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Medicaid Expansion and Implementation of Medication for Opioid Use Disorder Treatment Planning in U.S. Publicly Funded Specialty Treatment Systems

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Abstract

Objective:
Medications for opioid use disorder (MOUD) reduce overdose mortality; however, implementation within publicly funded specialty treatment systems remains uneven. Evidence is limited regarding whether Medicaid expansion was associated with documented MOUD planning in these systems.

Methods:
This retrospective study used U.S. Treatment Episode Data Set–Admissions (TEDS-A) records from 2006–2023, including more than 10 million opioid-related admissions. An event-study difference-in-differences model with state and year fixed effects estimated changes in documented MOUD planning across pre- and post-expansion periods. Models adjusted for demographic and clinical characteristics for outcome, planned MOUD at admission.

Results:
Overall, 28.7% of opioid-related admissions included a MOUD plan. Medicaid expansion was associated with increased odds of MOUD planning during the first two years following implementation (Year 1: aOR=1.58, 95% CI=1.14–2.19; Year 2: aOR=1.59, 95% CI=1.19–2.12), with no evidence of differential pre-expansion trends. Individuals experiencing homelessness, those referred through the criminal justice system, and those with co-occurring conditions had lower odds of MOUD planning.

Conclusions:
Medicaid expansion was associated with short-term increases in MOUD planning, but effects were not sustained. Overall implementation remained limited, and differences persisted among vulnerable populations, suggesting that insurance expansion alone may be insufficient to ensure equitable delivery of evidence-based opioid treatment.

1.0. Introduction

The age-adjusted rate of drug overdose deaths in the United States declined by 4.0% from 2022 to 2023; however, overdose mortality remains at historically elevated levels [1]. Opioids—particularly synthetic opioids such as illicitly manufactured fentanyl—were involved in approximately three-quarters of overdose deaths in 2023 [2]. In 2022, an estimated 6.1 million individuals aged 12 years or older had an opioid use disorder (OUD), yet only a minority received medications for opioid use disorder (MOUD) [3]. MOUD—including methadone, buprenorphine, and extended-release naltrexone—is the established standard of care for OUD and is associated with substantial reductions in opioid use and overdose mortality [4]. Although clinical guidelines recommend MOUD as a standard component of care for opioid use disorder [5], barriers to implementation remain within publicly funded treatment systems.

Despite the demonstrated effectiveness of MOUD, access to evidence-based treatment remains uneven across populations and geographic areas. Studies have documented variation in MOUD utilization by demographic and geographic characteristics, with lower treatment rates reported among individuals who

are female, Black, or living in non-metropolitan areas [4, 6–12]. Recent federal initiatives have sought to expand access to evidence-based treatment through reductions in regulatory barriers and efforts to increase treatment capacity [13, 14]. Despite ongoing efforts to expand access to evidence-based opioid treatment, important questions remain regarding whether major health financing reforms translated into changes in documented MOUD planning within publicly funded treatment systems.

Medicaid is the largest payer of behavioral health services in the United States and plays a central role in financing treatment for substance use disorders (SUDs). Following implementation of the Affordable Care Act (ACA), Medicaid expansion substantially increased insurance coverage among low-income adults, including individuals with behavioral health conditions [15, 16]. Multiple studies have documented increases in SUD treatment utilization in expansion states relative to non-expansion states. Multiple studies have documented increases in SUD treatment utilization in expansion states relative to non-expansion states [7, 17]. Evidence further suggests that Medicaid expansion was associated with increased use of MOUD, particularly buprenorphine [18, 19]. However, much of the existing literature has focused on insurance coverage, treatment utilization, prescription claims, or facility-level measures of MOUD availability, providing limited insight into implementation of documented MOUD treatment planning within publicly funded specialty treatment systems. This distinction is important because publicly funded treatment programs administered by Single State Agencies (SSAs) operate at the intersection of Medicaid reimbursement and federal block grant financing. Even in expansion states, Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds continue to support uninsured and underinsured individuals and remain a core component of the behavioral health safety net. Whether expansion of insurance coverage translated into changes in documented MOUD treatment planning within these publicly funded systems remains less well understood.

