Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: State Experiences Expanding Availability of Medication Assisted Treatment for Beneficiaries in Residential Settings

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RTI International

Introduction

Drug overdose is the leading cause of accidental 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 provides an in-depth look at implementation challenges faced by states aiming to expand the availability and accessibility of MAT for Medicaid beneficiaries in residential facilities as part of states' section 1115 SUD demonstrations. Specifically, this report addresses the following three research questions:

1. What steps have states taken to expand the availability and accessibility of MAT services in residential settings?
2. What barriers and challenges have states experienced?
3. How are states addressing these challenges?

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.

As of October 2022, 33 states and the District of Columbia had received approval for section 1115 SUD demonstrations; 3 other states had pending applications (**Figure 1**).

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[1] Centers for Disease Control and Prevention (CDC). (2022). *Drug overdose deaths remain high*. https://www.cdc.gov/drugoverdose/deaths/

[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/201MosFW090120.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.

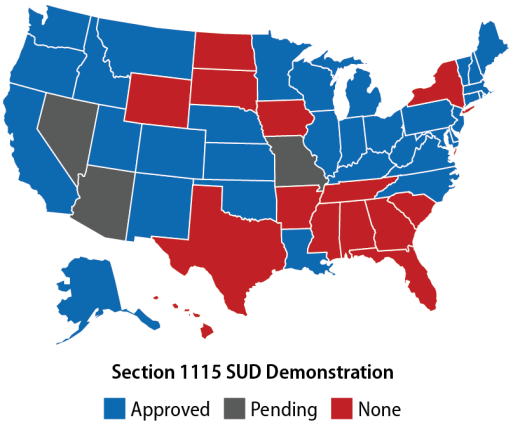
[6] Centers for Medicare and Medicaid Services (CMS). (2015). *SMD # 15-003: New service delivery opportunities for individuals with a substance use disorder*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf

[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). *Medication assisted treatment for substance use disorders*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

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:

Figure 1. Section 1115 SUD demonstration status



1. Access to critical levels of care for 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

Over three-quarters of section 1115 SUD demonstration states made policy changes to implement MAT requirements for residential providers. State officials described two approaches for ensuring provider adherence to the MAT requirements:

- Adding requirements in residential provider standards and the Medicaid application/renewal process.
- Implementing auditing and tracking approaches.

According to state officials, the most common challenges to implementing the MAT requirement were:

- Stigma among residential providers related to a treatment model for SUD that includes MAT.
- A shortage of office-based opioid treatment (OBOT) and opioid treatment programs.
- Lack of knowledge at residential facilities about how to store medications and manage patients taking medication.
- Lack of historical data on MAT usage to set reimbursement rates for residential services inclusive of MAT.

States used the following strategies to address these challenges:

- Conducting outreach to build understanding about the appropriateness of MAT, educate residential providers about new certification requirements, and convince more providers to become buprenorphine prescribers and Medicaid-certified OBOT providers.
- Using supplemental funding to support provider education and training efforts.
- Investing in non-emergency medical transportation to facilitate access to offsite prescribers for residential clients.
- Creating reimbursement rates for residential providers inclusive of costs associated with dispensing MAT onsite.

Approach

Findings in this report are based on interviews conducted between December 2020 and July 2021. All states with approved section 1115 SUD demonstrations at that time were invited to participate with the exception of Maine, because of the recent timing of its demonstration approval. Because California counties developed their own implementation plans within state parameters for the

demonstration, we interviewed government officials from three counties to reflect variation in implementation experience.[9] Thus, the report reflects 34 interviews in 30 states, 3 California counties, and the District of Columbia.[10] Key informants included state Medicaid officials, behavioral health administrators, and other state staff involved in the oversight of SUD and behavioral health services. **Appendix A** provides more information about the data collection methods used.

