Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Experiences of Managed Care and Provider Organizations with Expansion of Coverage of SUD Services

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RTI International

Introduction

Drug overdose is the 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 with the expansion of Medicaid coverage for SUD treatment services under the demonstrations.

Specifically, this report addresses the following three research questions:

1. What changes did managed care and SUD provider organizations make in response to the expansion of coverage of SUD services under 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.

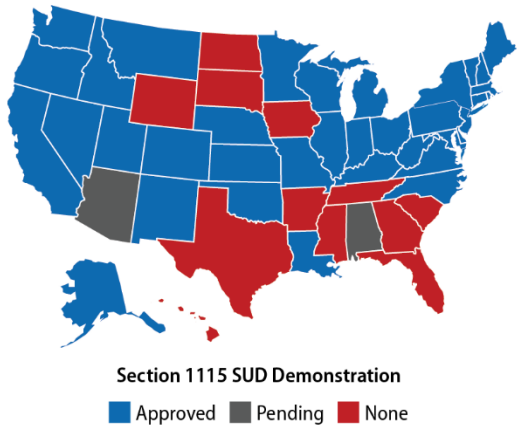
[6] Centers for Medicare and Medicaid Services (CMS). (2015). *SMD # 15-003: New service delivery opportunities for individuals with a substance use disorder*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf

[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

Of the 10 states included in our interviews, 9 began covering at least one new SUD service type (i.e., residential, intensive outpatient, partial hospitalization, recovery support, or methadone services) under Medicaid as part of their section 1115 SUD demonstration. Coverage for residential services was added or expanded in most of the states, as were new benefits for recovery support. Intensive outpatient and partial hospitalization services and methadone for MAT were already reimbursable in the majority of states in which we conducted interviews. Many of the study states made or are making changes to managed care arrangements for SUD services, creating a new delivery structure and new requirements for MCOs and providers alike.

In response to the expanded coverage of SUD services under the SUD demonstrations, MCO and provider respondents, from the 10 states in which we conducted interviews, reported the following changes:

- MCOs in several states developed relationships with new providers, recruited new providers for their networks, and offered provider training. MCOs also hired and trained more staff to meet increased demand for SUD services.
- SUD provider organizations in many states underwent credentialing to join MCO networks, expanded their SUD service offerings, hired more staff, and/or modified their administrative systems to manage prior authorization and billing requirements. Residential provider respondents in most states reported that they had begun to offer MAT on site or had added intensive outpatient programs.

MCOs and provider organizations encountered several challenges:

- Some providers experienced difficulties adjusting to new MCO prior authorization requirements and billing processes for SUD services.
- Providers from more than half the states reported increased administrative costs, including costs for establishing new administrative infrastructure and hiring new staff to support prior authorization and billing.
- Although Medicaid covers residential and off-site MAT under the demonstrations, respondents in a few states observed provider hesitance or resistance to administering MAT.
- MCO and provider respondents reported challenges recruiting, hiring, and retaining staff because of shortages of qualified candidates and rising salary demands.
- The COVID-19 pandemic caused providers to limit capacity in their facilities, but reimbursement for telehealth services and the suspension of utilization review facilitated providers' ability to treat beneficiaries during the pandemic.

MCOs and provider respondents generally had mixed opinions about whether these changes have impacted beneficiaries' access to and engagement in SUD treatment to date:

- Some respondents described increases in beneficiary access to treatment, while others did not specify any changes under the demonstrations. Respondents attributed improved access to increases in residential treatment bed capacity and provider network expansions as well as to Medicaid eligibility expansions.
- Provider respondents identified several challenges to engaging beneficiaries in treatment including instability in beneficiaries' life circumstances, denials or delays in obtaining authorizations from MCOs, and gaps in the availability of treatment in rural and frontier areas.

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.[9] 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." **Appendix A** provides more information about the data collection methods.

Results

Milestone 1 for the section 1115 SUD demonstrations promotes access to critical levels of care for OUD and other SUDs; this milestone emphasizes the "coverage of a) outpatient, b) intensive outpatient services, c) medication-assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state), d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management."[10] Early in their demonstrations, states were required to assess the availability of Medicaid providers across the levels of care (Milestone 4). As part of the demonstration, states worked toward improving access to treatment across the SUD continuum and building sufficient provider capacity to serve the Medicaid population in need of SUD treatment. As noted above, all demonstration states obtained authorization through the demonstration to receive a federal match for state expenditures for inpatient and residential care provided in IMDs. In addition, demonstration states made other changes to their Medicaid SUD benefits to expand access to critical levels of care for SUD.