The Treatment Episode Data Set–Admissions (TEDS-A) serves as the principal national reporting system used to monitor and evaluate treatment services supported through the SUBG. In addition to supporting federal performance measurement, TEDS captures whether MOUD is included as part of an individual's treatment plan at admission, providing a unique opportunity to evaluate implementation of evidence-based treatment planning within publicly financed substance use treatment systems. Using national TEDS-A data from 2006 through 2023, this study evaluates documented MOUD treatment planning within publicly funded specialty treatment programs and its association with Medicaid expansion. Specifically, we examine whether state Medicaid expansion was associated with changes in documented MOUD planning at admission, assess temporal patterns before and after expansion, and evaluate demographic, clinical, and geographic variation in documented MOUD planning. By examining implementation of treatment planning within the publicly financed specialty treatment system, this analysis provides policy-relevant evidence regarding how Medicaid expansion was associated with evidence-based treatment planning within the nation’s behavioral health safety net.

2.0. Methods

2.1. Study design and population

This study used data from the Treatment Episode Data Set–Admissions (TEDS-A), a U.S. national administrative dataset comprising episode-level records submitted by substance use treatment facilities receiving public funding through Single State Agencies (SSAs). TEDS captures standardized information on individuals aged 12 years and older entering publicly funded substance use treatment, including demographic, socioeconomic, clinical, and legal characteristics at admission. Established under the 1988 Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments (P.L. 100–690), TEDS serves as the primary federal reporting system for treatment services supported through the SUBG.

We analyzed public-use TEDS-A data from 2006 through 2023, restricting the sample to admissions involving opioid use. Data are submitted annually by all 50 states, the District of Columbia, and Puerto Rico. Each record represents a discrete treatment episode; therefore, individuals may contribute multiple admissions over time. The final analytic sample included opioid-related treatment admissions meeting study inclusion criteria. Although federal reporting requirements standardize data elements, variation in state data infrastructure and reporting practices may affect completeness and comparability across jurisdictions and years.

2.2. Measures

The primary outcome was documented MOUD planning at admission. TEDS captures whether the admission treatment plan included medications for opioid use disorder (MOUD), defined as planned use of methadone, buprenorphine, or extended-release naltrexone. This measure reflects documented treatment planning rather than confirmed medication receipt, initiation, adherence, or retention following admission. Within the SUBG reporting framework, documented MOUD planning represents the primary standardized MOUD-related performance measure currently available across publicly funded treatment systems. This measure enables national evaluation of evidence-based treatment planning practices across state-administered specialty treatment programs.

The primary exposure was state Medicaid expansion status. Medicaid expansion status was assigned using a state-specific coding framework based on the first full calendar year in which expansion was implemented. An event-time variable was constructed relative to each state's Medicaid expansion year, with one year prior to expansion serving as the reference period. Detailed state-level expansion coding has been previously published and is cited here for reference [20]

Admission-level covariates included age, race, ethnicity, sex, education, pregnancy status, criminal justice referral, prior treatment history, employment, housing status, injection drug use, and substance-use profile at admission.

2.3. Statistical Analysis

To evaluate whether documented MOUD planning changed following Medicaid expansion within publicly funded treatment systems, we employed an event-study difference-in-differences framework using multivariable logistic regression. This approach leverages variation in Medicaid expansion timing across

states to estimate within-state changes in documented MOUD planning while accounting for national secular trends.

State fixed effects were included to control for time-invariant differences across states, and calendar-year fixed effects adjusted for secular trends in documented MOUD planning. Standard errors were clustered at the state level to account for within-state correlation arising from shared policy environments, treatment systems, and reporting structures.

Models adjusted for admission-level demographic and clinical characteristics. Adjusted odds ratios (ORs) with 95% confidence intervals (CIs) are reported. Adjusted predicted probabilities were estimated using post-estimation marginal effects to facilitate interpretation of dynamic changes in MOUD planning over time. Detailed variable definitions, coding specifications, and model construction are provided in the Supplementary Methods.

Missingness in TEDS primarily reflects variation in state reporting practices rather than individual nonresponse. Variables with missing values—race (3.0%), sex (0.1%), education (7.1%), and prior treatment episodes (11.0%)—were retained using explicit “Not Reported by State” categories to preserve the analytic sample and account for reporting variation. Because missingness reflects structural reporting variation rather than random variation, imputation was not performed. All analyses were conducted using Stata 19.5 (StataCorp LLC, College Station, TX). This study used publicly available, de-identified administrative data and did not involve interaction with human subjects or access to identifiable private information. In accordance with 45 CFR § 46.102, this research does not constitute human subjects research and was exempt from institutional review board review.