Results

State Actions to Ensure Availability of MAT

In most cases, section 1115 SUD demonstration states are required to establish a requirement that participating residential treatment facilities offer MAT either onsite or facilitate access offsite for beneficiaries, consistent with Milestone #3. Beneficiaries could receive MAT onsite, or providers could facilitate access to MAT at offsite locations. Onsite provision of MAT generally refers to dispensing buprenorphine or naltrexone at residential facilities, or in some cases having an onsite MAT prescriber. Offsite access to MAT refers to facilitating transportation to an opioid treatment program (OTP) for methadone and/or to office-based opioid treatment (OBOT) for prescribing of buprenorphine or naltrexone and medical maintenance.

Over three-quarters of section 1115 SUD demonstration states made policy changes to implement MAT requirements for residential providers. Although many states did not have MAT requirements in place prior to the demonstration, some residential providers offered access to MAT, but this access varied substantially by state.[11] State officials explained that three entities were responsible for ensuring provider adherence to the MAT requirement: (1) the SUD single state agency (SSA), which often managed provider guidelines and state licensure/certification for all SUD providers to operate in the state, (2) the State Medicaid agency, which often managed Medicaid-specific enrollment and certification requirements for SUD providers, and (3) Medicaid managed care organizations (MCOs), which often implemented Medicaid-specific enrollment and certification requirements for SUD providers on behalf of the Medicaid agency.

State officials described two approaches for ensuring provider adherence to the MAT requirement: (1) adding requirements in residential provider standards and the application/renewal process, and (2) implementing auditing and tracking approaches. **Table 1** presents examples of strategies that were used to ensure provider adherence to the MAT requirement.

First, some states added MAT-specific clauses to residential provider standards. These changes included mandatory trainings, written plans for providing MAT access, prohibiting providers from discriminating against beneficiaries receiving MAT, and requiring providers to inform beneficiaries about all their options for MAT. Several states also added MAT-specific requirements directly in the application/renewal process for residential providers. For example, before providers received first-time or renewed licensure/certification, some state officials described new requirements for providers to submit self-attestation forms or additional documentation of policies and procedures detailing how they complied with the new MAT requirements. In states that contracted with Medicaid MCOs or similar entities,[12] MCOs had responsibility for certifying or enrolling providers and required providers to submit documentation of compliance before allowing them to enroll or re-enroll in their network.

Second, several states implemented auditing and tracking approaches to ensure adherence to the MAT requirement. Some states developed audit tools to periodically verify that providers offer MAT. Other states either enhanced or added in-person, onsite audits to verify access to MAT for beneficiaries in residential treatment. Several states have put these in-person visits on hold because of the COVID-19 pandemic and relied instead on alternative approaches like provisional certifications, provider self-attestations, and desk audits. In some states that contracted with MCOs, the states provided resources to MCOs to support enforcement and added contractual language stipulating that MCOs enforce the MAT requirement.

State officials reported variation in their ability to track whether residential facilities dispensed MAT onsite on an ongoing basis. During interviews, state officials did not routinely discuss if they tracked whether residential facilities dispensed MAT onsite within the facility. States that tracked MAT in residential facilities mentioned using claims or other state-specific data sources. In states that did not formally track MAT in residential facilities, state officials were generally aware of whether MAT was offered because of informal conversations with providers.

[9] California's section 1115 SUD demonstration is approved by CMS at the state level. Counties administer the Medicaid program and participate in the demonstration on a voluntary basis by operating Prepaid Inpatient Health Plans (PIHPs). California has facilitated SUD demonstration adoption by counties in waves beginning in April 2017. Counties that have submitted implementation plans and undergone the approval process by both the state and CMS can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

[10] For brevity, we refer to states, the District of Columbia, and counties as "states" and all interviewees as "state officials."

[11] Refer to the *Availability of Medications for Opioid Use Disorder in Residential Treatment Settings* rapid cycle report for more detail on the availability of MAT in residential settings.

[12] Examples of similar entities include prepaid inpatient health plans and regional accountable entities.