For the 10 states included in our interviews, **Table 1** identifies whether they added or expanded Medicaid coverage of residential, intensive outpatient, partial hospitalization, recovery support, and methadone services. Nine of the 10 states began covering at least one new SUD service type under Medicaid as part of their demonstration; Michigan was the exception. That state had covered the services prior to implementing their demonstration. In some states, Medicaid had already paid for at least some adult residential care in non-IMD settings, such as hospitals and small institutions with fewer than 16 beds, or in IMDs as an in lieu of service.[11] However, coverage for residential services was added or expanded in most of the states under their demonstrations. Also, in most of the 10 states, the demonstrations brought new benefits for recovery support (particularly peer support and/or case management services, and, in a couple states, housing and/or employment support services).[12] Intensive outpatient and partial hospitalization services and methadone for MAT were already reimbursable in the majority of the states in which we conducted interviews. For the SUD services not previously covered by Medicaid, state Medicaid officials had to establish new reimbursement rates, which state officials identified as an implementation challenge.[13,14]

[9] For brevity, we refer to states and the District of Columbia as "states."
[10] CMS. (2017). *SMD # 17-003: Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[11] MACPAC. (n.d.). *Payment for services in institutions for mental diseases (IMDs)*. https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/
[12] For details about supportive services added by each state, see the "Medicaid section 1115 substance use disorder (SUD) demonstrations: Features of state approaches to improve Medicaid SUD treatment delivery systems" rapid cycle report (https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-features.pdf).
[13] RTI International. (2022). *Medicaid section 1115 substance use disorder (SUD) demonstrations: Implementation challenges across states.* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-impl-chalngs.pdf
[14] RTI International. (2022). *Medicaid section 1115 substance use disorder (SUD) demonstrations: State experiences expanding availability of medication assisted treatment for patients in residential settings.* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-availability-mat.pdf

In addition to changes in Medicaid coverage of SUD services across the continuum of care, 7 of the 10 study states made or are making changes to managed care arrangements for SUD services, creating a new delivery structure and new requirements for MCOs and providers alike. For MCOs, this brought about new responsibility for delivering some or all SUD treatment services. For providers, transitioning to a managed care environment has entailed new contractual arrangements, requirements, and administrative processes.

Below we present (1) MCO and provider changes in response to expanded Medicaid coverage of SUD services under the demonstration, (2) challenges MCOs and providers experienced, and (3) perceived impacts of the changes on beneficiaries' access to and engagement in SUD treatment.

Table 1. Added or expanded reimbursable SUD services under section 1115 SUD demonstration

State	Residential	Intensive Outpatient	Partial Hospitalization	Recovery Support	Methadone
District of Columbia	⊖	⊖	⊖	⊕	⊖
Idaho*	⊕	⊖	⊕	↗	⊕
Kentucky	↗	⊖	↗	⊖	⊕
Massachusetts	↗	⊖	⊖	⊕	⊖
Michigan	⊖	⊖	⊖	⊖	⊖
New Jersey	⊕	⊕	⊕	⊕	⊖
New Mexico	⊕	↗	↗	⊕	⊖
North Carolina	⊕	⊖	⊖	⊕	⊖
Virginia*	⊕	↗	↗	⊕	⊖
West Virginia	⊕	⊖	⊖	⊕	⊕

⊖ Service already covered prior to demonstration; ↗ Service coverage expanded; ⊕ Service coverage added.

*Idaho added clinically managed residential services; Virginia increased reimbursement rates for intensive outpatient and partial hospitalization services covered before the demonstration.

MCO and Provider Changes in Response to Expanded Coverage of SUD Services

MCO changes

Expansion of MCO staff capacity. Coverage of new SUD services meant that MCOs needed to build staff capacity to respond to beneficiary needs, including hiring more staff and educating staff on SUD services. MCO respondents in several states shared that they hired clinical, call center, provider engagement, care coordination, and administrative support staff.