3.0. Results

3.1.Characteristics of Opioid-Related Treatment Admissions

Table 1 presents the characteristics of opioid-related treatment admissions by documented MOUD planning status. Between 2006 and 2023, TEDS-A recorded 32,947,133 publicly funded substance use treatment admissions nationwide. Of these, 10,155,496 admissions involved opioid use and comprised the analytic population. Among opioid-related admissions, 2,912,052 (28.6%) included a documented MOUD treatment plan, whereas 7,243,444 (71.4%) did not.

Table 1
Characteristics of Opioid-Related Treatment Admissions by Documented MOUD Planning Status, TEDS-A 2006–2023

Characteristic	No MOUD Plan (%)	MOUD Plan (%)	Total (%)
	n = 7,243,444 (71.4)	n = 2,912,052 (28.6)	n = 10,155,496 (100)
Race			
Not Reported	1.86	2.17	1.95
AI/AN	1.44	1.45	1.44
Asian/PI	0.39	0.53	0.43
Black/AA	12.77	15.02	13.41
White	73.75	68.74	72.31
Other Race	9.80	12.09	10.46
Sex			
Not Reported	0.03	0.07	0.04
Male	63.73	59.85	62.62
Female	36.24	40.08	37.34
Ethnicity			
Hispanic	12.42	15.92	13.43
Non-Hispanic	85.19	81.56	84.15
Not Reported	2.39	2.51	2.43
Prior Treatment Episodes			
Unknown	13.97	3.15	10.87
No Prior Treatment	24.94	25.23	25.02
One Prior Treatment	17.87	20.52	18.63
Two Prior Treatments	11.75	14.94	12.66
Three or More Prior Treatments	31.48	36.16	32.82
Education			
Not Reported	3.32	3.81	3.46
Less Than High School	27.71	27.35	27.61

Characteristic	No MOUD Plan (%)	MOUD Plan (%)	Total (%)
	n = 7,243,444 (71.4)	n = 2,912,052 (28.6)	n = 10,155,496 (100)
Race			
High School Graduate	45.72	47.10	46.11
Some College	18.96	17.31	18.49
College/Graduate Degree	4.29	4.43	4.33
Living Situation			
Not Reported	5.77	3.46	5.11
Experiencing Homelessness	16.52	10.13	14.69
Dependent Living	17.25	14.39	16.43
Independent Living	60.46	72.03	63.78
Pregnancy at Admission			
Pregnant	1.14	2.52	1.54
Not Pregnant	98.86	97.48	98.46
Age Group (Years)			
12–17	1.70	0.09	1.24
18–24	17.89	9.87	15.59
25–34	38.90	35.66	37.97
35–44	22.57	25.35	23.36
45–64	18.42	27.44	21.00
≥ 65	0.53	1.60	0.84

Among admissions with a documented MOUD plan, White individuals represented the largest racial group (68.7%), followed by Black individuals (15.0%) and individuals classified as other race (12.1%). Adults aged 25–34 years represented the largest age group among admissions with documented MOUD planning (35.7%), followed by adults aged 45–64 years (27.4%) and 35–44 years (25.4%). Males represented the majority of admissions both with (59.9%) and without documented MOUD planning (63.7%) of opioid-related admissions, respectively. Individuals with three or more prior treatment episodes were more common among admissions with documented MOUD planning (36.2%), whereas homelessness was less common among admissions with documented MOUD planning (10.1%). (Table 1 goes here).

3.2. Changes in Documented MOUD Planning Following Medicaid Expansion

Table 2 presents adjusted associations between Medicaid expansion and documented MOUD planning within publicly funded treatment systems. Pre-expansion event-time estimates were not statistically significant, providing support for the parallel trends assumption. Relative to the year immediately preceding Medicaid expansion, the odds of documented MOUD planning increased significantly one year after expansion (aOR = 1.58; 95% CI: 1.14–2.19) and two years after expansion (aOR = 1.59; 95% CI: 1.19–2.12). Although point estimates remained above unity in subsequent years, confidence intervals included the null and no statistically significant associations were observed beyond two years following expansion. Overall, Medicaid expansion was associated with a modest short-term increase in documented MOUD planning, but these gains were not sustained over time (Table 2 goes here).