Table 1. State strategies to ensure provider adherence the residential MAT requirement

Strategy	State Examples
Added requirements in residential provider standards and the application/ renewal process	• California mandated participation in state-directed provider training for staff, including administrative employees. • Kentucky added requirements that SUD residential treatment providers obtain the ASAM Level of Care Certification and have procedures regarding access to at least two medications approved by the FDA for the treatment of Opioid Use Disorder (OUD). • Louisiana passed legislation formally requiring residential providers to attest that they fulfilled the MAT requirement. The attestation became a requirement for provider licensing. • Washington created a rule mandating residential programs inform beneficiaries about their options for MAT and ensured beneficiaries could bring prescribed medications into facilities. Washington then required MCOs to only contract with residential providers who fulfill the MAT requirement. • The Oregon Health Services Commission added details in provider treatment guides for residential levels of care that clarify a provider's obligation to provide MAT.
Implemented auditing and tracking approaches	• New Hampshire developed a shared audit tool for use by MCOs to monitor compliance. • New Mexico uses site visits to verify that facilities attesting they provided MAT onsite were doing so. • Vermont monitors compliance using claims data and through weekly informal conversations about MAT held with residential facility medical directors. • Minnesota implemented a new effort to collect data on MAT utilization to support their priority of reducing racial/ethnic disparities in access to MAT. • Pennsylvania plans to develop a survey tool to capture how residential providers offer MAT.

Challenges to Expanding Availability and Accessibility of MAT in Residential Settings

This section summarizes the challenges to expanding the availability and accessibility of MAT in residential settings that were mentioned most frequently, and it also describes states' strategies to address these challenges. State officials identified challenges with implementation of the MAT requirement at the state level as well as challenges providers encountered in complying with the MAT requirement. According to state officials, the most common challenges to implementing the MAT requirement were:

- Stigma among residential providers associated with a treatment model for SUD that includes MAT.
- Shortage of OBOTs and OTPs to which residential providers could connect beneficiaries.
- Operational challenges at residential facilities.
- Setting reimbursement rates for residential services inclusive of MAT.

State officials reported few other state-level operational challenges in implementing, monitoring, or enforcing the residential MAT requirement. However, some state officials reported delegating enforcement to MCOs, and MCOs may have encountered challenges not captured by our interviews.

Stigma Among Residential Providers Associated with a Treatment Model for SUD that Includes MAT (21 States[13]). State officials in 21 states described resistance among residential providers to accepting an evidence-based SUD treatment model that included MAT. Officials in a few states believed that stigma did not hinder implementation of the MAT requirement, but in most states, officials described stigma against MAT as a moderate or large challenge. State officials reported that including the MAT requirement in residential provider standards and licensing and Medicaid certification gave them leverage to convince residential providers to include MAT in their SUD treatment model, because ultimately, providers had to comply with the requirement to maintain certification or receive Medicaid reimbursement.

> *Residential providers didn't want to have anything to do with any consumer that was on methadone. Absolute stigma. Absolutely not going to do it. Didn't want to do MAT.*
> –State Official

According to state officials, the resistance often manifested as residential providers stigmatizing specific medications (e.g., methadone) and denying admission to individuals seeking to continue MAT. State officials attributed the stigma attached to MAT among residential providers to the traditional social model for SUD treatment practiced by some residential providers, a lack of residential provider knowledge about the evidence base for MAT, and a fear that providing medication will attract large numbers of outsiders to the community to receive treatment. The social model emphasizes a medication-free, abstinence approach as the best model for recovery.

[13] This count includes all states that indicated stigma was a challenge to expanding the availability of MAT. Most states explicitly mentioned stigma among residential providers, but a few were not explicit about which provider population they were describing or focused their response on outpatient providers. We included these states in the count because we assumed that some residential providers could hold a similar bias.

