Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Experiences of Managed Care and SUD Provider Organizations with Changes in Care Coordination

RTI International

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Introduction

Drug overdose is a leading cause of injury death in America, and opioids were involved in 75 percent of overdose deaths in 2020.[1] Factors contributing to the high number of overdose deaths include low rates of treatment for substance use disorder (SUD),[2] the stigma associated with seeking treatment,[3] and a shortage of health care professionals to treat SUD.[4] Medicaid beneficiaries face additional barriers to finding a treatment setting that meets their needs because of low participation in Medicaid by SUD treatment facilities.[5] Moreover, many SUD services are an optional benefit in Medicaid, and most states historically have not covered the full continuum of SUD services. Through section 1115 demonstrations, the Centers for Medicare & Medicaid Services (CMS) is partnering with states to test means of increasing access to the full continuum of care for SUD, including medication assisted treatment (MAT) and residential treatment, as advocated by leading treatment addiction experts.[6,7,8]

This report is part of a series of rapid cycle reports intended to share findings and insights about section 1115 SUD demonstrations. This report summarizes the experiences of managed care and SUD provider organizations in 10 states implementing changes to achieve the demonstration milestone of improved care coordination and transitions between levels of care.

Specifically, this report addresses the following three research questions:

1. What changes did managed care and SUD provider organizations make to implement care coordination in response to the section 1115 SUD demonstrations?
2. What challenges did these organizations experience implementing these changes?
3. What are the perceived effects of these changes on beneficiary access to treatment, engagement in treatment, and retention in treatment, including health equity?

Understanding the changes states, Medicaid managed care organizations (MCOs), and providers made to meet demonstration requirements and the challenges they experienced in implementation will inform the meta-evaluation of section 1115 SUD demonstrations to be conducted and interpretation of observed demonstration impacts on key outcomes across states.

About Section 1115 SUD Demonstrations

The goals of section 1115 SUD demonstrations include increasing access to SUD treatment and raising rates of identification, initiation, and engagement in treatment; increasing treatment adherence and retention; reducing overdose mortality; decreasing preventable or inappropriate emergency department and inpatient hospital utilization; reducing preventable or inappropriate readmissions to the same or higher level of care; and improving access to care for physical health conditions.

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[1] Centers for Disease Control and Prevention (CDC). (2024). *Understanding the opioid overdose epidemic*. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. HHS Publication No. PEP20-07-01-001, NSDUH Series H-55. Rockville, MD: SAMHSA, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

[3] Cheetham A., Picco L., Barnett A., Lubman D.I., & Nielsen S. (2022). The impact of stigma on people with opioid use disorder, opioid treatment, and policy. *Substance Abuse Rehabilitation, 13*, 1-12. doi: 10.2147/SAR.S304566.

[4] Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health, 105*(8), e55–e63.

[5] MACPAC. (2018). *Access to substance use disorder treatment in Medicaid*. Chapter 4 in 2017 Report to Congress (June). MACPAC: Washington, DC.

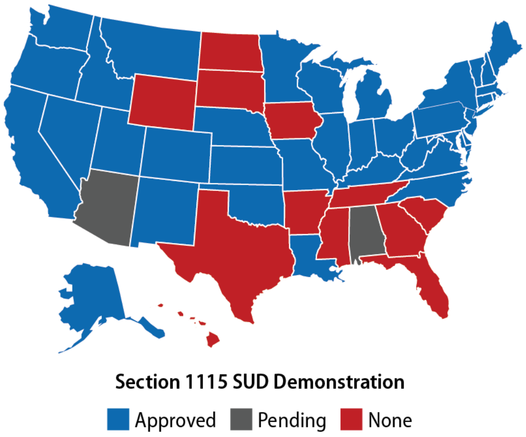
[6] Centers for Medicare and Medicaid Services (CMS). (2015). *SMD # 15-003: New service delivery opportunities for individuals with a substance use disorder*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf

[7] CMS. (2017). *SMD # 17-003: Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[8] CMS, SAMHSA, & National Institutes of Health. (2014). *Joint informational bulletin: Medication assisted treatment for substance use disorders*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

As of February 2024, 36 states and the District of Columbia had received approval for section 1115 SUD demonstrations; 2 other states had pending applications (**Figure 1**).

Figure 1. Section 1115 SUD demonstration status as of February 2024



Generally, to receive approval for a section 1115 SUD demonstration, states must outline their plans for expanding access to multiple levels of evidence-based care and explain how inpatient and residential SUD services will coordinate with community-based recovery services. States with approved section 1115 SUD demonstrations can receive federal financial participation (FFP) for SUD treatment services provided in residential and inpatient facilities that qualify as institutions for mental diseases (IMDs). These demonstrations generally require the state to submit and carry out implementation plans that set forth how the state will reach the following six milestones:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications, including implementation of a requirement that residential treatment facilities offer MAT on site or facilitate access off site.
4. Sufficient provider capacity at each level of care.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Overview of Findings