> *"When we implemented the changes for the specialty populations…, it was a big lift…A lot of staff expansion was needed. Capabilities, expansion was needed, obviously to accommodate that business. We had to bring on additional clinical staff, additional call center staff, so we certainly had to expand."*
>
> -MCO respondent

In addition to hiring staff, MCO respondents reported needing to train staff. Trainings prepared staff to work with beneficiaries with SUD. Internal trainings covered a range of topics, such as information about the SUD services available to beneficiaries, which provider types offered different SUD services, and how to engage beneficiaries in discussions about SUD treatment options. One MCO respondent described the trainings provided at their organization:

> *"To ensure that our members know about the services, and they are educated about it, we train all of our staff, our care coordinators, any member-facing team. They've been thoroughly trained about the new [SUD] service[s], which is the newest Medicaid service that we have onboarded, where the providers are, any newly contracted providers, the process to refer a member and how to speak to the members about this option of care. Whenever we speak to members about substance abuse care, it can be a touchy subject. Maybe they're not ready. So, the way that we talk to our staff is very much, meet the member where they're at, and you may have to repeat options multiple times until the member is ready. So that's the type of training."*

Recruitment of providers by MCOs. To enhance the SUD continuum of care in their provider networks and meet increased demand for SUD services, MCO respondents in several states described efforts to recruit new providers to their networks by using direct outreach and listening sessions, relying on professional associations to disseminate information, and sharing information on the MCOs' web pages. To identify and recruit providers, MCO respondents in a few states also collaborated with the state Medicaid agency, which gave MCOs lists of providers credentialed by the state agency or notified MCOs of providers who recently completed the state credentialing process. As one MCO respondent explained, *"It was a very quick sprint to get contracts established with all the SUD*

providers. The state did a good job providing us a list of all those providers so we could do the outreach quickly to get everything up and running." In one state, the state Medicaid agency and MCOs jointly held provider education meetings at the outset of the demonstration to engage providers.

MCOs in some states focused their recruitment efforts on specific provider types to fill gaps in the continuum of care. These respondents indicated the need for more residential and MAT providers to align with demonstration requirements. As one MCO respondent stated, *"We had zero residential providers in our network. We have contracted with 100% of willing providers at this point."*

> *"When [the demonstration] initially launched, [the state Medicaid agency] and the MCOs actually went around the state and held provider meetings, which really was to actually build the network. So, a lot of the recruitment was done in the beginning, kind of like you have to build the network before they come."*
>
> -MCO respondent

MCO respondents described their strategies for encouraging providers to credential with the MCO. For example, an MCO respondent in one state reported matching the fee-for-service reimbursement rates for outpatient services used by another payer organization in the state before the demonstration. Some MCO respondents also reported developing relationships with new provider organizations, establishing points of contact for each organization, and opening ongoing channels of communication. In doing so, MCOs learned about each provider's SUD services and the populations they served and developed closer relationships with providers. This allowed MCO case managers to better understand the SUD needs of their members, better integrate SUD care with mental health and physical health care, and practice holistic patient care. Their increased awareness of the SUD services available helped them to educate beneficiaries about a wider range of provider choices and help beneficiaries choose the most appropriate and preferred treatment by finding suitable special programs.

Provider training by MCOs. Many SUD providers lacked experience creating adequate documentation for billing Medicaid or billing for newly covered services (e.g., peer recovery support services, residential rehabilitation services). MCO respondents from over half the states described needing to develop and implement trainings for providers both currently in and new to their network. For new providers, MCOs often integrated training into the credentialing process. Trainings usually were taught via webinar or conference call and covered a range of topics, including what services are covered by the MCO, how to determine and document medical necessity, and how to request prior authorization for services. One MCO respondent described the trainings in this way:

> *"We met with providers, we credentialed with providers, we did trainings. We still do, actually to this day, monthly trainings with providers to strengthen our network [and] to make sure that authorizations, claims, everything is as smooth as possible."*
>
> -MCO respondent

> *"As services were carved into the plan, [training for staff involved] … meeting with our existing providers and educating them on what was now part of the MCO [coverage] for them to bill, as well as educating them if they'd never billed for the service. Again, how to request authorization if needed, how to bill appropriately to have claims paid."*

These trainings were intended to enable providers to successfully bill for services and avoid MCO prior authorization denials, which, in turn, would reduce administrative burden for providers and MCOs.

In a few states, MCO respondents noted that they proactively review claims data and prior authorization denials to determine whether a provider or small group of providers need individualized education. In these instances, they created tailored technical assistance. One MCO respondent explained, *"We proactively look at claims trends…to see if there are providers having trouble, and sometimes we'll reach out proactively and say, 'We kind of saw a trend. You have a lot of denials for this. Can we talk about that?'"* MCO respondents also emphasized the importance of keeping lines of communication open with providers and addressing questions and concerns from providers before they became problematic.

