Policy Brief

Access to Medication Assisted Substance Use Treatment by Medi-Cal Beneficiaries

January 2026

Executive Summary

Access to medication assisted treatment (MAT) among Medi-Cal enrollees varies greatly across California. This paper estimates the share of Medi-Cal adults in each county who were at risk of opioid misuse in 2022 and compares that with counts of adults receiving forms of MAT prescribed for their condition. Key findings include:

- Statewide, an estimated 336,000 adult Medi-Cal enrollees are at risk of opioid misuse, but only 31 percent of these are receiving MAT.

- In some counties, all or nearly all the at-risk population receives MAT. These counties do not include the major populations centers in the south of the state.

- In many of the large Southern California counties less than 25 percent of the at-risk population is receiving MAT.

There are differences across the counties in the strategies for providing MAT access for the at-risk population. Expanding access in counties now underserving the at-risk population will require increasing access to non-methadone forms of MAT through not only county contracted providers but also providers contracting with Medi-Cal managed care plans so that providing MAT becomes a routine aspect of the regular care system and not just the responsibility of a separate specialized system.

Estimating the At-Risk Population

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) conducts annual surveys to identify across the country the levels of use of various substances. It publishes national estimates for the number of individuals that misuse

opioids and, since 2022, has also estimated the level of fentanyl use. SAMHSA publishes estimates for the number of individuals in each state who misuse opioids, combining data from 2021 and 2022 surveys to improve the accuracy of estimates in smaller states. However, this survey has a sample size insufficient to make county-level estimates.

In 2022 the SAMHSA estimated that in California 967,000 adults (over 18) misused opioids in 2022. This did not include those that used fentanyl. However, the national survey results for fentanyl indicate that the total using population is about 8 percent greater than those using opioids other than fentanyl. Applying this adjustment to the population in California results in a total of 1,047,745 adults misusing opioids in 2022.

To understand how effectively we are reaching the adult at-risk Medi-Cal population in each county, we needed to arrive at county-level estimates for this at-risk population. To do this, we began with the total population identified in the SAMSHA survey as opioid or fentanyl misusers and then distributed that total population across all counties in proportion to each county's average opioid-related deaths over three years (2021 to 2023). The result is shown in Table 1. Here we are limiting our analysis to counties participating in the Organized Delivery System waiver in Medi-Cal which includes 95 percent of the adult at-risk Medi-Cal population and does not include some of the smaller counties where estimates are less precise.

To calculate the size of the Medi-Cal adult population who were at risk of opioid misuse in each county, we multiplied the total number of all at-risk adults in each county by the percentage of adults on Medi-Cal in that county. The results are also shown in Table 1.

Table 1

Estimating the Medi-Cal Adult Population At-Risk for Misuse of Opioids in Counties Participating in Organized Delivery System Waiver

2022

	3-year Average Deaths	All Opioid Misusers per SAMHSA Survey	Total Medi-Cal Adults	All Adults 2020 Census	Medi-Cal Share of Adults	Estimated Opioid Misusers on Medi-Cal
Alameda	247.0	35,172	337,498	1,338,388	25%	8,869
Contra Costa	181.3	25,821	209,869	902,672	23%	6,003
El Dorado	33.7	4,794	29,137	152,083	19%	918
Fresno	115.7	16,470	323,775	730,245	44%	7,303
Imperial	18.0	2,563	67,037	132,200	51%	1,300
Kern	301.0	42,861	292,920	651,739	45%	19,264
Los Angeles	1622.0	230,965	3,077,551	7,959,791	39%	89,300
Marin	42.0	5,981	38,590	209,451	18%	1,102
Merced/Mariposa	38.3	5,458	94,206	214,410	44%	2,398
Monterey	35.7	5,079	133,115	327,777	41%	2,063
Napa	16.7	2,373	24,249	110,473	22%	521
Nevada	27.3	3,892	19,762	84,331	23%	912
Orange	652.0	92,842	691,405	2,519,658	27%	25,476
Partnership ODS	249.7	35,551	237,802	763,982	31%	11,996
Placer	53.0	7,547	48,328	313,117	15%	1,165
Riverside	550.3	78,365	605,220	1,823,505	33%	26,009
Sacramento	263.3	37,497	405,763	1,217,309	33%	12,499
San Benito	11.3	1,614	12,702	47,915	27%	428
San Bernardino	384.7	54,775	597,082	1,629,042	37%	20,076
San Diego	703.0	100,104	679,654	2,608,768	26%	26,080
San Francisco	433.7	61,752	189,601	760,738	25%	15,391
San Joaquin	149.0	21,217	195,647	573,400	34%	7,239
San Luis Obispo	77.3	11,012	44,878	231,744	19%	2,132
San Mateo	83.3	11,866	113,866	610,236	19%	2,214
Santa Barbara	56.0	7,974	102,918	350,805	29%	2,339
Santa Clara	177.7	25,299	319,573	1,529,717	21%	5,285
Santa Cruz	72.7	10,347	58,747	219,764	27%	2,766
Stanislaus	128.3	18,274	161,661	407,908	40%	7,242