There's different ideas around what abstinence-based treatment is. I think that's the best way to describe where the challenges come in. And I think what we experienced in [the state] has more to do with methadone … but we also run into an idea of abstinence-based treatment that some providers have, which means you shouldn't use any medication for SUD. And if you are, you're not in an abstinence-based modality of treatment, which is just not what is supported by SAMHSA, ASAM, and the FDA.

–State Official

In contrast, the medical model for recovery identifies MAT as an effective treatment option. State officials described a range of residential provider viewpoints among proponents of the social model. Some proponents call it the "drug-free" model and do not support the use of either methadone or buprenorphine because both are viewed as replacement therapy.[14] Other residential providers only view methadone as contrary to the social model. One state official attributed bias against methadone to a lack of residential provider understanding of the science behind the safety and efficacy of methadone and the notion that use of methadone is merely "trading one drug for another."

To address residential providers' concerns and lack of knowledge about MAT, many state officials described multipronged outreach strategies for provider engagement intended to change provider culture, build understanding about the efficacy and appropriateness of MAT, and educate residential providers about new certification requirements. Outreach targeted residential and outpatient providers, and in some states, drug courts and correctional staff. Strategies included identifying a public health or physician champion to help with outreach and education, offering regular trainings on MAT for providers, using continuing education requirements to encourage provider participation in MAT training, and organizing media campaigns to address stigma in the community. As an example, Alaska developed a toolkit for residential providers offering clinical considerations and best practices for working with beneficiaries receiving MAT. As another example, New Jersey contracted with centers of excellence to provide trainings, technical assistance, and coaching to providers on how to integrate MAT into treatment. One state official also noted the importance of conducting regular site visits and on-site audits to ensure that SUD providers are meeting MAT access requirements. Another described including language specifically prohibiting discrimination against beneficiaries requesting MAT therapy in its contracts with SUD treatment providers.

In 15 states, officials identified supplemental funding outside of the section 1115 SUD demonstration and the Medicaid program as a facilitator for supporting provider education and training efforts. Supplemental funding sources included: (1) State Targeted Response (STR)/State Opioid Response (SOR) grants, (2) other substance abuse block grants issued by the Substance Abuse and Mental Health Service Administration (SAMHSA), (3) the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act grants, (4) grants issued by the Health Resources and Services Administration (HRSA), (5) public health emergency grants, and (6) state-sponsored grants.

Of the states that reported stigmatization of MAT, especially methadone, among residential providers as a moderate or large challenge, a few indicated substantial improvement in addressing this. For example, one state official described a "real culture shift in the last few years" and observed that the "divide [in philosophies] is closing." A few states described stigma as a continuing challenge, and some did not indicate the extent of stigma among residential providers or whether the challenge was a continuing barrier.

We've had to really help providers understand that somebody who's using a medication for whatever they're using a medication for, there shouldn't be different parameters put on somebody who is using that medication for a withdrawal symptom versus somebody who is using a medication for diabetes or for a heart condition, or for any other medical condition. Somebody who is withdrawing from opioids is having a true medical situation that can be alleviated with medication and [that medication] can keep that person engaged in treatment for longer.

–State Official

Shortage of OBOTs and OTPs to Which Residential Providers Could Connect Beneficiaries (12 States). Twelve states reported gaps in the number and geographic distribution of OBOTs and OTPs as a challenge to increasing access to MAT in residential settings. Because access to MAT often depends on the availability of OBOTs and OTPs in proximity to residential providers, state officials acknowledged that these shortages could hinder residential providers' ability to facilitate offsite access to MAT for beneficiaries and thus comply with MAT requirements. Of the 12 states reporting this challenge, almost all state officials emphasized a shortage of OBOTs and OTPs in rural areas as a challenge because of the long distances and travel times to reach a Medicaid prescriber willing and authorized to treat beneficiaries with MAT. One state official described concerns about the lack of OTPs in proximity to residential facilities and noted, "driving somebody two hours to go to an OTP complicates things at a minimum." The same state official mentioned that MAT prescribers might be present in a community but unwilling to serve new Medicaid beneficiaries from residential facilities, explaining: "You might not have a physician in the community that's openly doing the buprenorphine because they're keeping it to just their patients."

