Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder

Given the opioid epidemic's considerable effect on Medicaid beneficiaries, policymakers and stakeholders have expressed interest in better understanding how states complement coverage of clinical treatment of substance use disorders (SUDs) with payment for recovery support services. Recovery support services are non-clinical services that address psychosocial factors in an individual's environment and provide emotional and practical support to maintain remission. These services may include peer support, supportive housing, supported employment, and skills training and development.

Medicaid programs cover recovery support services to varying degrees. States are more likely to cover comprehensive community supports or peer support services than skills training and development, supported employment, or supportive housing (RTI 2019). Moreover, while some recovery support services may be available to a broader group of beneficiaries with an SUD, others, such as supported employment, are often restricted to beneficiaries receiving home- and community-based services (HCBS) who would otherwise require an institutional level of care. Most states allow certified peers and other licensed professionals such as social workers and professional counselors to bill for recovery support services, but providers of recovery support services also vary by state. Generally, recovery support services may be delivered in a variety of settings; however, some Medicaid programs only allow providers to deliver services in clinical settings, such as outpatient behavioral health clinics.

To document the extent to which state Medicaid programs are covering recovery support services, MACPAC contracted with RTI International (RTI) to identify and compile Medicaid coverage policies in all 50 states and the District of Columbia. We also interviewed subject matter experts and conducted further research to learn more about how states provide these services under Medicaid.[1]

This brief begins with background on Medicaid's role as a payer of recovery support services, including various authorities states may use to pay for these services. We then present results from our 50-state policy review including the types of providers who can be paid for providing recovery support services to Medicaid beneficiaries. Finally, we discuss opportunities to coordinate clinical treatment and recovery support services.

Medicaid's Role as a Payer of Recovery Support Services

Historically, Medicaid payment for recovery support services was mainly limited to beneficiaries with mental health conditions, and it was less common for states to pay for these services for beneficiaries with an SUD (RTI 2018). This is changing, however, due to two factors. First, states are responding to the opioid epidemic which has disproportionately affected Medicaid beneficiaries (MACPAC 2017). Second, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established SUD and mental health services, as well as rehabilitative services, as essential health benefits for individuals purchasing coverage in the individual health insurance market and those newly covered by Medicaid.

These changes led states to seriously consider whether they should pay for recovery support services to supplement coverage of clinical SUD care in Medicaid (RTI 2018).

Below we describe the various funding authorities states are currently using to pay for recovery support services in Medicaid, including the state plan, waivers, or demonstration programs. We also discuss the role of non-Medicaid funding to pay for these services. These funds play an important role in the provision of recovery support services in many states. We include findings from MACPAC's interviews with subject matter experts from federal agencies, Medicaid managed care organizations, recovery support services organizations, and state Medicaid programs as appropriate. [2]

Federal policy

Recovery support services are not defined in federal Medicaid statute, regulations, or policy guidance and there is wide variation in how states define and pay for these services in Medicaid. Several state officials noted that they use the Substance Abuse and Mental Health Services Administration's (SAMHSA) description of recovery as having four dimensions: health, home, purpose, and community. This captures multiple types of recovery support services (e.g., peer support, supportive housing, or supportive employment), as discussed below (RTI 2018).

In 2007, the Centers for Medicare & Medicaid Services (CMS) issued guidance to state Medicaid directors on coverage of peer support services for individuals with behavioral health conditions (Box 1). Because CMS required that peer support workers be supervised by a mental health professional in order to receive Medicaid payment, however, some stakeholders felt that the guidance was directed towards mental health providers rather than SUD providers (RTI 2018).

Box 1. CMS Guidance on Medicaid Coverage of Peer Support Services

Peer support services can be offered to beneficiaries with either mental health conditions or substance use disorders (SUDs). States may choose to deliver peer support services through several Medicaid funding authorities including the state plan rehabilitative services option, and Section 1915(b) or 1915(c) waivers. State Medicaid agencies have the authority to determine the service delivery system, medical necessity criteria, and the scope of peer support services. However, certain minimum service requirements must be addressed when states seek federal financial participation for peer support services:

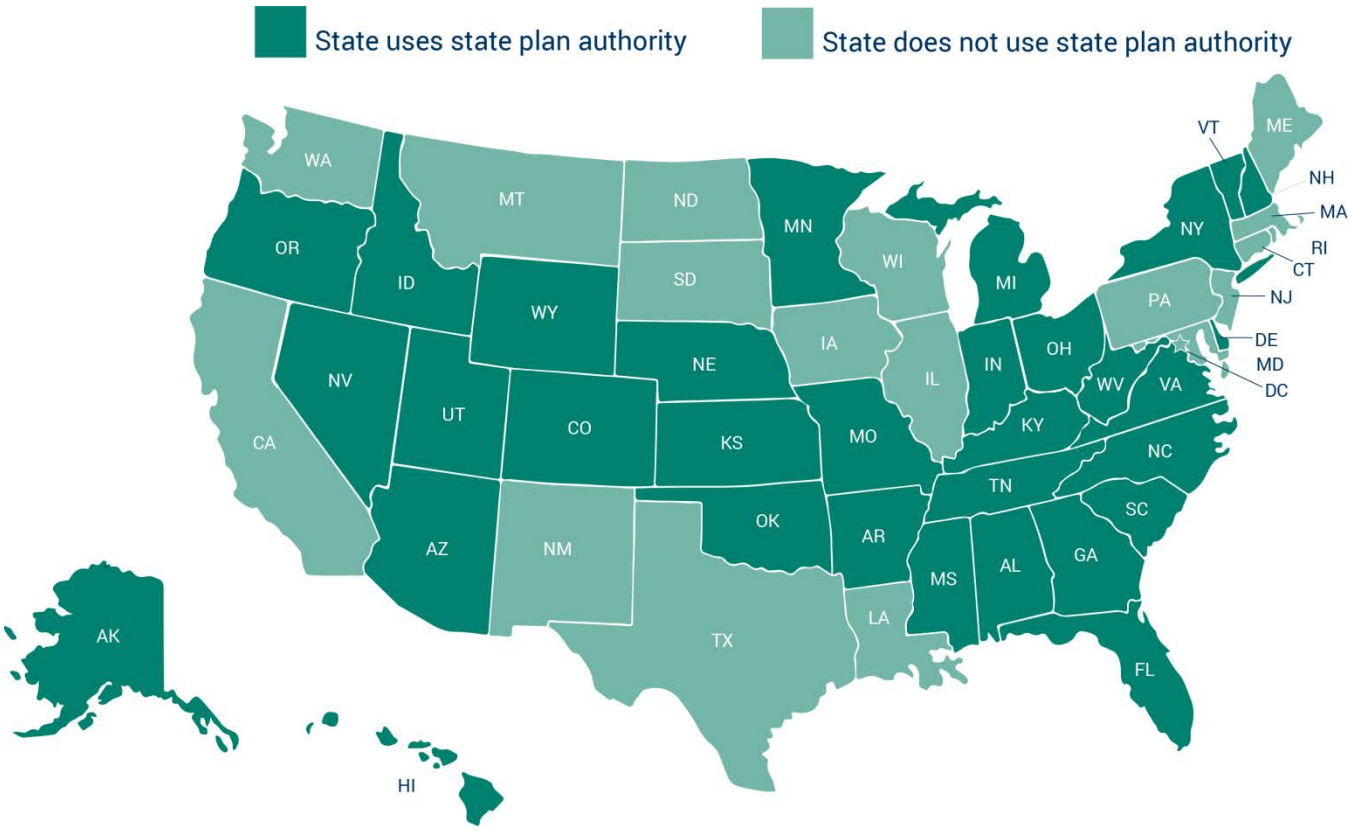
- **Supervision.** Peer support service providers must be supervised by a competent mental health professional, as defined by the state. The amount, duration and scope of supervision may range from direct oversight to periodic care consultation.
- **Care coordination.** Peer support services must be coordinated within the context of an individualized plan of care for the beneficiary. States should use a person-centered planning process that helps promote beneficiary ownership of the plan of care. Plans of care must also include specific individualized goals that have measureable results.
- **Training and credentialing.** Peer support providers must obtain training and certification as defined by the state. Training must provide peer support providers with a basic set of competencies as defined by the state. The peer must demonstrate the ability to support the recovery of others from mental illness or SUDs. Ongoing continuing educational requirements for peer support providers must also be in place.