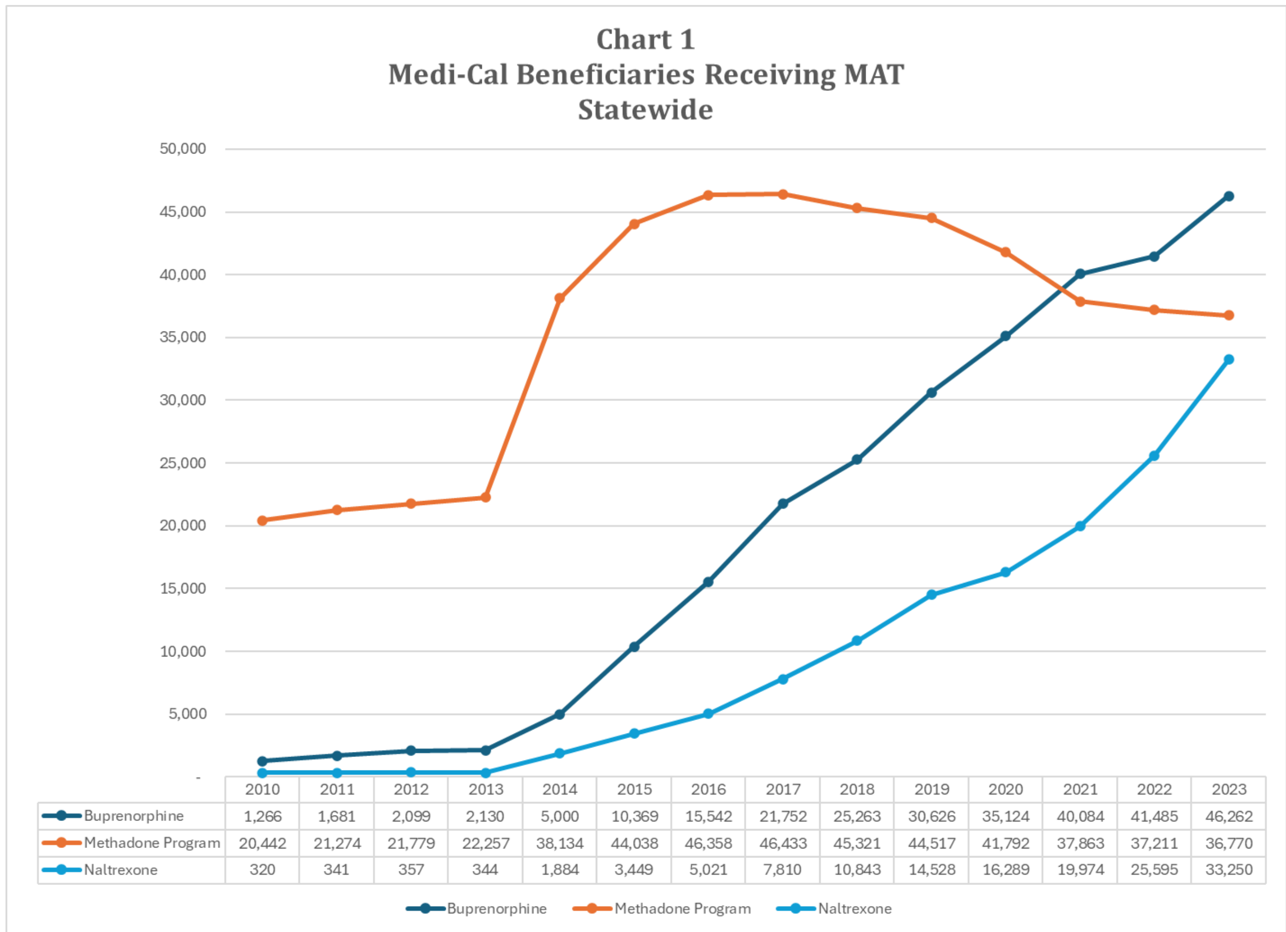
Tulare	58.7	8,354	168,535	331,093	51%	4,252
Ventura	207.7	29,571	162,323	656,198	25%	7,315
Yolo	18.7	2,658	40,978	171,256	24%	636