As part of their demonstrations, states added or strengthened provider requirements for care coordination; added peer supports or case management as a billable service; and added or updated requirements for care coordination.[9] Prior to the section 1115 SUD demonstrations, MCOs and providers in the 10 states in which we conducted interviews had experience with care coordination. However, care coordination for SUD was new to many MCOs, and billing Medicaid for care coordination was new to providers. Examples of the changes implemented included:

- MCOs built capacity for care coordination for SUD by hiring new types of staff with SUD expertise, reorganizing care teams to focus on SUD or better integrate physical and behavioral health, and training staff on SUD and integration of physical and behavioral health.
- MCOs made improvements to ensure availability of services, added more levels of care in their networks, and offered wraparound supportive services.
- Several provider respondents reported adding staff (e.g., peer support specialists, recovery coaches) to expand care coordination services and developing new administrative processes for billing.
- Some MCO and provider respondents shared anecdotal observations that consistent interaction with care coordination staff promoted ongoing engagement with providers and supportive services, which, in turn, supported longer-term recovery and improved access to physical health services.

Several factors created barriers to progress for MCOs and provider organizations:

- Provider respondents experienced a steep learning curve in billing Medicaid for care coordination and expressed concerns about the level of reimbursement.
- Because of federal and state waivers of utilization review requirements during the COVID-19 pandemic, MCOs had difficulty quickly identifying beneficiaries who needed care coordination services.
- Obtaining consent from individuals with SUD limited sharing beneficiary health information between MCOs and provider organizations.

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[9] RTI International. (2022). Medicaid section 1115 substance use disorder (SUD) demonstrations: Features of state approaches to improve Medicaid SUD treatment delivery systems. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-features.pdf

- Workforce shortages and the challenging credentialing process for peer support specialists limited MCOs' and providers' ability to expand their capacity to provide care coordination.
- The COVID-19 pandemic presented multiple challenges that affected MCOs and providers, including workforce challenges, trouble making referrals, increased workloads, impediments to connecting beneficiaries to supportive services, and reductions in in-person interactions and community outreach. However, the uptake of telehealth during the pandemic supported ongoing provision of care coordination services.

Approach

Findings in this report are based on 70 interviews conducted by RTI International between June and October 2022 in 10 states with section 1115 SUD demonstrations. These states were Idaho, Kentucky, Massachusetts, Michigan, New Jersey, New Mexico, North Carolina, Virginia, West Virginia, and the District of Columbia.[10] Selected states had at least two years of demonstration experience as of July 2022 and expanded or added coverage for residential care for SUD and/or added or updated their patient placement criteria or policies related to care coordination under the demonstrations. Across these states, we interviewed 33 representatives from organizations contracted to manage a Medicaid population (i.e., MCOs and accountable care organizations) and other organizations responsible for managing SUD provider networks or access to SUD services for Medicaid beneficiaries (e.g., prepaid inpatient health plans [PIHPs]). Throughout this report, we refer to these representatives as “MCO respondents.” We also interviewed 37 representatives from several types of provider organizations serving Medicaid beneficiaries, including residential service providers, nonresidential service providers, and providers offering both residential and nonresidential services. We refer to these representatives as “provider respondents.” During the interviews, we asked MCO and provider respondents about care coordination and transitions in care. MCO and provider respondents often used the terms care coordination, case management, care management, discharge planning, and care transitions interchangeably when responding to questions about care coordination. In this report, we adopt their language when providing quotes. **Appendix A** provides more information about the data collection methods.

Results

Milestone 6 for the section 1115 SUD demonstrations guided states to implement policies to support care coordination, which entailed ensuring “residential and inpatient facilities link beneficiaries, especially those with OUD, to community-based services and supports following facility stays.”[11] For the demonstrations, CMS provided reimbursement for care coordination services for SUD and also covered activities performed by certified peer support specialists (PSS) and recovery coaches. States could determine which specific care coordination services and staff types to cover and used different payment models, such as bundled rates, per beneficiary per month, or a lump sum payment. Nine of the ten states in this report added or updated state care coordination policies to align with Milestone 6. Policy changes included adding or strengthening provider requirements for care coordination (District of Columbia, Kentucky, New Mexico, Virginia); adding peer supports or case management as a billable service (Massachusetts, New Jersey); and adding or updating requirements for care coordination in MCO contracts (Idaho, North Carolina, Virginia).[12] In the demonstration's theory of change, Milestone 6 should translate into improvements in beneficiaries' access to, engagement in, and retention in treatment.