When electing to provide peer support services to Medicaid beneficiaries, state Medicaid agencies may choose to collaborate with state mental health departments (CMS 2007, CMS 2011).

State plan services

States that pay for recovery support services using Medicaid state plan authority have several options for tailoring the provision of services (Figure 1). This includes the state plan rehabilitative services option, the health home state plan option, and the Section 1915(i) state plan option.

FIGURE 1. Medicaid Coverage of Recovery Support Service Using State Plan Authority by State, 2018



Notes: Recovery supports services include peer support, supportive housing, skills training and development, comprehensive community support services, and supported employment. State plan authority includes the state plan rehabilitative services option, the health home state plan option, and the Section 1915(i) state plan option. Other Medicaid authorities not captured by this figure include Section 1915(b) waivers, home- and-community-based waivers and certified community behavioral health clinic demonstrations. States that do not use state plan authority may use other funding streams such as Substance Abuse and Mental Health Services Administration SAMHSA programs or dedicated funds from governors' commissions or task forces and general state revenue dollars.

Source: RTI 2019.

State plan rehabilitative services option. Authorized under Section 1905(a)(13) of the Social Security Act (the Act), the rehabilitative services option allows states to pay for discrete rehabilitative services for beneficiaries with an SUD, such as supported employment or skills training and development. Most states use this option to provide recovery support services, particularly peer support.

Health home state plan option. States may choose to establish health homes as a state plan option under Section 2703 of the ACA.[3] Health home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. States use this approach to pay for recovery support services via bundled payments to health homes that coordinate care for beneficiaries with chronic conditions, including SUDs. As of September 2018, 22 states had active health homes, of which 13 targeted beneficiaries with an SUD (CMS 2018a).

Section 1915(i). The 1915(i) state plan amendment (SPA) allows states to provide HCBS services under their Medicaid state plans without obtaining a waiver from CMS.[4] Like the Section 1915(c) waiver, the 1915(i) SPA allows states to design service packages targeted to people with specific needs, including special services for those who have developmental disabilities, physical disabilities, mental illness or SUDs. States may offer benefits to a specific age group without regard to comparability of services for those who do not receive the 1915(i) services, although they must abide by the statewideness rule, dictating that state Medicaid programs cannot exclude enrollees or providers because of where they live or work in the state. Unlike Section 1915(c) waivers, the 1915(i) SPA allows states to set the qualifying level for HCBS at an institutional level of care or lower (MACPAC 2016).

Under 1915(i) authority, states may offer a variety of HCBS services, such as case management or rehabilitative services, to beneficiaries. However, few states use this authority to pay for recovery support services for beneficiaries with an SUD. As of 2015, 16 states and the District of Columbia had a total of 23 approved Section 1915(i) SPAs but only 7 targeted adults with behavioral health conditions (ASPE 2016).

Waivers and demonstration programs

Waivers and demonstration programs offer states a variety of options for providing services to beneficiaries with SUDs. Since 2016, an increasing number of states have used Section 1115 waivers to cover recovery support services. Recovery support services are also being offered to beneficiaries receiving services through the certified community behavioral health clinic demonstration. A few states use HCBS waivers or Section 1915(b) waivers to pay for recovery support services.

Section 1115 demonstrations. Beginning in 2016, more states began to pay for SUD treatment services through Section 1115 SUD demonstrations. In the Commission's June 2018 report to Congress, MACPAC discussed how states are using these waivers to reduce gaps in the clinical SUD continuum of care, particularly for residential and inpatient treatment. States are also using these demonstrations to pay for both recovery support services and SUD case management (MACPAC 2018a).

Twenty-eight states and the District of Columbia have sought Section 1115 waivers related to SUD treatment. As of June 2019, 24 states have approved demonstrations and another 4 states and the District of Columbia have waiver applications pending CMS review. Of the approved demonstrations, eight states have incorporated one or more recovery support services into their Section 1115 demonstration state terms and conditions.