Data on Medi-Cal Enrollees Receiving Medication Assisted Treatment

Recently released data from the California Department of Health Care Services provides counts of Medi-Cal beneficiaries who have filled prescriptions for medications related to treatment of opioid use. The three primary medications for ongoing treatment of opioid addiction are methadone, buprenorphine, and naltrexone. For many years, methadone had been the primary form of medication assisted treatment (MAT) and was distributed by specialized clinics as a major element of the Drug Medi-Cal benefit. As seen in Chart 2 , the role of methadone has been superseded by buprenorphine and naltrexone. Since 2016 the use of methadone has steadily declined while the use of buprenorphine and naltrexone has increased to the extent that Medi-Cal users of buprenorphine exceeded those of methadone in 2021. In 2023 methadone users accounted for only 28 percent of Medi-Cal MAT users.

It is important to note that the period shown in the graph is prior to the lifting of the special requirements for physicians prescribing buprenorphine so that the rapid growth in the use of this medication occurred during a period when access was more limited than it is today.

This study's goal is to better understand the extent to which these medications are available across the counties in California for those at risk of opioid use. We review the scale of the use of buprenorphine, methadone, and naltrexone by Medi-Cal beneficiaries during 2022 in each county compared with the estimated population at risk.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Buprenorphine	1,266	1,681	2,099	2,130	5,000	10,369	15,542	21,752	25,263	30,626	35,124	40,084	41,485	46,262
Methadone Program	20,442	21,274	21,779	22,257	38,134	44,038	46,358	46,433	45,321	44,517	41,792	37,863	37,211	36,770
Naltrexone	320	341	357	344	1,884	3,449	5,021	7,810	10,843	14,528	16,289	19,974	25,595	33,250

Estimating How Accessible MAT is to Medi-Cal Beneficiaries

Table 2 shows the data for the Medi-Cal eligible users of MAT in each county as a proportion of the estimated number of adults on Medi-Cal that are opioid misusers based on the modified SAMSHA survey data. The share of adult Medi-Cal opioid misusers receiving MAT varies considerably across the counties, from a high of 108 percent in El Dorado County to a low of 17 percent in San Benito.

Two counties have rates of MAT use that exceed 100 percent of the estimated number of Medi-Cal opioid misusers. In part, this can be due to the fact that users of each type of MAT are counted separately, so the same individual can appear in the counts of one MAT tlype and another if they received prescriptions for both during the course of the year, It could also be due to some extend to the uncertainty in the estimate of at-risk Medi-Cal adults that comes from a variety of factors. First, state-level estimates from the SAMHSA survey have confidence intervals around the point estimates that are plus or minus 20 percent. Second, the confidence intervals for the rates of death due to overdose in these small counties are also about plus or minus 20 percent for the three-year estimates used in this calculation. Finally, death rates are probably influenced by how prevalent fentanyl is in the illicit drug supply. Counties with higher amounts of fentanyl could have higher death rates than a county with lower prevalence of fentanyl even though their at-risk populations are the same. Finally, we could be underestimating at-risk Medi-Cal adults in counties where Medi-

Cal beneficiaries are more likely to misuse opioids than average. What is important here is the differences across the counties and the fact that some counties seem to be meeting the needs for MAT while others are falling far short.