Once you get out of those urban areas, even if the residential provider wanted to really facilitate or offer MAT, it was pretty limited in their area, generally speaking. So, this requirement will be a lift both for our residential providers to implement the policy and the procedures to do this, but also in the efforts just to expand access to medication assisted treatment generally in the state.

–State Official

[14] Because of its classification as a full opioid antagonist, naltrexone is generally not viewed as a 'replacement therapy.' As such, the stigmatization of methadone and buprenorphine among residential providers did not appear to extend to naltrexone.

To address the shortage of MAT providers in Medicaid, state officials conducted outreach to community-based providers, drawing on the supplemental funding sources described earlier. They sought to convince more providers to become buprenorphine prescribers or become Medicaid-certified OBOTs through educational presentations stressing the benefits to people from MAT and explaining application procedures to become a Medicaid-certified provider or a buprenorphine-waived prescriber. Some states tried to procure funding to build new OTPs or convince existing organizations to build new facilities. Increasing supply in rural regions or other underserved areas was described as a focus in some states.

> *One mistake I think we made when it came around to residential is we had a choice when we worked with the provider on building rates. The choice was, let them do one blended rate for a residential day, depending on what level of residential it was, and inside that rate all things were inclusive. Then [External Quality Review Organization] came out that first year, and [they said], "How come you haven't done any MAT in residential?" We're like, "Well, we have." "Well, but you haven't billed any." I'm like, "No, it's in their rate." "Well, do you have proof?" I'm like, "Hm."*
>
> –State Official

Operational Challenges at Residential Facilities (9 States). Some state officials reported operational challenges to facilitating access to MAT at residential facilities. These operational challenges included how to arrange and pay for transportation to OTPs and training around how to store medications onsite and manage beneficiaries when they are on medications.

Officials in nine states described a need for more robust transportation services, especially in rural areas. Arranging and paying for transportation from residential facilities to OTPs and OBOTs was described as a challenge in some states. A few states focused on access to non-emergency medical transportation (NEMT) as one approach that could help residential providers comply with MAT requirements. One state official described investing in NEMT to facilitate access to offsite prescribers, citing it as “a major catalyst to get people to their appropriate setting to get outpatient treatment, or MAT." Another state official shared they created a bundled rate for residential providers inclusive of costs associated with dispensing MAT onsite at residential facilities, monitoring beneficiary self-dosing, and transporting beneficiaries to OTPs. This strategy was intended to help residential providers cover transportation costs to offsite MAT prescribers and officials asserted that the cost of ordering medications onsite was comparable to the cost of providing transportation to an offsite prescriber.

State officials reported that some residential providers lacked the appropriate knowledge to navigate the logistics of daily dispensing, medication storage and management, and monitoring of beneficiaries receiving MAT. One state official described efforts to train residential providers on how to work with prescribers to treat beneficiaries receiving MAT, specifically noting that “if [a residential provider sees] somebody nodding off in group…that doesn’t mean that they’re necessarily using again, that means that maybe their dose is wrong, and that’s a conversation that [the residential provider should] have with the MAT prescriber.” Another state official expected managing beneficiaries receiving MAT would require many facilities to conduct extensive staff training and hire new clinical staff; this was especially true for small facilities operated by individuals with lived experience, but little clinical training.

Setting Reimbursement Rates for Residential Services Inclusive of MAT (5 States). Because of differences in historical payment strategies, a few state officials reported challenges with developing reimbursement rates to account for the additional expectations of residential providers to provide access to MAT. In these states, officials identified a lack of historical data on MAT utilization at residential facilities as a key data gap in updating rates. One state official reported difficulty obtaining an actuarially sound base rate to measure the added cost of new MAT utilization, because they did not have data on MAT utilization in facilities prior to the section 1115 SUD demonstration.[15] This state required each facility to submit historical utilization data to set initial rates. Another state official described a monitoring-related challenge that arose when they set a bundled rate that integrated the cost of MAT into the facility package in the first year of the demonstration. After this change was made, they realized that the bundled rate made it impossible to verify MAT utilization took place in residential facilities and they intended to reverse the payment policy.