Certified community behavioral health clinic demonstrations. Section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) established a Medicaid demonstration program that allows participating states to certify and pay for certified community behavioral health clinics. These clinics serve individuals with serious mental illnesses and SUDs and provide intensive, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services. Certified

community behavioral health clinics are paid a daily or monthly prospective payment system rate that is clinic-specific and covers the expected cost of demonstration services.[5]

All states participating in the certified community behavioral health clinic demonstration must target beneficiaries with severe mental illness, children with severe emotional disturbance, and those with an SUD. However, several states have identified other subpopulations—including those with an opioid use disorder—as priority populations. Many of these states offer recovery support services, including supported employment and peer supports (CMS 2019).

HCBS waivers. Waivers under section 1915(c) of the Act can be used to provide services that are not available through the state plan to certain beneficiaries who are at risk for institutionalization. Generally states can use this authority to pay for discrete rehabilitative services for beneficiaries with an SUD, such as supported employment or skills training and development. However, states can limit HCBS services to a specific number of individuals or limit services to a certain region of the state. Nearly all states and the District of Columbia offer services through HCBS waivers; however, few use this authority to provide recovery support services to beneficiaries with an SUD.

Section 1915(b) waivers. This authority allows states to seek waivers of state plan requirements under Section 1902 of the Act to achieve one of four managed care program goals. States are using this authority to create a specialized or targeted program that provides a limited set of benefits or services to beneficiaries. For example, Colorado uses this authority to contract with behavioral health organizations to provide behavioral health services, including recovery support services, to beneficiaries across the state (CMS 2015).

Non-Medicaid funding strategies for recovery support services

When Medicaid does not pay for recovery support services through one of the authorities described above, such services may still be available to Medicaid beneficiaries through other funding streams. For example, SAMHSA has made funding available for these services through numerous programs including the Access to Recovery grants; State Targeted Response to the Opioid Crisis grants; Substance Abuse Prevention and Treatment Block grants; and, Bringing Recovery Supports to Scale Technical Assistance Center Strategy funding. States are also using dedicated funds from governors' commissions or task forces and general state revenue dollars to pay for recovery support services.

Many stakeholders interviewed by MACPAC indicated they must use multiple funding streams to provide comprehensive recovery support services to Medicaid beneficiaries; identifying a long-term source of funding for these services is needed. In addition, grant funding is often used to pay for recovery support services due to Medicaid restrictions on payment for certain services, such as room and board (RTI 2018).

State Coverage of Recovery Support Services

Documenting Medicaid coverage of recovery support services is challenging, in part because the majority of recovery support services are not defined, or even discussed, by CMS in policy guidance related to SUD. Since there is no federal definition for recovery support services under Medicaid, MACPAC created a framework to classify coverage of recovery support services in the 50 states and the District of Columbia. The framework includes five distinct service categories:

- comprehensive community supports;

- peer support services;
- skills training and development;
- supported employment; and
- supportive housing.

Medicaid programs pay for these services to varying degrees and using different authorities (Table 1, Table A-1).

TABLE 1. Medicaid Recovery Support Services for Beneficiaries with a Substance Use Disorder, 2018

Recovery support service	Medicaid coverage
Comprehensive community supports	
Services that address barriers that impede the development of skills necessary for independent functioning in the community.	Twenty-nine states cover some form of comprehensive community supports for beneficiaries with an SUD.
Peer support services	
Supportive services delivered by a person in recovery from an SUD.	Thirty-eight states cover some type of peer support for beneficiaries with an SUD.
Skills training and development	
Services that help a beneficiary with an SUD acquire new skills, ranging from life skills to employment readiness and restoration to the community.	Fifteen states cover some form of skills training and development for beneficiaries with an SUD.
Supported employment	
Helps individuals achieve competitive employment in community settings.	Thirteen states cover supported employment for beneficiaries with an SUD.
Supportive housing	
Evidenced-based intervention that combines housing assistance with wrap-around support services for people experiencing homelessness, as well as other people with disabilities.	Four states covered some form of supportive housing for beneficiaries with an SUD.

Notes: SUD is substance use disorder. For the purposes of this analysis, covered services are those paid for under the state plan, including the health home and rehabilitative option, HCBS waivers, Section 1115 demonstrations, and certified community behavioral health clinic demonstrations.

Source: RTI 2019.