Provider changes

Credentialing and enrollment as a Medicaid provider. To become certified Medicaid providers, providers needed to complete two separate credentialing processes. First, they needed to complete a credentialing application with their state and its Medicaid program to become authorized to bill Medicaid for each level of care they offered. Once they received state approval, providers completed a credentialing process with each Medicaid MCO in which they wanted to enroll. Provider respondents identified the processes as tedious and time intensive. One MCO respondent described the credentialing processes in their state, noting:

> *"But I'm going to say a year and a half to two years before we really saw any movement [in providers completing in the credentialing process]. And I think part of that was two sided. It was the credentialing process with the state and getting through that whole process. And then having to turn around and credential with each of the MCOs, which all of them have their own processes that slow things down. But yeah, it's been a good year and a half, two years. And really just in this last year I think I've seen a lot of movement in actually providers coming online and being able to provide the service. I think last year in the whole state, we had maybe two that had come on board and really were actually providing services. And now I can think of a handful that are up and running or in the process of completing their credentialing*."

Because completing credentialing processes required substantial time and administrative resources, at least one provider in one state enrolled only in some of the MCO networks available within the state.

Expansion of SUD treatment services offered by providers. As part of the demonstration, CMS encouraged states to increase access to care for SUD (Milestone 1) and increase provider capacity for critical levels of care, including MAT (Milestone 4). MCOs contracted with providers to ensure access to these services. MCO and provider respondents from the majority of states commented on expansions in SUD services, including residential services, MAT, intensive outpatient services, and peer support services (e.g., having staff who have recovered from SUD aid in care transitions, support engagement in treatment, and assist with identifying community resources).

With regard to residential services, residential provider respondents in several states reported that they increased beds available for their existing programs and established new programs for pregnant and post-partum women and individuals with co-occurring diagnoses. In some states, the demonstration did not translate into significant changes in the availability of residential services for Medicaid beneficiaries, as residential providers in those states received reimbursement for services via other funds (e.g., state block grants) prior to the demonstration.

Residential provider respondents in most states reported that they had begun to offer MAT on site or had added intensive outpatient programs (IOPs). Some MCO respondents also noted that more providers in their network had begun offering MAT during the demonstration. In one state, an MCO respondent reported that an increasing number of private office-based practices prescribing buprenorphine and opioid treatment programs (OTPs) offering methadone were enrolling in Medicaid. At least one respondent attributed the expansion of IOPs to a large increase in the reimbursement rate for this service. As one MCO respondent explained:

> *"Prior to … the benefit coming online, IOPs [were] reimbursed at a rate of $2 every 15 minutes (that's not the exact number, but it's around that level of funding). IOP is now reimbursed at $250 for two and a half hours. And the same was true for partial [hospitalization]. So, it made an attractive option to a lot of private providers."*

Organizations also were motivated to expand services for reasons unrelated to the demonstration, such as addressing gaps in SUD care in a region and improving access to care during the COVID-19 pandemic.

Modifications to provider administrative systems to accommodate billing for SUD services. As part of the demonstration, states revised MCO contracts to require coverage of SUD services or cover new services. MCOs and their contracted providers needed to update or create administrative systems to address those changes. With one exception, MCO respondents reported that changes were minor and entailed adding new services to the fee schedule, loading new service codes into their systems, or creating a new prior authorization form.

Although MCO respondents generally commented on minor changes, provider respondents from most states conveyed the need for more significant administrative changes to create infrastructure or enhance their existing infrastructure for billing. These efforts required learning the billing procedures and requirements for Medicaid (for providers newly billing Medicaid), of each MCO, and for each level of care. In some cases, providers hired staff to manage increased administrative demands arising from new prior authorization requirements and billing practices. In some states, providers also continued to provide and bill for services in fee-for-service Medicaid. One provider respondent described the substantial changes in infrastructure made at their organization to bill and obtain prior authorizations:

> *"Before the waiver, I had probably two people who were dedicated to billing. And really, at one point I only had one person. I now have an entire revenue cycle team. I have practice managers who manage authorization and member services. I have people who manage just submitting claims, I have people who are doing collections and appeals. So, I have a large revenue cycle team now. Nobody paid for that. There was nothing in this process that helped to fund that infrastructure development."*

Challenges

Provider navigation of billing requirements. Although some providers created infrastructure for and hired staff to manage prior authorization and billing processes, neither building infrastructure nor hiring was easy for provider organizations. Provider respondents reported administrative burden and frustration in obtaining prior authorization and in billing because of variations in requirements across MCOs. A provider respondent elaborated the challenges:

> *"Each of them have their specific ways of doing things, right? You have to make sure you set it up on the front end correctly. It's tough when one company wants a UB-04 [claim form] instead of a 1500 [claim form]….Or, they want one box checked off, but not the other box. Everyone's different in terms of what their requirements are."*