Table 2
Adjusted Odds Ratios for Documentation of a MOUD Plan at Admission Following Medicaid Expansion, TEDS 2006–2023

Event Time Relative to Medicaid Expansion†	Adjusted Odds Ratio	95% CI
≤ 8 Years Before	0.64	0.30–1.38
7 Years Before	0.70	0.40–1.25
6 Years Before	0.75	0.47–1.22
5 Years Before	0.89	0.57–1.39
4 Years Before	0.78	0.43–1.41
3 Years Before	0.88	0.71–1.09
2 Years Before	0.98	0.87–1.10
Expansion Year	1.12	0.88–1.43
1 Year After**	1.58	1.14–2.19
2 Years After**	1.59	1.19–2.12
3 Years After	1.68	0.99–2.83
4 Years After	1.51	0.87–2.62
5 Years After	1.26	0.80–1.98
6 Years After	1.26	0.77–2.05
7 Years After	1.48	0.86–2.53
≥ 8 Years After	1.20	0.69–2.09

†Reference category is one year prior to Medicaid expansion. MOUD plan refers to documented planned use of methadone, buprenorphine, or extended-release naltrexone at admission. **p < 0.01.

Supplemental Fig. 1 presents adjusted predicted probabilities of documented MOUD planning relative to Medicaid expansion. Predicted probabilities showed modest variation during the pre-expansion period. Following Medicaid expansion, the probability of documented MOUD planning increased, peaking approximately three years after implementation. Thereafter, predicted probabilities gradually declined and stabilized, consistent with the event-study estimates indicating modest short-term increases in documented MOUD planning that were not sustained over time (Supplemental Fig. 1 goes here).

Table 3 presents adjusted associations between admission characteristics and documented MOUD planning from the fully adjusted difference-in-differences model. After accounting for event-time effects, state fixed effects, calendar-year effects, and admission characteristics, substantial variation in documented MOUD planning remained across populations.

Table 3
Adjusted Odds Ratios for Documented MOUD Planning at Admission from the Fully Adjusted Difference-in-Differences Model, TEDS-A 2006–2023.

Characteristic	Adjusted Odds Ratios	95% CI
Race		
Not Reported (reference)		
American Indian/Alaska Native	1.21	0.98–1.48
Asian/Pacific Islander	1.23	0.97–1.56
Black/African American	1.13	0.93–1.37
White*	1.21	1.02–1.44
Other race*	1.22	1.03–1.44
Sex		
Not reported (reference)		
Male	0.67	0.38–1.18
Female	0.82	0.47–1.42
Not Hispanic (reference)		
Hispanic ethnicity	1.09	1.00–1.20
Age		
12–17 years (reference)		
18–24 years***	7.71	5.28–11.25
25–34 years***	12.17	8.39–17.65
35–44 years***	15.68	10.62–23.17
45–64 years***	20.42	13.33–31.29
≥ 65 years***	28.57	17.12–47.68
Education		
Not reported (reference)		
Not a high school graduate	0.99	0.57–1.75

Note: Estimates derived from the same multivariable logistic regression model presented in Table 2, including event-time indicators for Medicaid expansion, state fixed effects, calendar-year fixed effects, and cluster-robust standard errors at the state level. Reference categories are indicated for each characteristic. *p < 0.05 ** p < 0.01 *** p < 0.001.

Characteristic	Adjusted Odds Ratios	95% CI
Race		
High school graduate	0.93	0.53–1.64
Some college	0.91	0.50–1.64
College/graduate degree	0.82	0.48–1.40
Social and Clinical Characteristics		
Pregnant at admission***	2.72	2.10–3.52
Criminal justice referral	0.55	0.33–0.91
No prior treatment episodes	1.01	0.83–1.22
Unemployed	1.04	0.91–1.18
Experiencing homelessness ***	0.49	0.37–0.64
Injection drug use reported***	1.26	1.13–1.40
Hallucinogens***	0.51	0.35–0.75
Cannabis**	0.77	0.64–0.93
Stimulants***	0.41	0.28–0.60
Cocaine	0.85	0.68–1.06
Alcohol***	0.36	0.30–0.44
CNS depressants***	0.7	0.58–0.84
Other drugs	1.04	0.84–1.28
Constant	0.02	0.01–0.08
Year		
2007	0.89	0.66–1.19
2008	0.85	0.59–1.23
2009	0.75	0.49–1.16
2010	0.85	0.54–1.33
2011	0.72	0.39–1.32

Note: Estimates derived from the same multivariable logistic regression model presented in Table 2, including event-time indicators for Medicaid expansion, state fixed effects, calendar-year fixed effects, and cluster-robust standard errors at the state level. Reference categories are indicated for each characteristic. *p < 0.05 ** p < 0.01 *** p < 0.001.