Officials in another state had not decided whether they would add medication management for residential facilities into a bundled rate or retain the service as separately billable. They were leaning toward a bundled approach because residential providers were restricted from using the medication management billing code in the billing system. Changing this policy would take time, and in the interim the state would need a work-around in their billing system so that residential providers could be reimbursed. However, officials believed that the added complexity to the billing procedures from a work-around would discourage residential providers from seeking reimbursement.

Conclusion

As part of their section 1115 SUD demonstrations, states implemented policies to ensure residential providers offer access to MAT onsite or offsite. This report summarizes the steps states took to implement the MAT requirement for Medicaid beneficiaries in residential facilities, the major challenges states encountered, and states’ approaches to addressing challenges. To ensure provider adherence to the MAT requirement, the SSAs, State Medicaid agencies, and MCOs added requirements in residential provider standards and the application/renewal process and implemented auditing and tracking approaches. The most common barriers states

[15] To establish new payment rates that are actuarially sound, states need to have historical data on utilization to estimate a change in cost to providers for delivering additional services under the modified payment rate. In this case, additional MAT utilization and corresponding costs would then be estimated—for the period after the MAT requirement was in place—to arrive at a new actuarially sound rate.

identified were stigma among residential providers associated with MAT and shortage of OBOTs and OTPs to which residential providers could connect beneficiaries. States also reported operational challenges at the facility level around transportation to offsite MAT and adequate staff training to manage beneficiaries receiving MAT. State-level operational challenges, like developing reimbursement rates, were much less commonly reported.

State strategies to address challenges arising from implementing the MAT requirement could have longer-run effects on access to MAT. Many states used provider education and outreach, funded by SAMHSA and SUPPORT Act grants, to encourage providers to become MAT prescribers and reduce the stigma associated with offering MAT. However, the impact of state efforts may be hampered by continuing shortages in the behavioral health workforce. Less commonly, states changed reimbursement for residential providers to cover facility costs of meeting new MAT requirements. Better financial incentives could increase residential providers' willingness to offer MAT onsite.

External factors of greatest concern and outside of states' control were the COVID-19 pandemic and the shortage in the behavioral health workforce, which were both reported to be limiting expansion of access to MAT in residential settings. If the COVID-19 pandemic continues and labor shortages continue to overwhelm providers, this will slow implementation of MAT requirements and related staff training in provider settings. Capacity for residential providers to offer MAT or transport beneficiaries to other places to receive medication is limited by the number of MAT prescribers. Recent federal policy actions could increase access to MAT prescribers. Notably, CMS included the MAT requirements for residential providers as a condition of state participation in the section 1115 SUD demonstration. This strategy may provide states with needed leverage to encourage residential providers to offer MAT, a point that was made by at least one state official. Compliance with the MAT requirements is another area where CMS could work with states to help enforce new expectations. In addition, section 1006(b) of the SUPPORT Act added coverage of MAT as a mandatory benefit in state Medicaid plans and plan waivers beginning October 1, 2020 through September 30, 2025, and section 2005 of the SUPPORT Act added an OTP benefit service category in Medicare, effective January 1, 2020. Other federal policy levers that could potentially increase access to MAT include support of workforce development and continuation of federal telehealth policies established during the public health emergency to allow more providers and settings to bill for telemedicine appointments.