In addition to navigating multiple MCO requirements and processes, provider respondents reported difficulties and delays in managing service denials and disputes over claims. Provider respondents in a few states gave examples of how they had handled denials in some cases, including turning away beneficiaries that would not be covered, shortening a beneficiary's stay, continuing a beneficiary's stay without authorization (and, hence, without MCO payment), and billing services at an authorized level of care while providing services at a higher level of care. Each of these approaches had consequences for beneficiaries or providers. In some circumstances, beneficiaries did not receive the level of care their provider identified as medically necessary. In other cases, providers did not receive

sufficient compensation for services, and the organization assumed financial responsibility or had to cover the costs of care with alternate funds (e.g., grants, private funds).

Claims disputes over medical necessity resulted in lengthy delays in payment. Provider respondents from most states reported they had many disputes early in the demonstrations and their organizations drew down cash reserves or had short-term operational deficits.

> *"When the SUD waiver came along, we went to a per diem rate….We bill completely different. We had to set that up. We also had the SUD waiver demonstration for the 3.5 and the 3.1 level of services [clinically managed medium-intensity and low-intensity residential services, respectively] that we had provided but billed them differently. We had to change that billing portion… There were some requirements that were a part of the SUD waiver that were not part of the block grant when we did it that way... what became more difficult, quite frankly, was the authorization piece of it."*
>
> -Provider respondent

As described earlier, MCOs attempted to reduce denials by offering training and technical assistance on prior authorization and billing processes; some MCOs had staff dedicated to assisting providers with those processes. However, the level and types of assistance varied by MCO. As one provider respondent explained, *"Some [MCOs] had dedicated professionals within their organization to help manage the transition and help providers to get acclimated to the system. Some had none and you would just bounce around."* Another provider respondent described challenging relationships with MCOs and ensuing administrative burden, saying:

> *"Once we do get authorizations, we go to bill and we find that there's problems with the billing. Claims get denied. We don't get very clear definitions and understanding of why claims are being denied. And we have to resubmit and resubmit and resubmit. And then eventually, we get some of them paid and some of them we don't, but it's a much more challenging process. And, generally, when there is a denial, when we try to reach out again for technical support, we don't seem to get the technical support that we need. It's been very challenging working with those MCOs."*

Respondents in several states reported that the state eventually standardized the prior authorization form that MCOs used, which significantly reduced but did not eliminate prior authorization delays and service denials. In one state, a provider respondent described the continuing high volume of disputes and service denials as unsustainable for their organization over the long run.

Increased operational costs relative to reimbursement rates. Provider respondents from more than half the states noted that implementation of the demonstration increased administrative costs for provider organizations, including costs of establishing new administrative infrastructure and hiring new staff to support prior authorization and billing. The new costs associated with building infrastructure and hiring administrative staff were usually challenging for provider organizations that previously relied on state block grants, had little commercial business, or had not contracted with Medicaid MCOs before.

The perceived impact of new prior authorization requirements and billing processes varied by provider organizational size. Larger organizations already had comprehensive billing departments because of their commercial business, while others that primarily served Medicaid beneficiaries described staffing up entire billing departments to support billing Medicaid MCOs. Although large providers could manage the transition more easily, provider respondents from these organizations noted that adding administrative staff was not subsidized or supported by Medicaid. As a few provider respondents noted, the new prior authorization requirements and billing processes presented difficulties for smaller provider organizations because they did not have staffing capacity or financial resources to make changes, even with the training and support from MCOs and states. These organizations often had few billing staff, and clinicians often supported billing.

In several states, provider respondents said reimbursement rates for residential levels of care were adequate to cover the costs of service provision initially, but when costs increased over time—and during the COVID-19 pandemic in particular—states did not adjust rates. Respondents also commented on lost revenue when clinicians could not bill as many hours for care because they had to spend time talking with MCOs about service authorizations, disputing service denials or continued stays, or generating supporting documentation.

Residential provider respondents in several states cited concerns about low reimbursement levels as a factor in their decisions not to offer new levels of residential care (e.g., clinically managed population-specific high-intensity residential services and clinically managed medium-intensity residential services) or programs for special populations, such as mothers of young children, people experiencing homelessness, and those with behavioral comorbidities. Further, provider respondents from several states explained that wraparound services (e.g., childcare, housing) for special populations were not reimbursable by Medicaid but were essential for serving these populations. A few provider respondents already serving these populations reported funding wraparound services with grants.