Table 2

Share of At-Risk Adults on Medi-Cal who Received Any Form of Medication Assisted Treatment in 2022

County	Share of At-Risk Medi-Cal Adults Receiving MAT		County (cont'd)	Share of At-Risk Medi-Cal Adults Receiving MAT
Statewide	31%		Riverside	22%
Alameda	47%		Sacramento	50%
Contra Costa	47%		San Benito	17%
El Dorado	108%		San Bernardino	21%
Fresno	37%		San Diego	34%
Imperial	47%		San Francisco	29%
Kern	15%		San Joaquin	33%
Los Angeles	21%		San Luis Obispo	54%
Marin	56%		San Mateo	45%
Merced/Mariposa	30%		Santa Barbara	81%
Monterey	77%		Santa Clara	40%
Napa	64%		Santa Cruz	59%
Nevada	78%		Stanislaus	31%
Orange	24%		Tulare	32%
Partnership ODS	38%		Ventura	40%
Placer	105%		Yolo	96%

What accounts for the large variation in the share of at-risk Medi-Cal enrollees getting MAT?

There are three types of MAT available to Medi-Cal enrollees. Almost all counties in California provide access to methadone through local contracted providers in their own or neighboring counties. Methadone clinics across the state provide access to the drug

through clinics that generally require individuals to attend daily to receive the medication, although at home dosing is available for individuals after receiving services at the clinics for a period of time. Beyond methadone, many counties provide access to non-methadone alternative forms of MAT – buprenorphine and naltrexone -- at a variety of settings. These latter two medications can also be prescribed by physicians treating individuals with opioid use disorder who are enrolled in managed care plans that pay for these services.

Chart 2 shows the overall availability of MAT in each county, showing availability of each form of MAT -- methadone, buprenorphine, or naltrexone. The counties with the highest levels of MAT availability tend to be those where buprenorphine and naltrexone are relatively more available than methadone. El Dorado, Placer, and Yolo show the highest share of at-risk population receiving MAT in any form, and these counties show large shares of buprenorphine.

All but one of these ODS counties provide methadone, and in some counties, methadone contributes a substantial share of access to MAT. This is particularly true in Central Valley counties such as San Joaquin and Fresno. In the largest counties -- Los Angeles, Orange, Riverside, and San Bernardino – methadone is provided to less than 10 percent of the at-risk population, and it constitutes less than half of the MAT provided. Access to forms of MAT other than methadone is not sufficient to raise the level of access in these large counties to the levels achieved in other counties in the state.