Prior to the demonstrations, over half the states in which we conducted interviews had state-level Medicaid policies that bolstered care coordination for SUD, such as strengthening existing provider requirements for care coordination; expanding the scope of existing Medicaid-billable services for PSS, recovery coaches, and SUD case managers; and amending MCO contract language to strengthen existing requirements related to care coordination for SUD. Four states adopted new policies as part of the demonstrations.[12] New state policies included adding care coordination requirements for residential and inpatient facilities and adding peer support and case management benefits. Although Medicaid care coordination policies were new in some states, provider respondents from nearly every state reported performing care coordination for individuals with SUD before the demonstrations. MCO respondents from most states also said their organizations provided care coordination prior to the demonstrations, but care coordination specific to SUD was new. This experience with care coordination, in general and specific to SUD, meant MCO and provider respondents usually did not identify significant organizational changes required to meet this milestone. However, across all 10 states, MCO and providers described some changes related to providing care coordination in response to the demonstrations and identified implementation challenges. Some anecdotally shared how care coordination affected beneficiaries. This section describes (1) MCO and provider changes in response to the implementation of care coordination under the demonstrations, (2) challenges MCOs and providers experienced, and (3) perceived impacts of the changes on beneficiaries' access to and engagement in treatment.

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[10] For brevity, we refer to states and the District of Columbia as “states.”

[11] CMS. (2017). *SMD # 17-003: Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[12] RTI International. (2022). Medicaid section 1115 substance use disorder (SUD) demonstrations: Features of state approaches to improve Medicaid SUD treatment delivery systems. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-features.pdf

MCO and Provider Changes to Respond to Care Coordination Requirements

MCO changes. Because most MCOs we interviewed were new to care coordination for SUD, the organizations needed to make some changes to align their services with the needs of beneficiaries with SUD. MCO respondents described several changes their organizations or provider networks made in response to new or updated policies in their states, including creating enhanced care teams and expanding the continuum of SUD providers in their network.

MCO respondents in half the states reported enhancing existing care teams by (1) hiring new types of staff to support care coordination for SUD, (2) creating care teams focused on SUD care coordination and care transitions, or (3) providing SUD-specific trainings for care managers and other staff. First, the organizations added staff to fill new roles, such as a recovery and resilience manager, recovery support nurse, certified alcohol and drug treatment counselor, recovery coach, support navigator, and PSS. These new staff strengthened the care coordination services the MCOs offered, brought SUD expertise to existing care coordination teams, and educated providers and beneficiaries about the types of services available. Second, a few MCOs constituted new care teams dedicated to care coordination and transitions in SUD care as well as supporting integration between physical and behavioral health services. In some cases, they hired new staff, and in other cases they reorganized existing staff into specialty teams. Such specialty teams consisted of a range of roles that provided whole-person care, including integrating physical, mental, and behavioral health, and addressed social determinants of health. MCO respondents from two states described having interdisciplinary team calls to discuss the behavioral and physical health needs of beneficiaries. One MCO respondent described the composition of their team dedicated to SUD, *"We have a housing specialist who works with the care coordinators. We have a justice-involved specialist for folks coming out of jail and prison settings….The care coordination program is robust. And, we have peer support workers, too."* Lastly, a few MCO respondents reported providing training on SUD topics to the care coordination staff. These trainings centered on educating care coordination staff about meeting demonstration requirements for care coordination, integrating physical and behavioral health care, and coordinating beneficiary care across the SUD continuum of care. MCO respondents also discussed training providers on availability of resources to support integration of physical and behavioral health services.

Across half of the states, MCO respondents recognized that to offer care coordination and SUD services across the care continuum, they needed to ensure availability of services. Several MCO respondents described adding more levels of care in their networks. For example, one MCO respondent reported that to prevent unnecessary use of residential care, the organization added more levels of care for withdrawal management and early intervention:

> *"[Our organization is] plugging in our access, making sure that we're assisting providers and clients,…so there is no high utilization of residential, just making sure to not have that perpetual circle of 3.5 level of care [clinically managed medium-intensity residential services]...we worked with providers, hand-in-hand, making sure they know that all the levels of care are available and can be utilized, so we can avoid some of the high utilization of higher level of care."*

> *"It's very important to train our teams about all of these [demonstration] changes and what it means to their role in supporting our members…What does an adult substance use RTC [residential treatment center] do? What does that mean to us? How do we support our members? A lot of training. A lot of understanding the service, understanding where it's available, understanding…when it's appropriate for a member, understanding the components of transitions of care."*
>
> -MCO respondent

Several MCO respondents also described beginning to offer wraparound supportive services, such as housing support, transportation support, and food assistance to address beneficiaries' other needs. Having the full array of services available facilitated referrals between levels of care.

Provider changes. The section 1115 SUD demonstrations allowed for reimbursement of care coordination services for SUD, including services performed by certified PSS and recovery coaches. Provider respondents in nearly every state, especially those at large organizations, reported that they offered care coordination and care management for SUD well before the demonstrations began. Provider respondents explained that, prior to the demonstrations, they used multiple funding sources to cover care coordination costs (e.g., Substance Abuse and Mental Health Services Administration [SAMHSA], state, and private foundation funds). For these organizations, the demonstrations mainly changed billing and reimbursement for these services. At least one provider in every state explained that the demonstrations did not result in major changes in service provision, but they could now bill for care coordination services for SUD. The ability to bill for services helped to cover costs for providing care coordination and increase the sustainability of these services. As a provider respondent explained:

> *"It's been very helpful to have reimbursement for those [case managers and peer support] services because we were eating a lot of [costs associated with care coordination]."*
>
> \- Provider respondent