Barriers to providing MAT. As part of the demonstration, states required residential facilities to offer MAT on site or support off-site access. Although MCOs covered residential and off-site MAT, provider respondents in a few states observed provider hesitance or resistance to administering MAT, which they primarily attributed to lingering stigma about MAT among clinicians. To address these concerns, some respondents described providing educational materials to clinicians to dispel stigma and assuage concerns regarding MAT. Provider respondents in at least one state mentioned partnering with a recovery advocacy group to help educate their providers. However, per one provider respondent, provider organizations sometimes struggled to connect beneficiaries to MAT even when they were open to doing so because of a lack of qualified clinicians in their area or the prohibitive cost of employing a prescriber. In one

state, an MCO respondent also noted provider concerns about insufficient supports (e.g., counselors) at provider facilities to accompany MAT and not being able to ensure continued MAT treatment following discharge. Despite some ongoing provider reservations about MAT, provider respondents in a few states noted more provider organizations offered MAT after the start of the demonstration, either because of new reimbursement or because it had become professionally accepted.

> *"We still, of course, have workforce issues, which affect our ability to make intensive outpatient services available in our more rural areas of the state, which is probably the most significant challenge we have at this point in terms of making care available and accessible, to our members."*
>
> -MCO respondent

Workforce shortages. MCO and provider respondents in nearly every state identified provider supply challenges across different levels of care, which in some cases limited availability of services for beneficiaries, particularly those living in rural areas. Provider respondents in a few states described difficulties having enough staff with the qualifications (e.g., licensure or education level) required by the demonstration to provide a service.

Respondents attributed these workforce challenges to national shortages of qualified SUD providers, increased demand for services arising from the demonstration, competition from MCOs who needed staff with SUD experience and private SUD provider organizations who entered the market because of expanded Medicaid coverage, and staff turnover because of increased workloads and burnout. MCO and provider respondents from multiple states also noted that the COVID-19 pandemic exacerbated workforce shortages (discussed below).

Respondents reported few strategies for alleviating workforce shortages. However, a few provider respondents reported increasing staff salaries and offering bonuses to retain staff, and a MCO respondent in one state reported partnering with out-of-state providers offering telehealth to ensure access to treatment for beneficiaries in rural areas.

COVID-19 pandemic. MCO and provider respondents called attention to two main impacts of the COVID-19 pandemic. First, in response to the pandemic, providers made operational changes and reduced service capacity. Several residential service providers reported closing temporarily or making significant capacity reductions for a year or more beginning in March 2020. Upon reopening, residential providers significantly reduced bed capacity and limited admissions to accommodate social distancing and quarantine requirements. Because of quarantines, social distancing protocols, and additional operational costs (e.g., costs of personal protective equipment, COVID tests), providers lost revenue and incurred increased costs that were not covered.

Second, provider respondents reported losing staff during the COVID-19 pandemic, and some respondents noted they still had not completely recovered to operate at full capacity as of spring 2022. Workforce competition and staff burnout from stress and workload contributed to turnover; staff illness and death from the virus also created shortages.

Many MCO and provider respondents pointed to federal and state policy as essential for offsetting revenue losses from limits on residential admissions and for supporting the continuation and expansion of care for beneficiaries. Federal policies established during the national public health emergency authorized more providers in more settings to see beneficiaries through telehealth appointments and to conduct group therapy using video conferencing. To support the transition to telehealth, MCO respondents in a few states reported quickly shifting operations to help beneficiaries navigate telehealth technology and educating providers on new billing nuances. Provider respondents reported that making these transitions created short-term disruptions in access to their programs but allowed providers to continue seeing beneficiaries and, in some cases, allowed them to increase the volume of people treated in outpatient settings. MAT providers also offered beneficiaries take-home medications to reduce appointment volume and limit the need for beneficiary travel.

Medicaid's suspension of utilization review during the national public health emergency enabled providers to continue offering residential care without requesting prior authorization.[15] One MCO respondent also reported arranging for beneficiaries to stay at a higher level of care if a lower level was unavailable because of the COVID-19 pandemic.

Perceived Impacts of Changes in Coverage of SUD Services on Beneficiaries' Access to, Engagement in, and Retention in Treatment

When asked how changes in coverage of SUD services affected beneficiary access to and engagement and retention in treatment, MCO and provider respondents' observations were often anecdotal. Some MCOs shared that they did not track or did not have baseline data to measure changes in beneficiary outcomes.