Characteristic	Adjusted Odds Ratios	95% CI
Race		
2012	0.66	0.33–1.31
2013	0.65	0.30–1.37
2014	0.65	0.31–1.35
2015	0.70	0.31–1.59
2016	0.66	0.27–1.65
2017	0.80	0.28–2.27
2018	1.01	0.38–2.70
2019	1.14	0.45–2.90
2020	1.41	0.52–3.84
2021	1.36	0.51–3.60
2022	1.51	0.54–4.25
2023	1.67	0.61–4.55
Note: Estimates derived from the same multivariable logistic regression model presented in Table 2, including event-time indicators for Medicaid expansion, state fixed effects, calendar-year fixed effects, and cluster-robust standard errors at the state level. Reference categories are indicated for each characteristic. *p < 0.05 ** p < 0.01 *** p < 0.001.		

Several groups demonstrated significantly lower odds of documented MOUD planning, including admissions involving homelessness (aOR = 0.49; 95% CI: 0.37–0.64) and criminal justice referral (aOR = 0.55; 95% CI: 0.33–0.91). Lower odds were also observed among opioid admissions involving alcohol (aOR = 0.36; 95% CI: 0.30–0.44), stimulants (aOR = 0.41; 95% CI: 0.28–0.60), hallucinogens (aOR = 0.51; 95% CI: 0.35–0.75), cannabis (aOR = 0.77; 95% CI: 0.64–0.93), and central nervous system depressants (aOR = 0.70; 95% CI: 0.58–0.84). Higher odds of documented MOUD planning were observed among pregnant admissions (aOR = 2.72; 95% CI: 2.10–3.52) and admissions reporting injection drug use (aOR = 1.26; 95% CI: 1.13–1.40). (Table 3 goes here).

Calendar-year estimates demonstrated a gradual upward trend over the study period. However, Bonferroni-adjusted comparisons of calendar-year effects relative to 2014 were not statistically significant (Supplement Table 1), indicating that the observed temporal increases were modest after adjustment for multiple comparisons.

Figure 1 demonstrates considerable geographic variation in documented MOUD planning after adjustment for admission characteristics, calendar-year effects, and Medicaid expansion timing. Higher adjusted levels of documented MOUD planning were concentrated in several Northeastern and Western

states, whereas comparatively lower levels were observed across portions of the South and Midwest. (Fig. 1 goes here).

4.0. Discussion

This study evaluated documented MOUD planning among opioid-related treatment admissions reported through TEDS-A between 2006 and 2023. Medicaid expansion was associated with modest short-term increases in documented MOUD planning during the first two years following expansion, and pre-expansion estimates provided no evidence of differential trends between expansion and non-expansion states. However, these increases were not sustained over time. Although documented MOUD planning became more common nationally during the study period, substantial variation persisted across populations and states after adjustment for Medicaid expansion timing, admission characteristics, and secular trends. Prior work has demonstrated substantial geographic clustering of buprenorphine treatment capacity across the United States, with provider availability concentrated in specific regions despite continued treatment gaps. Consistent with those findings, the present analysis identified substantial state-level variation in documented MOUD planning even after adjustment for Medicaid expansion timing and admission characteristics, suggesting that implementation of evidence-based opioid treatment remains heterogeneous across publicly funded treatment systems [21].

These findings suggest that expanded insurance coverage alone may be insufficient to produce sustained changes in implementation within publicly funded specialty treatment systems. Medicaid expansion appears to have facilitated an initial increase in documented MOUD planning, likely reflecting greater access to reimbursement and broader adoption of evidence-based treatment approaches during early implementation. However, the absence of long-term effects indicates that insurance coverage and implementation capacity represent distinct dimensions of treatment system performance. Publicly funded treatment programs supported through the SUBG operate within a complex financing environment that include Medicaid reimbursement, federal block grant funding, state appropriations, and other funding streams. While expanded coverage may increase reimbursement opportunities, it does not necessarily alter treatment planning practices, provider capacity, workforce availability, reporting systems, technical assistance infrastructure, or implementation approaches within state-administered treatment systems.