> *"It's something we've been doing all along. We were providing those services, case management, also working in conjunction with MCOs to provide care managers, or care management, in coordination with clients we have in common…. So, I guess in some ways [getting reimbursed through the demonstration] help[s] to shore up what we were already doing, making it more sustainable."*

Several provider respondents described adding staff, such as PSS, recovery coaches, or more case managers, to their existing care coordination teams or departments because of the increased demand for care coordination services. Provider respondents in a few states described enhancements to discharge planning. One provider organization added a discharge planning team; two other provider respondents emphasized that their discharge planning teams began to focus on developing quality discharge plans from the time a beneficiary was admitted. One provider respondent elaborated:

> *"As far as expansions, [we have] really been trying to make sure that we focus a lot more on quality discharge…And… the big key piece with ASAM [American Society of Addition Medicine] accreditation was really thinking about that from day one at the point of admission about a strong discharge plan. Even if people discharge against medical advice, that we have people walk out the door with a safety plan and follow up planning, that's been a big focus."*

Only one provider respondent described pursuing a more substantial organizational change. This provider organization became a "community partner" within an MCO network. Becoming a community partner required them to implement new data monitoring and tracking systems, establish care management teams, and conduct more outreach to other local physical and behavioral health providers.

Although the demonstrations allowed providers to receive reimbursement for care coordination, a few providers representing smaller organizations noted that they did not provide care coordination services before the demonstrations and did not have the staffing capacity to offer care coordination after the demonstrations went into effect. These respondents conveyed that small organizations did not have resources to support a full-time care coordinator and could not support case management for integrating physical and behavioral health. These providers referred beneficiaries to other providers when appropriate, but they could not track whether the beneficiary engaged in care after the referral.

Challenges

Provider challenges with reimbursement and billing. States varied in the care coordination services and staff roles that they covered and the payment model for reimbursing these services. A few states covered care coordination only for populations with unique needs (e.g., pregnant beneficiaries with SUD, beneficiaries with co-occurring mental health disorders and SUD). Provider respondents in almost half the states described challenges with reimbursement for care coordination, including (1) concerns about the level of reimbursement and (2) difficulty with the administrative processes and documentation for billing. In a few states, provider respondents commented that Medicaid reimbursement was not sufficient for comprehensive care coordination. One provider respondent commented, *"I think that the reimbursement is limited. There's a lot of services that the case managers and recovery support specialists do that they can't get reimbursed for."* Another added that reimbursement rates are not high enough to cover the staff salaries. Because the level of reimbursement did not align with the providers' level of effort, according to respondents, their organizations used other funding sources to cover the remaining costs. As one provider respondent explained:

> *"Yeah, we could never adequately fund our care coordination [with] Medicaid-reimbursed services…. It's an overwhelming amount of documentation required for a very low reimbursement rate. So, we do most of that through SAMHSA-funded grants. So, we can get reimbursed through Medicaid, but it's not how we fund most of it."*

A few provider respondents described hurdles to establishing administrative processes for billing for care coordination or documenting care coordination appropriately to receive reimbursement. Even though providers had offered care coordination services prior to the section 1115 SUD demonstrations, billing Medicaid was new. Negotiating the rules and documenting appropriately presented a learning curve and entailed developing internal practices to fulfill billing requirements. For example, one provider respondent stated:

> *"The billing got really convoluted with that [care coordination services]. That's complicated billing…. We're providing services where that's all fine, but it's the management and administration of the billing rules and what we've had to do on the back end to manage the billing rules."*

Because billing for care coordination was new, the provider organizations had not figured out what would satisfy MCOs to receive reimbursement. Further, provider respondents explained some MCOs did not routinely accept the documentation they submitted, which created frustration as well as additional administrative burden for the provider organization. One provider respondent said:

> *"And then how do you document [the care coordination provided]? And then how do you make the biller happy and the payer happy in the codes?.... So, that's been the biggest hindrance…arguing with the [MCO]…on how to properly document and code what you have."*

In spite of the challenges and complex start-up, providers ultimately developed internal administrative processes to bill. When an MCO denied a claim and the provider could not obtain payment after trying to resolve the denial, some providers relied on other funding sources to cover care coordination efforts and minimize financial losses.