Beneficiary access to treatment. Some respondents described increases in beneficiary access to treatment while others did not specify any changes under the demonstrations. Respondents attributed improved access to increases in residential treatment bed capacity and provider network expansions, as well as to Medicaid eligibility expansions.

MCO and provider respondents from half the states agreed that availability of residential beds and access to residential care increased under the demonstration. However, perceptions about changes in access to lower levels of care were mixed with some respondents

[15] 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

reporting improved or new access to OTPs, partial hospitalization, and intensive outpatient treatment, and others in a few states describing ongoing gaps in these services as well as recovery services (e.g., peer support services, 24-hour care in recovery home). When fewer lower-intensity services were available, a beneficiary exiting residential care could not move optimally between levels of care, could transition to an inappropriate level of care, or could return unnecessarily to residential care. As one provider respondent explained:

> *"There's more beds now than ever. Clients can get into residential treatment. It's whether they're able to stay in and effectively work treatment plans that involve them staying there for a length of time…There's really not effective data to say, "Is this really helping clients get better?"…. Somebody may get approved for 3.5 [clinically managed medium-intensity residential services], three different times, but maybe they really needed a 3.5 and four months of 3.1 [clinically managed low-intensity residential services], but because there was such a push to [refer beneficiaries to community-based services]....There's just such a focus for folks with opioid use disorder to be put on to access MAT, for instance…I think sometimes people that are really complicated in their substance use disorder don't get the extended care that they need. There's such a push to put them out into MAT programs or recovery housing."*

Several MCO and provider respondents attributed improved access to expanded Medicaid eligibility, which enabled more people to enroll in Medicaid and obtain treatment. As one provider respondent explained, "Now that Medicaid is paying, especially when it first started, we noticed a boom in people coming into treatment." Although some respondents reported that Medicaid expansions increased the number of beneficiaries with SUD who were enrolled in Medicaid, some could not determine whether enrollment translated into use of SUD services.

Although most providers described increases in access to treatment, provider respondents from some states reported minimal impact on beneficiary access under the demonstration. A few of these respondents explained that beneficiaries' ability to access treatment may not have changed because providers merely shifted from billing block grants to billing Medicaid. Some provider respondents commented beneficiaries did not notice changes because the provider organizations offered the same treatment as before the demonstrations. In some cases, MCOs authorized a lower level of care than a provider recommended; providers would, nevertheless, treat the beneficiary at the recommended higher level of care while billing the MCO for the lower and authorized level of care. The provider organization assumed financial responsibility for the treatment or used other funds to subsidize the shortfall. Some respondents also attributed improvements in beneficiary access to other initiatives and sources of funding that supplemented demonstration efforts.

Beneficiary engagement and retention in treatment. Respondents from a few states reported some improvements to beneficiary engagement and retention in treatment, commenting that they observed beneficiaries staying in treatment longer than before the demonstration. One MCO respondent commented that they are tracking Healthcare Effectiveness Data and Information Set (HEDIS) measures related to initiation and engagement of treatment (IET) and that their organization met their targets for IET. Other respondents reported that the demonstration likely allowed or encouraged beneficiaries to engage in treatment. One MCO respondent commented:

> *"We've had a dramatic increase… we've had an increase by 60% of unduplicated members getting residential substance use treatment, which is a massive increase…But I think because we continue to grow. We continue to have more of the residential providers, I mean, I think that's the main reason [for increased engagement in treatment], just the access is there."*

A few respondents attributed improvements in engagement in treatment to increases in availability of services and a comprehensive continuum of SUD care. For example, one MCO respondent explained that having multiple levels of care under a single provider organization improved retention because it eliminated the need for a beneficiary to transfer between provider organizations. Similarly, a provider respondent reported that beneficiaries engaged in residential treatment longer when the provider added MAT.

However, some respondents expressed concerns about caps on the lengths of stay in residential care, which were shorter than what some providers saw as necessary to complete treatment. A few MCO and provider respondents explained that, despite increases in engagement in residential treatment, beneficiaries were authorized for shorter lengths of stay in residential treatment. These shorter stays, they explained, could truncate treatment and lead to recurrence of SUD. One provider respondent explained:

> *"Thirty days is usually not even good enough for them [beneficiaries], but that's what they get. Literally, it's a hamster wheel that we're seeing in the state. They're just going back through. And the problem is they don't get the opportunity to keep going on that hamster wheel because they end up relapsing and they overdose and die. They don't get that chance to get back into a detox and start over."*

In some states, provider respondents reported that beneficiary engagement and retention in treatment could decrease or remain unchanged despite the expansion of coverage of SUD services under the demonstration. Respondents reported that, even with increases in treatment availability, some beneficiaries' engagement in treatment was unaffected by the demonstrations because of the instability in their life circumstances. Further, denials or delays in obtaining authorization or insufficient lengths of stay could disrupt beneficiary retention in treatment.