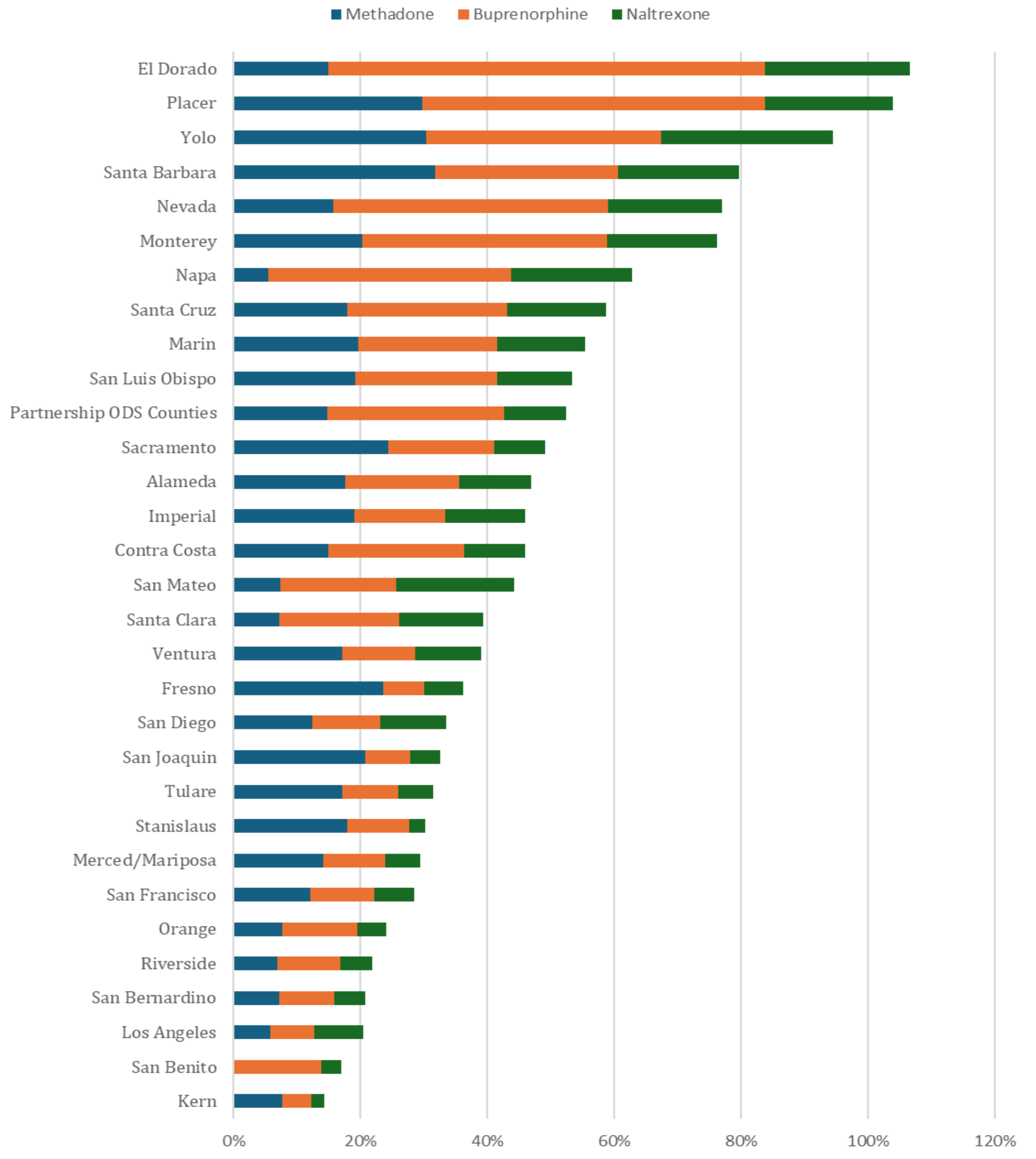


Chart 2
Share of Adult Medi-Cal who Misuse Opioids Receiving MAT
by Type of MAT - 2022
Methadone
Buprenorphine
Naltrexone
El Dorado
Placer
Yolo
Santa Barbara
Nevada
Monterey
Napa
Santa Cruz
Marin
San Luis Obispo
Partnership ODS Counties
Sacramento
Alameda
Imperial
Contra Costa
San Mateo
Santa Clara
Ventura
Fresno
San Diego
San Joaquin
Tulare
Stanislaus
Merced/Mariposa
San Francisco
Orange
Riverside
San Bernardino
Los Angeles
San Benito
Kern
0%
20%
40%
60%
80%
100%
120%

Chart 3 shows the sources of MAT in the ODS counties, distinguishing between individuals receiving MAT from county providers and those receiving MAT from private prescribers. The chart shows the total individuals receiving MAT in three groups: 1) those receiving methadone from a county provider, 2) those receiving a non-methadone form of MAT from a county provider, and 3) those receiving a non-methadone form of MAT from a non-county source funded by Medi-Cal. The chart is organized by regions of the state, and it is striking how the levels of access to MAT seem to follow regional lines.

The counties with the highest levels of access to MAT are in the Sacramento area, where the counties surrounding Sacramento have very high levels of access achieved largely by providing access to non-county non-methadone MAT. Sacramento County access is lower, at a level similar to the Bay Area.

The region with the next highest level of access is the Central Coast, where access to MAT is above average and achieved through different strategies. Santa Barbara has a relatively high level of county-provided methadone. Santa Cruz and San Luis Obispo complement their relatively low levels of methadone with county provided non-methadone alternatives, while Monterey relies on non-county sources of MAT for the majority of the population served.

The Northern California region, including the ODS counties served by the Partnership Health Plan as well as Marin and Napa, show the next highest levels of access. Here most individuals are served with non-county MAT, although Marin offers a significant amount of non-methadone MAT through county providers

In the Bay Area, the pattern the counties is fairly consistent with the majority of MAT funded by Medi-Cal from non-county sources, All the counties provide methadone, and San Francisco provides some access to non-methadone forms of MAT through the county system, Despite this, San Francisco reaches the lowest share of the at-risk population among the Bay Area counties.