States are more likely to pay for comprehensive community supports or peer support services for certain beneficiaries with an SUD, compared to other services such as skills training and development, supported employment, or supportive housing (RTI 2019).

Below we describe the types of recovery support services covered by state Medicaid programs and the populations that can access these services. We then identify the types of providers (e.g., peers, mid-level practitioners) and treatment settings (e.g., behavioral health clinics or HCBS providers) in which recovery support services may be delivered.

MACPAC also documented coverage of three types of case management services for beneficiaries with an SUD: transitional case management, targeted case management, and recovery management.[6] Often states use these services to ensure that clinical and non-clinical services are coordinated. The role of these services, as well as opportunities states are taking to pay for recovery support services, will be discussed in greater detail later in this document.

Coverage of comprehensive community supports

Twenty-seven states cover some form of comprehensive community supports for beneficiaries with an SUD.[7] These are services that address barriers that impede the development of skills necessary for independent functioning in the community. They may include assistance with identifying and coordinating services and supports, supporting individuals in crisis situations, and providing individualized interventions to develop or enhance an individual's ability to make independent choices.

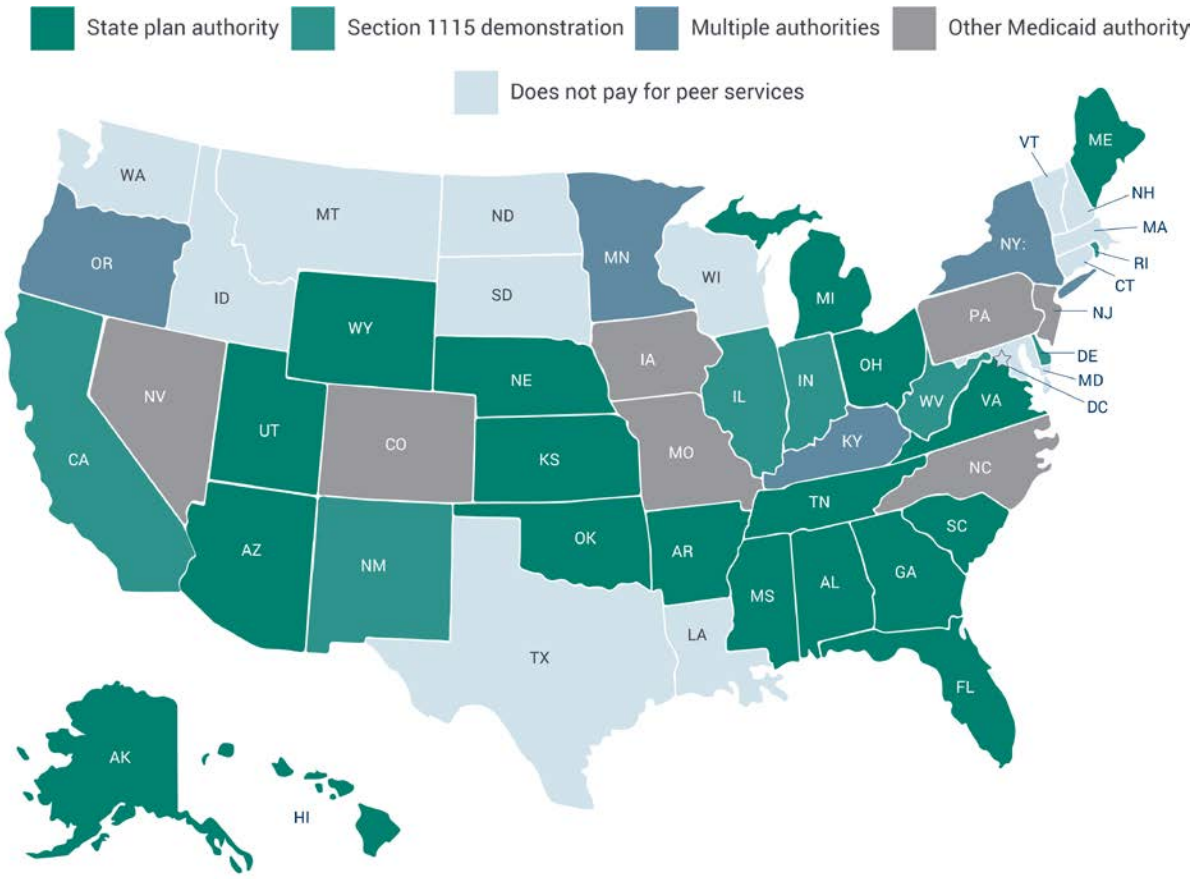
Generally, access to comprehensive community supports is limited to beneficiaries with a long-term chronic SUD, beneficiaries with significant functional impairment as a result of their SUD, beneficiaries with co-occurring conditions, or those at risk of being homeless. New Mexico, for example, offers comprehensive community supports to beneficiaries with a severe mental illness, chronic drug abuse, or both. However, these services can only be provided in certain settings, such as community mental health centers or core service agencies (RTI 2019).

