Policy Considerations to Expand Medications for Addiction Treatment (MAT) in Residential Substance Use Disorder Services

Context and background

Across the spectrum of state-licensed substance use disorder (SUD) services, residential treatment settings are unique in offering longer-term inpatient care (typically up to 90 days) (Exhibit 1). Although residential facilities often represent a relatively intensive SUD service option due to their residential nature, they were used by nearly 1 in 5 Californians engaged in SUD services at state-licensed facilities in 2022 – 2023, an increase from 2020 – 2021.[1]

Exhibit 1: Examples of State-Licensed Substance Use Disorder (SUD) Treatment Facilities

Outpatient: provided in a variety of settings, including primary care offices, community clinics, and SUD treatment clinics	**Detoxification:** includes clinical management of withdrawal in residential or hospital setting	**Residential (non-hospital):** provides SUD treatment and 24-hour support in residential setting	**Hospital inpatient:** SUD treatment and detoxification in inpatient hospital setting	**Narcotic treatment programs:** provides opioid MAT and other maintenance services in brick and mortar or mobile settings

California's Medicaid program (Medi-Cal) plays a significant role in SUD treatment coverage for lower-income patients, making it key to equitable access to SUD services. In the context of California's opioid use epidemic, Medi-Cal has played a growing role, with an estimated 203,000 – 353,000 Medi-Cal beneficiaries experiencing opioid use disorder in 2022.[2,3] Medi-Cal coverage of medications for addiction treatment (MAT)—such as methadone and buprenorphine—is especially important, as these medications have consistently been associated with substantial reductions in opioid-related morbidity and mortality, all-cause mortality, and serious opioid-related acute care.[4-7]

Since 2022, California law has required residential SUD facilities offer MAT directly or through referral.[9] While data on the extent to which Medi-Cal residential SUD providers provide MAT onsite are not readily available, a 2025 assessment led by The Center at Sierra Health Foundation found that residential providers experienced substantial barriers to providing MAT through Medi-Cal. On the next page we explore these barriers and possible policy considerations to address them.

Medi-Cal plays a pivotal role in expanding SUD service access equitably, including in residential SUD facilities.

Coverage of **Medications for Addiction Treatment (MAT)**, such as methadone, buprenorphine, and naltrexone, is key in residential SUD service settings because these medications can substantially reduce opioid use morbidity and mortality.

A statewide qualitative study of MAT providers found substantial **barriers to providing MAT within residential SUD service settings**.

CHALLENGE 1:

Medi-Cal does not cover MAT services in all state-licensed SUD residential programs

Medi-Cal coverage of residential MAT services occurs through two streams: (a) the state-run Drug Medi-Cal (DMC) program, in which counties and certified SUD providers bill the state for a limited menu of DMC covered opioid use disorder services, and (b) the county-run Drug Medi-Cal Organized Delivery System (DMC-ODS), in which counties administer opioid use disorder service coverage, essentially acting as their own managed care plans. These two Medi-Cal streams cover MAT in some residential SUD service settings and can be supplemented by more flexible state and federal grant funds (Exhibit 2).

Exhibit 2: Funding Mechanisms for Residential MAT Services in California. [10,11]

Funding Mechanism	PATH 1: Drug Medi-Cal (DMC) program	PATH 2: DMC Organized Delivery System (ODS)*	State & Federal Grant Funding
Administrative Lead	• Administered by the California Department of Health Care Services (DHCS) • County and certified SUD providers bill directly for covered opioid use disorder services	• Administered by counties who opt-in • SUD providers bill the county for covered SUD services	• Administered by state/ federal funders and their grantmaking partners • Grant recipients receive and implement funds in line with grant purpose
Residential Opioid Use Disorder and MAT Services Covered	• More limited menu of SUD services • Residential opioid use disorder services, including MAT, are only covered in specific settings (e.g., perinatal SUD services in small facilities; youth SUD services)	• Covers an expanded list of opioid use disorder services and provider types beyond DMC (e.g., peer support specialists) • Residential opioid use disorder services, including MAT, are covered	• Grant funds typically support opioid use disorder services, including MAT, in ways not already supported by the federal government or Medi-Cal • Examples might include supporting start-up of MAT in residential settings and focusing on populations with limited MAT access

Notably, while residential SUD providers in DMC-ODS counties can bill Medi-Cal for residential MAT services for all patient types, residential providers in DMC counties can only bill for specific types of residential MAT, such as perinatal MAT and youth MAT in small residential settings.[12] The discrepancy in billing options means that residential providers in DMC counties are unlikely to offer MAT directly unless they have other funding sources (such as grant funding), creating inequity between DMC-ODS and DMC counties. Moreover, if grant funding is being used to launch residential MAT programs, this limitation of DMC coverage reduces the sustainability of grant-funded residential MAT in DMC counties.

Policy Considerations	Rationale and Details
☑ **Add residential SUD provider settings to Medi-Cal coverage for DMC counties**	• DHCS could add residential SUD service settings as covered settings in the DMC billing structure to allow MAT services to be reimbursed for providers in DMC counties.

* The Drug Medi-Cal Organized Delivery System (DMC-ODS) was piloted in August 2015 through an amendment to the State's prior Section 1115 demonstration project for SUD services. The state received approval from CMS in December 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver and CalAIM Section 1115 demonstration through December 31, 2026.