Health equity. MCO and provider respondents offered limited perspectives on the implications of coverage changes for health equity. A few MCO respondents noted that they did not examine data through a health equity lens or that their data was insufficient to do so. Providers from several states reported minimal impacts on health equity under the demonstration and that disparities in SUD care remain a concern. Some respondents described new or expanded initiatives under the demonstration focused on beneficiary populations with unique needs such as mothers, beneficiaries who are incarcerated, and beneficiaries with a dual mental health diagnosis or dependence on multiple substances.

Several respondents explained that they continued to experience challenges in engaging individuals experiencing homelessness, persons who are incarcerated, and persons living in rural and frontier areas because services may not be available or accessible to these populations despite coverage expansions. In a state where lower levels of care were not consistently available, one provider respondent noted that the lack of availability made retaining beneficiaries experiencing homelessness challenging because they did not have stable housing after discharge from residential settings. Further, insufficient access to care for persons in rural areas made engagement and retention in treatment more difficult. A few MCO respondents described strategies for improving access to treatment for beneficiaries in rural areas by partnering with out-of-state providers offering telehealth or connecting beneficiaries to transportation services.

Conclusions

This report highlights the changes managed care and SUD provider organizations in 10 states made in response to the expansion of Medicaid coverage of SUD services under the section 1115 SUD demonstrations. Of the 10 states included in our interviews, 9 began covering at least one new SUD service type (i.e., residential, intensive outpatient, partial hospitalization, recovery support, or methadone services) under Medicaid as part of their section 1115 SUD demonstration. Coverage for residential services was added or expanded in most of the states, as were new benefits for recovery support. Intensive outpatient and partial hospitalization services and methadone for MAT were already reimbursable in the majority of states in which we conducted interviews. Many of the study states made or are making changes to managed care arrangements for SUD services, creating a new delivery structure and new requirements for MCOs and providers alike.

MCO and provider respondents from most of the states in which we conducted interviews noted an increase in SUD services, including residential services, MAT, intensive outpatient services, and peer recovery support services. In response to the expanded coverage of SUD services under the SUD demonstrations, MCOs in several states developed relationships with new providers, recruited new providers for their networks, and offered provider training. MCOs also hired and trained more staff to meet increased demand for SUD services. SUD provider organizations in many states underwent credentialing to join MCO networks and expanded their SUD service offerings. Provider respondents also reported hiring more staff and modifying their administrative systems to manage prior authorization and billing requirements for SUD services.

MCOs and provider respondents generally had mixed perceptions about whether these changes had affected beneficiaries' access to and engagement in SUD treatment to date. Some respondents described increases in beneficiary access to treatment, while others did not specify any changes under the demonstration. Respondents attributed improved access to increases in residential bed capacity and provider network expansions as well as to Medicaid eligibility expansions.

MCOs and provider respondents reported several challenges in navigating changes in coverage and reimbursement of SUD services under the demonstrations. Some providers struggled to adjust to new prior authorization requirements and billing processes for SUD services, especially when these procedures varied among MCOs. Provider respondents from more than half the states noted that their costs increased, including costs of establishing new administrative infrastructure and hiring new staff to support prior authorization and billing. Although residential and off-site MAT are covered by Medicaid under the demonstrations, provider respondents in a few states observed ongoing provider hesitance or resistance to administering MAT. MCO and provider respondents alike reported challenges recruiting, hiring, and retaining staff because of shortages of qualified candidates and rising salary demands. The COVID-19 pandemic caused providers to limit capacity in their facilities, but reimbursement of telehealth services and the suspension of utilization review during the public health emergency facilitated providers' ability to treat beneficiaries during the pandemic. Provider respondents identified challenges in engaging beneficiaries in treatment including instability in beneficiaries' life circumstances, denials or delays in obtaining authorizations from MCOs, and gaps in the availability of treatment in rural and frontier areas because services.

This rapid cycle report highlights the changes managed care and provider organizations made to address Milestone 1 of the section 1115 SUD demonstrations and the challenges that arose during implementation. Demonstration impacts may vary among states based on the extent and nature of challenges states experienced. The findings from 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 District of Columbia.[16] 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.

[16] For brevity, we refer to states and the District of Columbia as "states."