Coverage of peer support services

Thirty-seven states cover some type of peer support for beneficiaries with an SUD (Figure 2). Peer supports are typically delivered by a person in recovery from mental health or an SUD, or in the case of family peer support, a family member of a person living with a behavioral health condition. These services may be provided on an individual or group basis, as determined by the state. Generally, states that pay for peer support for beneficiaries with an SUD also offer this service to those with a mental health condition.

A minority of states limit peer supports to a smaller population of beneficiaries with an SUD. For example, in Delaware, beneficiaries with an SUD must also be in need of HCBS to receive peer supports. Some states, including Alaska, limit use of peers to beneficiaries who are transitioning from an institutional setting into the community (RTI 2019).

FIGURE 2. Medicaid Coverage of Peer Support Services Using Various Medicaid Authorities, 2019



Notes: State plan authority includes the Medicaid rehabilitative services state plan option, the Section 1915(i) state plan option, and the health home state plan option. Other Medicaid authorities include Section 1915(b) waivers, home-and-community-based waivers and certified community behavioral health clinic demonstrations.

Source: RTI 2019.

Skills training and development

Eleven states cover some form of skills training and development (defined as services that help with acquisition of skills ranging from life skills to employment readiness and restoration to the community) for beneficiaries with an SUD. Such services can be provided as an individual or group service. States often limit eligibility for these services to those with a long-term or chronic SUD or those with greater functional impairment. For example, Georgia pays for skills training and development through psychosocial rehabilitation. Among other things, this service helps restore a beneficiary's maximum possible functional level. Services may include structured skills practice, skills training and coaching techniques, or developing problem-solving abilities. These services may be provided either in a clinic or community-based setting to beneficiaries with a mental illness or SUD who are determined to need rehabilitative services (RTI 2019).

Supported employment

Eleven states cover supported employment for beneficiaries with an SUD. Generally this service helps individuals achieve competitive employment in community settings.[8] Typically, supported employment is only available to beneficiaries who have a serious or long-term SUD or would otherwise require an institutional level of care in the absence of HCBS. For example, New York pays for supported employment for beneficiaries with significant behavioral health needs, including those with an SUD. These services are delivered by employment specialists and designed to assist beneficiaries in obtaining or maintaining a job that pays above minimum wage (RTI 2019).

Supportive housing

Four states covered some form of supportive housing for beneficiaries with an SUD. Supportive housing is an evidence-based intervention that combines housing assistance with wraparound support services, such as tenancy supports, for people experiencing chronic homelessness, as well as other people with disabilities (MACPAC 2018b). While such supports do not include payment for room and board, they can help a beneficiary obtain and maintain tenancy through services such as education and training on the role, rights, and responsibilities of the tenant and landlord. For example, the state of Washington is using a Section 1115 demonstration to provide pre-tenancy and tenancy supports to beneficiaries who have certain behavioral health conditions and are at risk of being homeless, are frequently admitted to residential or inpatient programs, whose in-home caregivers have a high turnover rate, or who are considered high-risk of being homeless (RTI 2019). In comparison, Colorado offers supportive housing through a Section 1915(b) waiver.

Provider Qualifications and Treatment Settings

State Medicaid programs pay a wide range of providers, from peers to physicians, to deliver recovery support services. In most states, paraprofessionals provide recovery support services and bill Medicaid. Peers deliver many services, including peer supports, recovery management services, and supported employment.

