; 2) placement of the claim data in the long-term service file, to which we did not have access; or 3) T-MSIS data did not contain all necessary data elements to properly identify residential OUD claims.

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