Lack of real-time data to identify beneficiaries who may need care coordination. MCOs could not identify beneficiaries who needed care coordination because they lacked real-time data on beneficiaries' use of SUD services. The lack of data arose (1) from the suspension of utilization review by CMS and some states and (2) from beneficiaries seeking treatment from providers outside the MCO network. In over half of the 10 states, MCO respondents described a lack of information from providers about beneficiaries in their network. In response to the COVID-19 public health emergency, CMS and half the states waived the utilization review requirements for hospital admissions.[13,14] This means that in some cases, providers admitted beneficiaries and MCOs did not learn about the admission until they received a claim for the service. MCOs also lacked timely information on beneficiaries entering treatment with a provider outside the MCO network or transitioning to different levels of care unless the provider contacted the MCO directly. As one MCO respondent reported:

> *"One of the huge barriers for us is not having that UM [utilization management] data. We do not always know when people are getting residential care. We don't know when they're being discharged. I mean, we're really basing that off claims…. We've been really dependent upon people letting us know, calling the managed care company and saying, "You might want to outreach this person," or "You might want to help with this," [but] that has not been a priority of providers."*

In other cases, MCOs explained the lack of real-time data meant that they could not facilitate discharge planning or respond to other beneficiary needs quickly. As one MCO respondent explained:

> *"[Our organization was not] immediately aware within at least 24 hours that someone had entered into [residential and inpatient] levels of care...having the pulse of what is going on and where our members were and being able to identify the needs immediately versus after a week or two weeks after they've been in a level of care."*

> *"There is no centralized tracking system…that allows folks that are involved in [care coordination] …to see in real time when patients are being admitted and discharged. And so, care coordination and transitions of care in many ways is directly tied to those admissions and discharges. And if we don't have a window into when they're actually happening, it's virtually impossible to do good real time in-depth care coordination."*
>
> -MCO respondent

To mitigate this challenge, some MCOs embedded staff in provider organizations. Embedded MCO staff served as liaisons in psychiatric hospitals and emergency departments to identify beneficiaries with care coordination needs. MCOs employing this approach tended to assign liaisons in larger hospitals or residential facilities with substantial beneficiary volume. Two MCO respondents described their efforts to better coordinate with providers and identify beneficiaries in need of care coordination more quickly:

> *"[The MCO] assigned care coordination [liaisons] to every psychiatric hospital... [The care coordinator's] job would be to work with transitioning members out or trying to engage with frequent flyers, patients who were really difficult to engage. They would try to get to know them and help them get engaged in care coordination."*

> *"[Our organization] also ha[s] an initiative with some of the hospitals where we have recovery coaches that go out that are actually in the ER [and are instrumental in] identifying those individuals, especially those individuals who have been determined as having an overdose…. And those recovery coaches are working with [beneficiaries] and developing and assisting them and linking them and making referrals to services."*

One MCO added admission, discharge, transfer (ADT) notifications to electronic health records; these alerts drew on multiple data elements and an algorithm to help the MCO predict which beneficiaries could use care coordination. The MCO respondent explained:

> *"We already have [created] ADTs in terms of notifications....which is intended to enhance the care coordination piece, whether [the beneficiaries are ending up in] the emergency departments, whether they're getting hospitalized, whether there is somebody who is recurrently getting hospitalized...we have created these alerts."*

The ADT notifications provided this MCO with data on beneficiaries' current engagement in treatment so that they could identify individuals needing care coordination services. Embedding staff and using alerts gave MCOs information on beneficiaries more quickly than relying on claims alone. At the time of the interviews, the federal and state waivers were still in place; however, a few respondents reported that the state would lift its waiver in the upcoming months and that the lack of real-time data may not continue to be a problem.

Challenges with obtaining consent to share health information. Federal regulation 42 C.F.R., Part 2, the Confidentiality of Substance Use Disorder Patient Records, requires beneficiary consent to transfer health information related to SUD between organizations and among providers within an organization; MCO and provider respondents from half the states commented on concerns about adhering to the 42 C.F.R while trying to obtain consent from individuals with SUD, who may have instability in their life circumstances. Difficulty obtaining consent from individuals seeking SUD services limited sharing beneficiary health information between MCOs and provider organizations and constrained care coordination efforts. The federal regulation presented a challenge because individuals with SUD often opt not to give consent or do not have reliable contact information (e.g., no permanent address, disconnected phone lines) for MCOs to follow up post-discharge to obtain consent. One provider respondent reported that organizational leadership, in collaboration with the legal department, developed a "universal waiver" of consent. This universal waiver allowed a beneficiary to sign one consent form for all of the SUD providers within the network so that SUD providers within the network could more easily review and share beneficiary health information.

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[13] CMS. (2020). *COVID-19 emergency declaration blanket waivers for health care providers.* https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

[14] KFF. (2021). *Medicaid emergency authority tracker: Approved state actions to address COVID-19*. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/

“So, you can receive a peer recovery support specialist certificate…And you do your 30 hours or 38 hours of coursework. You do 500 hours of supervised internship. I don’t know if they make you take a test. Nowadays, you pay $250, and you get a beautiful certificate. Turns out to be credentialed with Medicaid, you need to be a national certified peer recovery support specialist…So you need to take another test or another course and pay another $250. We have yet to get somebody to that point.”