Peer support workers engage in a wide array of activities, including advocating for people in recovery, leading recovery groups, and mentoring and setting goals (SAMHSA 2018). Providers of peer support services may include certified recovery support specialists, certified family support specialists or family support peer advocates, certified recovery coaches, and youth peer support specialists. Often, peers are individuals recovering from a behavioral health condition who have obtained specific training and certification requirements defined by the state. Such training generally includes a basic set of competencies, such as personalizing peer support and supporting recovery planning, as well as ongoing continuing education requirements (SAMHSA 2015).

In addition to certified peers, professionals, including social workers, psychologists, and addiction counselors can typically bill for recovery support services, including skills training and development and comprehensive community support services. In some states, physicians, nurse practitioners, and physician assistants can also bill Medicaid for certain recovery support services (RTI 2019).

Generally, states do not restrict provision of recovery support services to specific settings, allowing payment for services delivered in both clinical settings, such as outpatient behavioral health providers, and

in community settings, such as a beneficiaries' home or workplace. A few states restrict the delivery of recovery support services to behavioral health treatment facilities (RTI 2019). Many interviewees voiced a preference for making recovery supports available to beneficiaries throughout the continuum of care, including once treatment is complete, rather than limited to specific treatment settings such as residential treatment (RTI 2018).

Challenges in providing recovery support services

Stakeholders noted a number of challenges in providing recovery support services. For example, the workforce is often comprised of paraprofessionals or peers who may have difficulty enrolling and billing as Medicaid providers. In order to enroll as a Medicaid provider, federal guidance requires peers to undergo training and certification, but no standardized certification process exists at the national level. Some stakeholders noted that Medicaid's documentation and supervision requirements for peers are limiting compared to the less stringent requirements of grant funding. In one state, peer providers faced barriers to employment as providers of recovery support services if they had criminal histories. Most organizations that deliver recovery support services may also lack the infrastructure needed to bill Medicaid or other insurers. One state has addressed this problem by contracting with facilitating organizations to assist providers of recovery support services in billing under Medicaid.

Nevertheless, in some circumstances, providers of recovery support services may not be interested in billing Medicaid. Several stakeholders noted that some recovery support service providers may be less medically oriented and prefer a peer-driven model supported by government grants or private funds that is not intertwined with the rest of the health care system.

Finally, many stakeholders expressed interest in better coverage of recovery support services, often citing unmet needs for supportive housing and recovery housing as these services are often rarely covered by Medicaid. Most stakeholders agreed that payment for supportive housing would have a significant impact on the recovery system (RTI 2018).

Opportunities to Coordinate Clinical Treatment and Recovery Support Services

As we have noted in prior work, providing access to SUD treatment services along a continuum of care is important for effective treatment and for an individual's continued recovery (MACPAC 2018a). Because the severity of an individual's SUD determines the type and intensity of services, individuals with SUD need a continuum of care that offers progressive clinical treatment, such as outpatient services and medication-assisted treatment, and non-clinical supports, such as recovery services (Mee-Lee et al. 2013).

Moreover, as individuals move through the continuum, appropriate transitions between levels of treatment are important for their recovery. Case management can help facilitate these transitions, and help individuals identify and access needed long-term resources, such as recovery supports, in the community. Case management can also avoid gaps in service (SAMHSA 2000). Our interviews highlighted how case management is being used to coordinate clinical care and recovery support services. One state is using targeted case management to help coordinate physical health care and behavioral health services for people with SUDs. Another state requires institutions for mental diseases (IMDs) to develop a shared care

plan using a standardized assessment to address social determinants of health. The assessment helps inform the care plan between community providers (RTI 2018).

Below we discuss three types of case management services states are using to coordinate care for beneficiaries with an SUD. States may use numerous Medicaid authorities to pay for case management. However, Section 1115 SUD demonstrations provide an opportunity for states to adopt comprehensive strategies to improve access to clinically appropriate SUD care and provide coverage for recovery support services, and adopt case management strategies to better support beneficiaries with an SUD.

Coverage of case management

SAMHSA describes case management for beneficiaries with an SUD as a coordinated approach to the delivery of physical health, SUD, mental health, and social services. In addition to their SUD, clients arrive in treatment programs with numerous social challenges. For example, clients may be unemployed or under-employed, lacking job skills or work experience. They may also experience homelessness, difficulty accessing safe and affordable housing, or involvement with the criminal justice system. Case management focuses on the whole individual, providing individuals with a comprehensive assessment, service planning, and service coordination to address multiple aspects of their lives (SAMHSA 2000).