CHALLENGE 2:

Licensure requirements carry a significant administrative burden that may prevent residential sites who wish to offer MAT from doing so

To be reimbursed by Medi-Cal to provide MAT, residential SUD services facilities first must apply for a separate Incidental Medical Services (IMS) state-level certification, in addition to being licensed SUD treatment providers under Medi-Cal's DMC program.[†,13] Many residential providers have described this process as burdensome and time-consuming. In particular, they noted a long wait time between application submission and approval, as well as difficulty in understanding their application's status due to communications being routed through mail and/or email.[14]

> "Getting IMS was just a lift for us. We're not big organization. We don't have a whole bunch of admin. I did most of the application heavy lifting myself at my agency. I'm the executive and the maintenance person and insurance and HR and so I mean, that thing had me up at night."
>
> *-Residential MAT Provider*

Second, to align with new federal guidance in 2022,[‡] DHCS began to automatically designate all newly enrolling DMC applicants with a narcotic treatment program or a heroin detoxification program as moderate or high categorical risk, when they had previously been low categorical risk.[15] This decision by DHCS is more restrictive than the federal guidance, which states that increased categorical risk categories must only be applied to *Medicare*-funded programs based on their theoretical potential for waste, fraud, and abuse. By choosing to apply this requirement to Medical-funded programs as well, DMC MAT providers are now subjected to additional screening requirements, despite previously being categorized as low categorical risk. The additional screening requirements for providers can be lengthy and burdensome, including site visits for moderate and high-risk providers, and fingerprint submission and criminal background checks for high-risk providers.

Policy Considerations	Rationale and Details
☑ **Streamline the IMS application review process**	• DHCS could consider how to reduce the application burden for residential providers who wish to offer MAT onsite. • This might include limiting the number of application revisions to shorten the approval timeline (i.e., providing all feedback at once) and/or creating an online platform that tracks application progress, feedback, and communications. • Notably, DHCS recently launched an online licensing and certification portal that may address licensing challenges by allowing providers to apply, track progress, and communicate with DHCS through the online portal.
☑ **Revisit risk categorization standards**	• DHCS could revisit risk categorization standards to ensure that they do not pose more barriers to MAT provision than are required under federal guidance.

[†] The full suite of IMS services includes: obtaining medical histories; monitoring health status; testing associated with detoxification from alcohol or drugs; providing alcoholism or drug abuse recovery or treatment services; overseeing patient self-administered medications; and treating substance abuse disorders, including detoxification.

[‡] In 2022, the federal Centers for Medicare and Medicaid Services (CMS) designated newly enrolling narcotic treatment programs (NTPs) as "high" or "moderate" categorical risk for waste, fraud, and abuse, which subjected *Medicare* providers to additional screening requirements.

CHALLENGE 3:

Medi-Cal residential SUD providers are not required to provide MAT

Unlike several other states, residential SUD providers in California are not required to provide MAT. Instead, state-licensed residential SUD providers must demonstrate that they either directly offer MAT or have an effective referral mechanism aligned with state guidelines. This creates variability and inequity across the state regarding which residential providers offer MAT. Because MAT has been shown to reduce overdose and all-cause mortality better than non-medication forms of opioid use disorder treatment,[16] variability in access to residential MAT is a critical health equity issue.

Policy Considerations	Rationale and Details
☑ **Require residential SUD providers to offer MAT**	• The California legislature could consider a policy bill requiring that state-licensed SUD providers offer MAT, instead of allowing providers to utilize a referral mechanism. ○ A number of states—including Florida, Maryland, Mississippi, Missouri, Nevada, New York, Oklahoma, Oregon, Texas, Utah, and the District of Columbia—have implemented a similar requirement through state law and regulation to require residential providers to offer MAT as an expansion of SUD services, requiring institutions of mental disease (IMDs) participating in the state's 1115 waiver to provide MAT.[17,18] • Notably, as described in challenges #1 and #2 from this brief, required on-site MAT would simultaneously require the ability to bill Medi-Cal for residential MAT services in all residential settings, as well as improvements to the licensing process to minimize administrative burden at residential treatment sites.
☑ **Continue to identify grant funding to support training and start-up costs for residential MAT**	• While start-up costs are not typically a Medi-Cal-reimbursable expense, DHCS and DMC-ODS participating counties could continue to partner with public health agencies to identify grant funding to assist residential providers with training and start-up costs of providing MAT.
☑ **Review and support MAT referral processes initiated by residential providers**	• During its review of residential MAT policies (as required by California law) DHCS could review referral processes to assess consistency across residential sites to identify any disparities or gaps. • DMC-ODS counties could support partnerships between local residential facilities and MAT providers to streamline referral processes.

Conclusion

Residential SUD services play a key role in MAT provision. Through its innovative DMC and DMC-ODS programs and policy requiring residential SUD settings to provide or refer to MAT services, California has substantially increased coverage for MAT services in residential settings. However, gaps remain, particularly as a result of the burden that residential providers face in getting reimbursed for MAT services through Medi-Cal. Both DHCS and DMC-ODS counties have an important role to play in better understanding the gaps that persist across the state and identifying and implementing policy solutions to close those gaps. This is particularly important as the state prepares for a volatile federal funding landscape; it will be critical for DHCS and DMC-ODS to support efficient and coordinated use of resources across Medi-Cal and other grant funding sources to ensure that MAT within residential SUD services remains as accessible as possible.

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