-Provider respondent

Challenges identifying credentialed peer support specialists and recovery coaches. Identifying credentialed PSS and recovery coaches or helping such individuals obtain a credential proved difficult in a few states. PSS and recovery coaches are persons who have overcome SUD and have obtained a certification to assist individuals with SUD. They can serve valuable roles in an individual’s care plan by aiding in care transitions, supporting ongoing engagement in treatment, and assisting with identifying community resources. Provider respondents welcomed that the new contracts allowed them to bill for PSS and recovery coach services. However, finding staff to provide these services was challenging because of the tight labor market and state policies. A provider respondent described this challenge:

> *“I think the demand [for PSS] is great, and the support is not so great for two reasons. One is that our general labor market in every state is a bit diminished at the moment, but the other thing…especially as it relates to peer support recovery specialists is that the barrier [is the] crimes statute in [state makes it] hard to launch a program. Because to be a peer support recovery specialist, you have to be someone in recovery, and many people in recovery have a past…I can’t hire anybody that cares for patients if they stole a pocketbook in a grocery store 25 years ago.”*

State credentialing requirements for Medicaid reimbursement compounded the ongoing SUD provider workforce shortages. To manage this challenge, provider organizations continued to offer peer support services and paid for it with other funds (e.g., private or non-Medicaid state funds) while staff worked toward their credentials.

Challenges with workforce shortages. SUD provider workforce shortages meant that provider organizations had difficulty hiring staff to support care coordination. MCO and provider respondents from over half the states described workforce shortages among a range of SUD providers, including social workers, recovery coaches, and PSS. These shortages meant that MCO and provider organizations often had vacancies and the care coordination staff were overburdened.

To fill staffing needs quickly, one provider respondent said their organization hired a “sourcer” who actively recruits licensed staff from other organizations. MCO respondents described some approaches to addressing staffing shortages, including using risk stratification to identify beneficiaries with the greatest and most immediate care coordination needs and having an MCO liaison support discharge planning from residential facilities for those beneficiaries. The MCO respondent who used risk stratification explained:

> *“[We] also honed [beneficiary data] around risk stratification to say, “Where can we be more proactive from a care coordination standpoint?,” as well as provide the much needed care to areas where the risk stratification demands immediate care because you only have limited staffing. You only have what you can do. And staffing is a national issue…, so how do we make the most with what we’ve got?”*

Recognizing that providers in their network were struggling with staffing shortages, an MCO respondent also described offering staffing support to providers in their network:

> *“And another challenge also is that these [residential] facilities are extremely busy, and they do have turnover…So what we do is try to facilitate and make it easy for them to communicate with us about members preparing to discharge and coordinating with us that discharge. So, we have one liaison that’s assigned to each of the facilities in [network], and that person is their single point of contact.”*

Despite the workforce shortage, provider organizations continued to offer care coordination services, but at reduced capacity. Existing staff assumed heavier workloads, which contributed to staff burnout.

Challenges created by COVID-19. The COVID-19 pandemic presented several challenges for care coordination, but it also led to an increase in telehealth to support care coordination when in-person interaction became untenable. MCO and provider respondents from nearly every state described challenges arising from the COVID pandemic.

First, COVID-19 worsened the workforce shortages, as staff became ill or preferred to leave health care during the pandemic, which made it harder to maintain optimal staffing levels and increased staff workloads. COVID-19 required existing staff to implement additional safety protocols to reduce outbreaks, which further increased their workload. One provider respondent explained, *“[We’re] also running twice the amount of groups because we reduced the size of the groups…trying to keep that separation and reduce outbreaks in the facility.”*

Second, provider respondents described encountering difficulties in making referrals to other levels of care and to supportive services. Provider respondents commented that the demand for SUD services increased, while at the same time provider organizations could accommodate fewer beneficiaries because of safety protocols and reduced staffing levels. This meant that staff needed to do more outreach to identify a provider organization to provide the right level of care and beneficiaries who may have been ready for discharge could not be efficiently placed in the appropriate level of care. As one provider respondent explained, *“[Because of COVID], I think there were [fewer] placement options available for people…. It was more phone calls [to make referrals]. It wasn’t easy....”* Access to supportive services also became more constrained during the COVID-19 pandemic, making it more difficult to connect beneficiaries to food stamps, housing, employment, and transportation resources.

MCO respondents in a few states noted the elimination of face-to-face interactions hindered care coordination by reducing visibility in the community and impeding in-home visits. As an MCO respondent explained:

> *"I think COVID impacted us quite a bit. Again, part of the thing with care coordination is visibility, and visibility whether you're in the community mental health center [or] out there connecting with those providers and the members in the community."*

MCO and provider respondents in the majority of states identified telehealth as a way to provide care coordination and engage beneficiaries during COVID-19 shutdowns. However, they recognized that not all beneficiaries preferred telehealth and some beneficiaries' use of telehealth services was limited because they did not have access to the required technology. Although providers and MCOs found ways to navigate the difficulties they encountered, overall COVID-19 created multiple stresses for them.