From a federal program evaluation perspective, these findings are particularly relevant because TEDS remains the only national admission-level reporting system capable of monitoring documented MOUD planning within publicly funded specialty treatment programs. The results suggest that implementation of documented MOUD planning remained relatively stable despite one of the largest health financing policy changes in recent decades. As federal agencies increasingly seek evidence demonstrating the effectiveness of public investments, national administrative data systems such as TEDS provide an important opportunity to evaluate implementation within publicly funded treatment systems without imposing additional reporting requirements on treatment providers or state agencies, helping reduce administrative burden on an already constrained behavioral health workforce. The findings also reinforce

the importance of distinguishing between policies that expand insurance coverage and those that directly influence implementation of evidence-based clinical practices.

Several findings indicate that implementation of documented MOUD planning remains uneven within publicly funded treatment systems. Admissions involving homelessness and criminal justice referral were less likely to include documented MOUD planning, and substantial geographic variation persisted after adjustment for Medicaid expansion timing and admission characteristics. These patterns are consistent with longstanding challenges involving care coordination, treatment continuity, and integration of MOUD within correctional, residential, and other specialty treatment settings. Individuals with opioid use disorder frequently experience co-occurring psychiatric conditions, polysubstance use [22, 23], housing instability, criminal justice involvement, and other social challenges that complicate treatment engagement and recovery [4, 20, 24]. Consequently, variation in documented MOUD planning may reflect differences in service integration, treatment planning practices, provider capacity, workforce availability, and implementation approaches rather than differences in medication availability alone.

The observed geographic variation is particularly noteworthy because state fixed effects account for stable differences in treatment infrastructure, financing arrangements, and policy environments. Persistent variation following adjustment suggests that implementation practices continue to differ across publicly funded treatment systems independent of Medicaid expansion status. These differences may reflect variation in provider networks, workforce capacity, technical assistance efforts, reporting practices, treatment system organization, and state implementation priorities.

An additional consideration is the degree of flexibility afforded to states in documenting and implementing MOUD planning. TEDS defines MOUD planning as inclusion of methadone, buprenorphine, and/or naltrexone within a client's treatment plan [25], but federal reporting guidance does not prescribe how MOUD planning should be operationalized within broader treatment planning processes. An additional consideration is the degree of flexibility afforded to states in documenting and implementing MOUD planning. Greater standardization of treatment planning expectations and monitoring guidance is required across jurisdictions and strengthen the utility of TEDS as a national performance-monitoring system.

The findings also highlight the importance of robust performance-monitoring systems for publicly funded treatment programs. As behavioral health services are increasingly delivered across diverse clinical and community settings, consistent documentation and measurement become essential for evaluating implementation of evidence-based practices. More standardized approaches to treatment, planning documentation and performance measurement may improve comparability across jurisdictions and strengthen the ability of federal and state agencies to monitor implementation over time.

These findings should be interpreted considering several limitations. First, TEDS captures documented treatment planning rather than medication receipt, initiation, adherence, or retention. This reflects a data collection limitation rather than a methodological limitation and is described in detail in the Supplementary Methods. Second, variation in state reporting practices and data infrastructure may

affect completeness of certain variables despite standardized federal reporting requirements. Third, although the difference-in-differences framework controlled for state and calendar-year effects and pre-expansion estimates demonstrated no evidence of differential trends, unmeasured time-varying factors may have influenced observed associations. Finally, TEDS captures treatment admissions rather than unique individuals, and repeated treatment episodes by the same individual cannot be identified within public-use files.

5.0. Conclusion

Medicaid expansion was associated with modest short-term increases in documented MOUD planning, but these effects were not sustained over time. The findings suggest that broader insurance coverage alone may be insufficient to fundamentally alter implementation patterns within publicly funded specialty treatment systems. Persistent geographic variation and disparities among vulnerable populations indicate that implementation of evidence-based treatment practices continues to depend on factors beyond insurance coverage, including treatment system organization, service integration, provider capacity, and implementation infrastructure. Strengthening performance monitoring, data standardization, and evaluation capacity within publicly funded treatment systems may improve the ability of federal and state agencies to assess implementation of evidence-based treatment practices and inform future SUPTRS Block Grant performance measurement and program evaluation efforts.

Declarations

Consent to Publish declaration: not applicable.