State experiences described in this report should be interpreted with several considerations in mind. First, many states were early in their section 1115 SUD demonstration and still developing monitoring and enforcement strategies for the residential MAT requirement. As demonstrations continue, new monitoring and enforcement strategies could impact the accessibility of MAT in residential facilities. We will continue to track those developments through MCO interviews, behavioral health provider leadership interviews, and document review. Second, state officials could not always speak directly to challenges faced by MCOs or by residential facilities in implementing the MAT requirements. Future interviews may uncover additional operational challenges faced by facilities and MCOs. Some states delegated enforcement of MAT requirements to MCOs, and MCOs may have encountered challenges not captured by our interviews. Third, interviews were limited in how much time was available to discuss implementation and challenges associated with the residential MAT requirement and our report may not represent all challenges faced by each state.

State experiences summarized here have several implications for the meta-evaluation of section 1115 SUD demonstrations. First, corresponding to the two most commonly reported barriers, we expect the stigma state officials said was associated with MAT and gaps in OBOT and OTP capacity will limit the impact of the MAT requirement on the availability and accessibility of MAT in residential settings. In states where stigmatization of MAT and other factors continue to be a barrier, increases in MAT access could be smaller than in states without this challenge. Likewise, in states where gaps in OBOT and OTP capacity were described as acute (e.g., states with a higher proportion of rural areas), increases in MAT access in residential settings could be smaller than in states with more capacity. Second, non-Medicaid resources were the most commonly reported facilitator to address stigma and provider shortages. We expect demonstration states that leverage resources outside of Medicaid may be better positioned to increase MAT utilization in residential facilities. Third, changes in residential service payment methods could alter the extent to which MAT utilization is observable in claims data, a factor that several state officials already described as impacting their capacity to reliably monitor trends in MAT utilization.

Authors and Acknowledgments

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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 between December 2020 and July 2021. All states with approved section 1115 SUD demonstrations at that time were invited to participate with the exception of Maine, because of the recent timing of their demonstration approval. Because California counties developed their own implementation plans within state parameters for the demonstration, we interviewed government officials from three counties to reflect variation in implementation experience.[16] Thus, the report reflects 34 interviews in 30 states, 3 California counties, and the District of Columbia.[17] Key informants included state Medicaid officials, behavioral health administrators, and other state staff involved in the oversight of SUD and behavioral health services.

The interviews used a common, semi-structured protocol that covered multiple topics; those relevant for this report included steps taken to expand residential treatment, changes in residential treatment provider standards for state licensure and pre-enrollment certification and related changes in state contracts, changes in reimbursement for services to cover MAT in residential facilities, challenges encountered, and strategies to address these challenges. Interviews were 90 minutes in length.

Interviews were audio recorded with informant permission and transcribed. RTI 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 experiences with expanding the availability and accessibility of MAT in residential settings across states. The team held regular coding reviews and debriefings and conducted intercoder reliability assessments for quality control purposes.

In this report, we discuss state experiences with expanding availability and accessibility of residential MAT. This analysis has a few limitations. One is our reliance on key informant interviews as the primary source of data. Although we provide a count of states that reported each challenge, these numbers are not meant to be exact. Counts are intended to give readers a sense for the prevalence of certain challenges or experiences and to help prioritize areas for future inquiry.[18] Additionally, states' perspectives may have varied depending on how far along they were in implementation. At the time our interviews were conducted, some states had only been engaged in implementation for six months or less whereas others had been operating their section 1115 SUD demonstration for one year or longer. Furthermore, COVID-19 could have had different impacts on states' experiences.

[16] California's section 1115 SUD demonstration is approved by CMS at the state level. Counties administer the Medicaid program and participate in the demonstration on a voluntary basis by operating Prepaid Inpatient Health Plans (PIHPs). California has facilitated SUD demonstration adoption by counties in waves beginning in April 2017. Counties that have submitted implementation plans and undergone the approval process by both the state and CMS can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

[17] For brevity, we refer to states, the District of Columbia, and counties as "states" and all interviewees as "state officials."

[18] California is included as a state in the counts, but the three counties are not counted separately. If one or more California county official identified a topic or challenge, they are included as part of a single count for the state.