The Original Investigation by Keshwani and colleagues in this issue of *JAMA Health Forum* uses Medicaid data to measure changes in buprenorphine prescribing after 2 states lifted prior authorization (PA) requirements for the medication. The authors find markedly different results in the 2 states, observing an immediate, statistically significant increase in both the level and rate of prescriptions in Illinois, though no comparable change in California. This study highlights the complexity of research conducted on opioid use disorder (OUD) treatment in a rapidly evolving policy environment. With this Invited Commentary, we aim to add context to help guide those engaging in this urgently needed work within Medicaid programs and populations.

A first challenge is to quantify the policy of interest. In this case, the authors put considerable effort into identifying state Medicaid programs that had fully removed PA requirements for buprenorphine (as opposed to partial removal). Their analysis thus supports a “best case scenario” test of PA removal. Notably, of the 50 states and the District of Columbia, only 2 had such straightforward PA policy changes during the study years, along with enough follow-up time points. This highlights several unique challenges associated with understanding the consequences of an OUD-related policy change within Medicaid. First, resource-intensive primary data collection is often needed to understand the details of the Medicaid policy change, which inevitably differ by state. Consider the variation in states’ PA removal policies that the authors uncovered in their careful policy scan. Delaware Medicaid, for example, removed prior authorization for preferred buprenorphine formulations but not for nonpreferred formulations. Georgia removed prior authorization only for those in fee-for-service plans. Kentucky, Ohio, Pennsylvania, Wisconsin, and West Virginia removed prior authorization, but these policies were subjected to quantity limits, dose limits, and/or were not constant across eligibility groups within the state. Definitional questions of when a policy is—or is not—present may in fact explain many long-standing debates about the likely effect of major social and health policy programs.

A second concern is that the removal of prior authorization for buprenorphine within Medicaid reflects a broader shift in policies related to OUD treatment, making it difficult to isolate the effect of even a well-defined policy change. Across the states, Medicaid OUD treatment policy changed dramatically during the 2014 through 2020 study period. Some of these changes were broader in scope, such as the continued expansion of Medicaid eligibility under the Affordable Care Act or the provision of State Targeted Response grants under special federal appropriations. Other policy changes were uniquely implemented in the states. For example, both Illinois and California received institutions for mental disease waivers by the Centers for Medicare & Medicaid Services to cover residential rehabilitation services; these were part of a broader continuum of care that included augmented access to medications for OUD. As part of its waiver, Illinois began coverage of methadone maintenance in January 2017, which profoundly altered access to OUD services for Medicaid enrollees in the state (independent of policy related to buprenorphine). These concurrent policy changes can introduce unknown biases, sometimes causing policy effects to be under- or overstated. The work by Keshwani and colleagues is not immune to this, and their results should be considered in this context.

There is no silver bullet approach to solving these complex policy analyses, but there are some practical steps that may improve identification. In some cases, clever analytic approaches (such as that used by Alpert et al) may reduce bias from contemporaneous policy changes. More generally, understanding the details of program implementation and the broader state contexts can improve the
interpretation of policy effects. Partnership with legislators, clinicians, and Medicaid state officials can help inform these efforts. Likewise, qualitative research focused on Medicaid beneficiaries can add important details about how policy changes are experienced by those who are directly affected.

In the context of the current study,¹ there may be important insights gained by understanding the ostensible rationale that state officials have for imposing utilization management on buprenorphine. Prior authorization is one of the few tools that Medicaid programs have to contain the cost of medications (because they generally are not able to directly negotiate prices) and is often pursued in conjunction with the decision of whether to place medications on a preferred drug list. Before buprenorphine-naloxone sublingual strips became available as generic medications in 2018,⁵ the branded manufacturer had greater leverage over Medicaid programs, making these issues a more pressing concern. Understanding Medicaid’s competing imperatives to control cost and maintain access to services can provide important insights about how policies such as PA are implemented in practice (and indeed, the circumstances under which such policies may impede timely care). On this point, future work will need to extend beyond prescribing trends to other major policy objectives—especially the goals of promoting treatment retention and improving access to services that promote recovery and lower overdose risk. The goal of removing PA is not, per se, to increase the use of the medication, but rather to effect a series of changes that culminate in better health and well-being for Medicaid enrollees.

The study by Keshwani and colleagues¹ adds new evidence that is badly needed, especially as advocacy continues to grow for removing PA in state Medicaid programs and through national legislative efforts.⁶ The great hope of policy research is that better evidence will make for better advocacy, and ultimately better health for Medicaid enrollees.