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Data Availability declaration: Data used in this study are publicly available through the Substance Abuse and Mental Health Services Administration Treatment Episode Data Set–Admissions (TEDS-A) at SAMHSA.gov/data.

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Figures

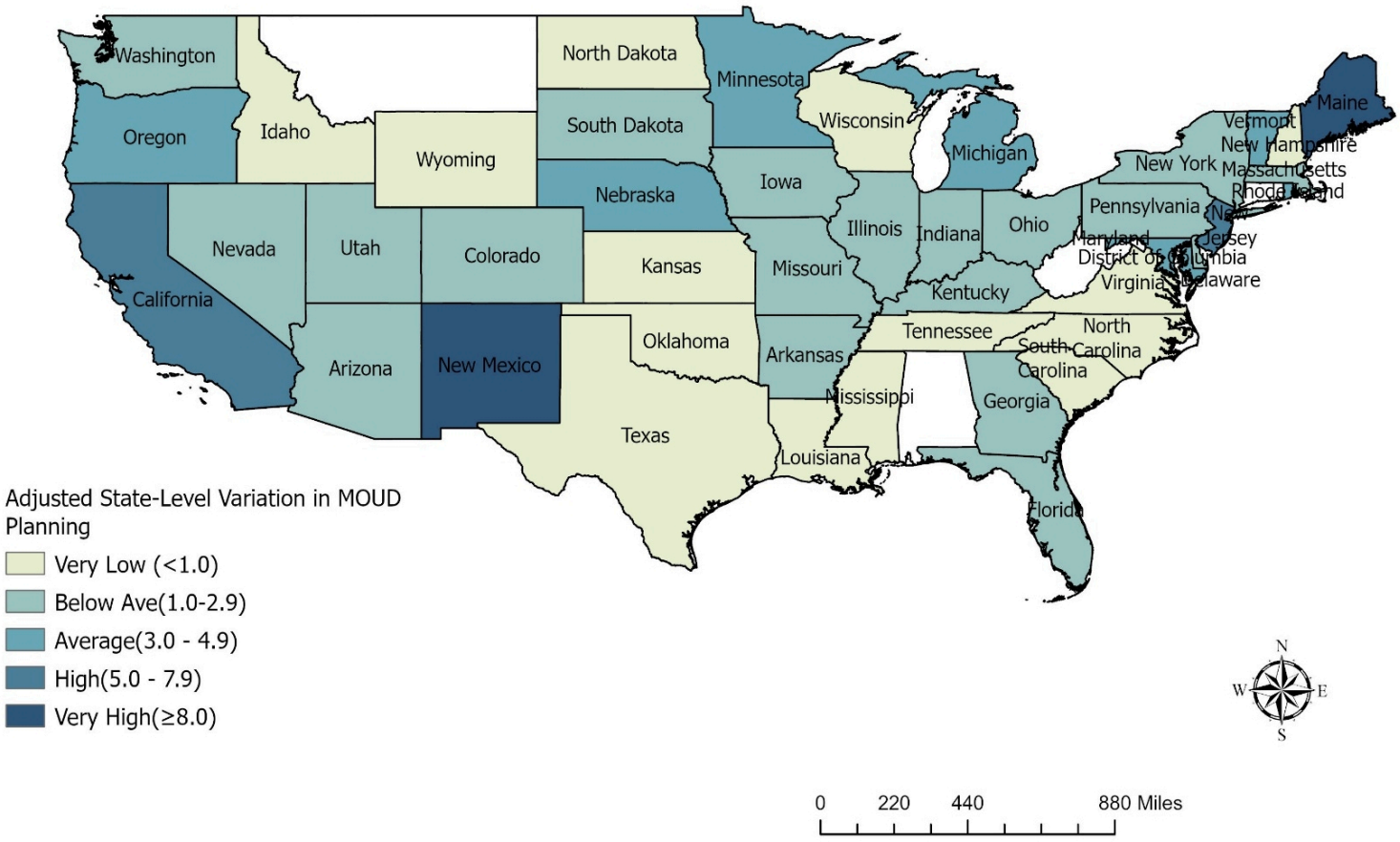


Figure 1

Adjusted state-level variation in documented medication for opioid use disorder (MOUD) planning

Supplementary Files

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- SupplementMethodology.docx
- SupplementTable1.docx
- Supplementfigure1.tif