In the Central Valley region, the county with the lowest estimated access to MAT is Kern where the majority of MAT is the methadone provided by the county. Eight percent of the at-risk population receives MAT, an additional 3 percent have access to county-provided MAT in forms other than methadone, and 3 percent from non-county sources.

Finally, the large counties of the Southern California region show some of the lowest levels of access in the state. In part, this is because the methadone clinic capacity is significantly smaller than is needed given the large size of the at-risk population. Nor has the supply of MAT from non-county sources expanded to make up for the low methadone capacity. In Southern California, only the smaller counties (Imperial and Ventura) have levels of access that are similar to those in the Bay Area.

Access to MAT in California is not equal across the state. Counties in more rural parts of the state show levels of use of MAT that indicate that it is more available there than in the larger urban counties. Large urban counties in the state show use levels that do not meet

the needs for MAT based on indicators of the extent to which opioids are misused in these counties.

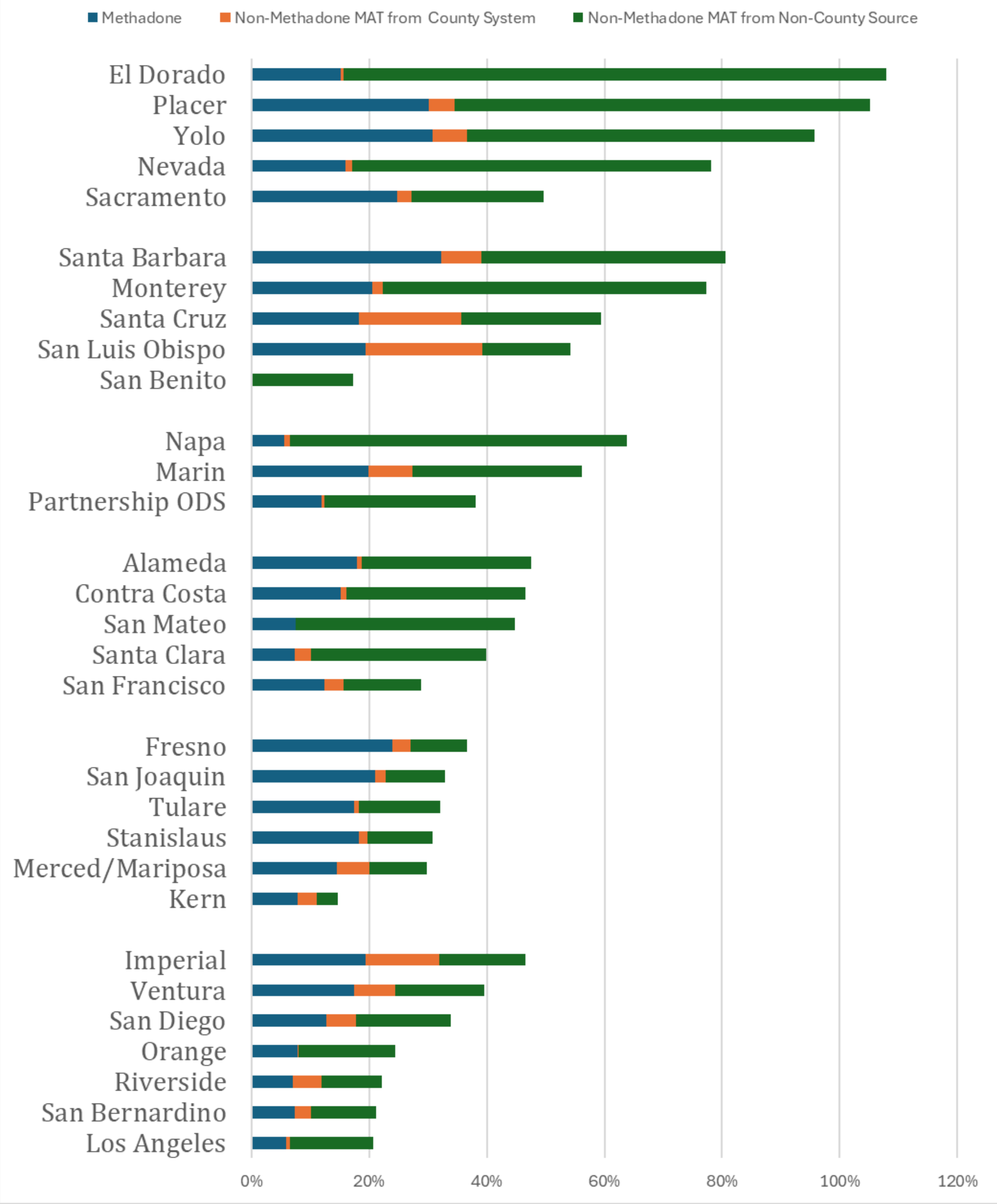


Chart 3
Share of Medi-Cal Adults Reveiving MAT,
by Source and by Region - 2022
Methadone
Non-Methadone MAT from County System
Non-Methadone MAT from Non-County Source
El Dorado
Placer
Yolo
Nevada
Sacramento
Santa Barbara
Monterey
Santa Cruz
San Luis Obispo
San Benito
Napa
Marin
Partnership ODS
Alameda
Contra Costa
San Mateo
Santa Clara
San Francisco
Fresno
San Joaquin
Tulare
Stanislaus
Merced/Mariposa
Kern
Imperial
Ventura
San Diego
Orange
Riverside
San Bernardino
Los Angeles
0%
20%
40%
60%
80%
100%
120%

Reaching those at-risk of opioid use in rural counties may be easier to accomplish than in more urban settings in that it takes only a few medical providers willing and able to meet the MAT needs of the relatively small population. Urban counties require a much larger cadre of medical providers either contracted by counties or practicing privately to achieve the broad reach into the at-risk population that small counties have achieved.

Efforts being made to increase access to MAT in California may show results in the years after 2022. First, the removal of the x-waiver requirement that limited the number of physicians who could prescribe buprenorphine will likely result in increase in its use. Second, the California Bridge program has made efforts to provide ready access to MAT in emergency room settings and support through navigators to identify community resources that can maintain access to MAT in the long run.