> *"[COVID was] a huge problem. Essentially everything became telephonic, and it [care coordination] became much, much more difficult to do….Before [COVID], everybody got a home visit, unless there was some good reason not to do it. The care coordinator would look at the person's living situation or visit them wherever they are, if they were in a homeless shelter, or in jail, or hospital, whatever. All that came to a halt, and I think that's made engagement much more difficult."*
>
> -MCO respondent

Perceived Impacts of Care Coordination on Beneficiaries' Access to, Engagement in, and Retention in Treatment

At the time of the interviews, many MCO and provider respondents reported that it was too early to determine changes in beneficiary outcomes. Other MCO and provider respondents shared anecdotal information about improvements in several outcomes arising from care coordination supported by the section 1115 demonstrations, including increases in beneficiary access to, engagement in, and retention in SUD treatment; improvement in long-term recovery; reductions in emergency department use; and increased access to physical health services. Having new staff dedicated to care coordination and increased provider education about the availability of care coordination services gave beneficiaries more supports and raised awareness about care coordination for SUD. A few provider respondents spoke about how care coordination increased retention of Medicaid beneficiaries in treatment by keeping them connected with their health care providers. One respondent spoke about how coordination at different levels of care contributes to beneficiaries building a trusting relationship with the SUD provider to feel comfortable coming back for additional services:

> *"Once [beneficiaries] get connected with us, sometimes building [a] relationship with a peer in the emergency room, and then they build relationships with the staff that are here at different various levels of care, all the way through housing. And they stay connected with us...their medical providers...their mental health provider...case managers...[beneficiaries] trust us...they know that they're going to get all of the things that they need for here that care about them."*

One MCO respondent commented that recovery support staff were crucial for beneficiary retention:

> *"Whenever you can have somebody that you're talking to every day, that's positive about your recovery, supporting you, asking what your needs are, you're going to stay engaged longer than you would without that service. [Recovery support staff are] an important component, and [they] have a real positive impact overall."*

In several states, provider respondents reported that care coordination supported long-term recovery because it gives beneficiaries resources for maintaining their recovery. A provider respondent reported:

> *"[Care coordination] has significantly increased the likelihood of [beneficiary] long-term recovery because access to those services was next to impossible before this [demonstration] program came into being, and before we started having care coordinators on our side and linked [beneficiaries] to care coordinators."*

One MCO respondent shared that their organization also has identified reduction in emergency department use among beneficiaries with SUD and suggested that care coordination efforts contributed to that reduction. A few MCO respondents discussed that their care coordination efforts supported integration between physical and behavioral health. One respondent reported increased access to physical health services as an impact of care coordination.

MCO and provider respondents from about half the states noted that they lacked data to determine whether the care coordination implemented through the demonstrations helped to address health disparities. Despite the lack of data, some respondents identified programs in their states that offer care coordination services as part of broader SUD treatment for specific populations, such as pregnant and postpartum women, mothers of children born with substance dependence, justice-involved individuals, indigenous populations, and refugees.

Conclusions

This report highlights the changes that MCOs and SUD provider organizations in 10 states made to implement care coordination and associated administrative processes in response to their states' section 1115 SUD demonstrations. As part of their demonstrations, states added or strengthened provider requirements for care coordination; added peer supports or case management as a billable service; and added or updated requirements for care coordination.[12] MCO respondents shared that they made improvements to ensure availability of services, added more levels of care in their networks, supported integration of physical and behavioral health, and offered wraparound supportive services. Provider respondents reported adding some staff (e.g., peer support staff, recovery coaches) to expand care coordination services and developed new administrative processes for billing.

This report also describes the challenges they encountered and summarizes MCO and provider observations on beneficiary impacts arising from the demonstrations to date. The MCO and the provider respondents from most states had some experience using care coordination and supporting transitions in care before the demonstrations. However, care coordination for SUD was new to many MCOs, and billing Medicaid for care coordination was new to providers. MCOs built capacity for care coordination for SUD by hiring new types of staff with SUD expertise, reorganizing care teams to focus on SUD, and training staff on SUD.

MCO and provider respondents lacked data to specify beneficiary impacts, but some shared anecdotal information on how care coordination efforts affected beneficiaries; respondents noted that that consistent interaction with care coordination staff promoted ongoing engagement with providers and supportive services, which, in turn, should support longer-term recovery and improved access to physical health services.

External factors presented the most challenges to implementing care coordination. COVID-19 contributed to ongoing workforce shortages, limited in-person interaction, limited the availability of residential and other placements, and required provider staff to attend to multiple safety protocols, which left less time for other responsibilities like care coordination. Policies related to the national public health emergency, specifically the waiver of utilization review, meant MCOs had more difficulty quickly identifying beneficiaries who might need care coordination. Further, beneficiaries with SUD are often hard to reach and reluctant to give consent to share health information, which also created barriers to coordinating their care. Workforce shortages, compounded by the difficulty of credentialing PSS, meant that MCOs and providers did not have their preferred staffing levels for care coordination efforts.

These challenges could affect beneficiary experiences and limit the effectiveness of care coordination, but the context in which the demonstrations are implemented is evolving, especially with COVID-19 abating. Although COVID-19 reduced provider capacity and limited access to treatment, providers are returning to pre-COVID service provision, including more in-person engagement of beneficiaries. Policies arising from the national public health emergency may be lifted or changed in the upcoming months; MCO leaders are anticipating that utilization review will be reinstated, which will allow better tracking and monitoring of beneficiary needs. Serving hard-to-reach populations is not new to MCOs or SUD providers, and both can implement in-person outreach to support engagement in care among these populations, including supporting access to wraparound social services (e.g., housing, food assistance, employment assistance). However, workforce shortages may continue and likely have a greater impact on states with large rural and frontier populations.