It is also important that Medi-Cal managed care plans and other organizations that are contracted to provide care for Medi-Cal beneficiaries ensure that they are providing access to MAT for their enrollees. With methadone numbers declining both in absolute and relative numbers, it is important to make sure that those who have initiated treatment with forms of MAT other than methadone can easily access MAT in the community, either through county-contracted providers or Medi-Cal managed care providers.

Conclusion

For the first time this paper attempts to estimate the Medi-Cal population at risk of opioid misuse and compare that number with how many are receiving appropriate medications. Based on the rates of opioid-related overdose deaths, the rate of misuse across counties in California varies considerably so that county measures of access to substance use treatment are of little use without controlling for the prevalence of opioid use.

Many California counties have a significant lack of access to medications that have been shown to be effective in treating opioid addiction. This analysis provides a roadmap to places where access to MAT is adequate and where it is not. It also offers a map of the strategies that have succeeded in expanding access, offering clues as to how to improve access to MAT where it is low.

The lowest levels of access in the state exist in some of the largest and most urban counties, places where the opioid epidemic is taking the largest toll. Fifteen years ago, the state depended largely on methadone as the primary medication to treat opioid addiction among the Medi-Cal population. But now with the availability of other forms of treatment, we should be providing a wider range of options to help treat people with substance use disorder.

State and county officials responsible for providing substance use services to Medi-Cal recipients should take note of the disparities identified by these data. The data provide information about where access to MAT is lacking, and they show the ways that counties have successfully addressed this issue. One conclusion is clear – we cannot provide access to medication assisted treatment solely through the county treatment systems. The clinics and physicians who are now responsible for providing medical care to these Medi-Cal beneficiaries need to expand their capacity to provide the medications that can be an important element in successful substance use treatment.

About the Author

- **Dr. David Maxwell-Jolly** is a Senior Advisor with CalHPS. He has over thirty years of experience with the California state government and has held a series of senior executive positions. He was the Chief Deputy Executive Director at Covered California, Undersecretary and Deputy Secretary at the Health and Human Services Agency, and Director of the Department of Health Care Services.

About California Health Policy Strategies (CalHPS), L.L.C.

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.
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