All challenges discussed above hindered implementation of care coordination, but their impacts on progress toward meeting demonstration Milestone 6 will vary across states, both because of differences in state context (such as rurality or the timing and extent of COVID impacts) and differences in MCOs' and providers' success in addressing these challenges. Demonstration outcomes may vary among states based on the extent and nature of challenges states experienced. The findings from these interviews may help to contextualize state-specific results from the impact analysis and meta-analysis or may support operationalization of new variables for those analyses.

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The Federal Meta-Analysis Support Contract

In 2018, the Centers for Medicare & Medicaid Services (CMS) commissioned the Federal Meta-Analysis Support contract (HHSM-500-2014-00037I) to learn from each Medicaid section 1115 demonstration and the groups of such demonstrations with similar features. Under this contract, RTI International is conducting meta-evaluations of selected groups of Medicaid section 1115 demonstrations.

Rapid cycle reporting is central to the Federal Meta-Analysis Support contract, providing CMS with timely, practical findings, and supporting dissemination of findings to key stakeholder audiences. This report is one of several rapid cycle reports prepared by RTI International under the contract.

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews conducted by RTI International between June and October 2022. Key Medicaid MCO and provider informants in 10 states with SUD demonstrations participated in the interviews. These states were Idaho, Kentucky, Massachusetts, Michigan, New Jersey, New Mexico, North Carolina, Virginia, West Virginia, and the District of Columbia.[15] Selected states had at least two years of demonstration experience as of July 2022 and expanded or added coverage for residential care for SUD and/or added or updated their patient placement criteria or policies related to care coordination under the demonstrations. To identify potential respondents, we asked state Medicaid officials to share contact information for organizations contracted to manage a Medicaid population (i.e., MCOs and accountable care organizations), other organizations responsible for managing SUD provider networks or access to SUD services for Medicaid beneficiaries (e.g., PIHPs), and Medicaid provider organizations offering residential and nonresidential SUD services. We conducted up to 8 interviews in each state, totaling 70 interviews with representatives of 33 MCOs or other organizations responsible for managing SUD care (herein collectively referred to as “MCOs”) and 37 SUD provider organizations (9 offering residential services, 11 nonresidential services, and 17 both residential and nonresidential services). We interviewed MCOs and provider organizations that represented different regions of the state and both urban and rural geographic areas. We targeted provider organizations that were operating in the state prior to the demonstrations and could compare delivery of SUD services before and after the implementation of the demonstrations.

We developed two semi-structured interview protocols, one for interviews with MCOs and one for interviews with SUD provider organizations. The protocols covered operational and administrative changes made in response to state changes under the demonstration in (1) Medicaid coverage, billing, and reimbursement (particularly for residential care); (2) patient placement criteria and utilization review; and (3) care coordination. The protocols also included questions about implementation challenges and facilitators and perceived impacts of the demonstrations on beneficiaries’ access to care, beneficiaries’ engagement and retention in SUD treatment, and health disparities in SUD treatment. Interviews were 60 minutes in length.

Interviews were audio recorded (with respondent permission) and transcribed. We analyzed the transcripts using NVivo 12.0. The initial analysis phase entailed a deductive coding process with prescribed codes for topics that aligned with the interview protocol. After this initial phase, the analysis team initiated an inductive coding process to identify and synthesize common changes organizations made, challenges to implementation, and perceived impacts on beneficiaries across states. The team held regular coding reviews and debriefings for quality control purposes.

In the report, we use quantifying language (e.g., “all states” or “some respondents”) to give readers a sense of the number of respondents who mentioned a topic during an interview and therefore the prevalence of topics that respondents raised or addressed. We do not provide exact counts of respondents who mentioned a topic because the interviews were semi-structured in nature. Unlike the case of a structured survey with identical questions and response sets, we cannot conclude from semi-structured interviews that a particular topic was or was not relevant or meaningful to respondents who did not mention a particular topic.

This analysis has several limitations. First, we conducted interviews in 10 of 34 states with an approved section 1115 SUD demonstration. Findings may not represent experiences in the states implementing demonstrations that were not included. Second, our interviews did not necessarily include all MCOs or other organizations responsible for managing SUD care for Medicaid beneficiaries and included a convenience sample of Medicaid SUD provider organizations in each state. The perceptions and experiences of the respondents may not represent those of other organizations in the state. Finally, states had ongoing initiatives to address substance misuse unrelated to the demonstrations, making it difficult in some cases to attribute changes and impacts to the demonstrations. In some cases, MCO and provider respondents were not aware of the section 1115 SUD demonstrations, compounding difficulties attributing changes to the demonstrations.

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[15] For brevity, we refer to states and the District of Columbia as “states.”