In our review of state Medicaid programs, we captured instances in which states are paying for case management for beneficiaries with an SUD. This includes recovery management, transitional case management, and targeted case management (Table 2). States may use several different authorities to pay for these services (Table A-2).

TABLE 2. Medicaid Case Management Services for Beneficiaries with a Substance Use Disorder, 2018

Case management service	Medicaid coverage
Recovery management	
Recovery management includes case management or checkups to assess where an individual is in the recovery cycle and what additional recovery support services may be necessary.	Ten states cover some form of recovery management for certain beneficiaries with an SUD.
Transitional case management	
Care management services for a patient following a discharge from a hospital, or facility-based care.	Seventeen states cover transitional case management for certain beneficiaries with an SUD.
Targeted case management	
Case management services that assist individuals in gaining access to needed medical, social, educational, and other services.	Forty-one states cover targeted case management to certain Medicaid beneficiaries with an SUD.

Notes: SUD is substance use disorder. For the purposes of this analysis, covered case-management services are those paid for under the state plan, including the health home and rehabilitative services option, home- and community-based services waivers, Section 1115 demonstrations, and certified community behavioral health clinic demonstrations. Roughly half of states pay for recovery management through a Section 1115 SUD demonstration, while the remainder of states offer a similar service to beneficiaries enrolled in a health home or through their state plan. Generally, transitional case management is restricted to beneficiaries enrolled in a health homes; however, some states provide this service through Section 1115 SUD demonstrations, or through their state plan. The majority of states pay for targeted case management through the state plan rehabilitative services option; however some states pay for it as a bundled service to beneficiaries enrolled in a health home (12 states) or a certified community behavioral health clinic (4 states).

Source: RTI 2019.

Comprehensive strategies to coordinate clinical treatment and recovery support services

Increasingly, state Medicaid programs are using Section 1115 demonstrations to improve access to clinically appropriate, comprehensive SUD care, including recovery support services and case management services (MACPAC 2018a). For example, several states have begun paying for peer support under Section 1115 demonstrations (California, Illinois, Indiana, Rhode Island and West Virginia). Some states have chosen to further tailor the availability of peer supports. In California, beneficiaries may receive peer support services after completing their course of treatment whether they have relapsed or as a preventive measure to prevent relapse.

Some states (California, Indiana, Massachusetts, and Rhode Island) are paying for case management services for beneficiaries with an SUD (RTI 2019). Often, case management is used to ensure an individual's treatment plan is fully addressed, that clinical and non-clinical services are coordinated, and that transitions between levels of SUD treatment are uninterrupted.

Below we discuss how some states are using Section 1115 demonstrations to ensure that beneficiaries have access to clinical SUD treatment and non-clinical recovery supports, and that these services are coordinated to meet the individual needs of beneficiaries.

Illinois

In addition to expanding access to residential treatment in IMDs, Illinois pays for multiple pilots through a Section 1115 SUD demonstration. This includes pilot programs that provide:

- **SUD case management.** Case management services are provided to beneficiaries with an SUD who are involved with the criminal justice system and request diversion into SUD treatment as an alternative to incarceration. These services will help beneficiaries access medical, social, educational and other services as necessary and include comprehensive assessment and reassessment; transitions to higher or lower levels of SUD care; communication, coordination, and referral; monitoring beneficiary progress; and patient advocacy.
- **Peer recovery support services.** Peer supports are paid for under a pilot program that targets a specific geographic area of the state.
- **Supported employment services.** The supported employment pilot is available to beneficiaries with a serious or persistent mental illness or an SUD. Additionally, the beneficiary must meet one of the following risk factors: has been unable to be gainfully employed for at least 90 consecutive days due to their mental illness or SUD; has had more than one instance of inpatient SUD treatment in the past 2 years; or at risk of deteriorating from their mental illness or SUD (CMS 2018b).

Previously, these services were only supported with grant funds.

Massachusetts

In the state's Section 1115 SUD demonstration, Massachusetts added two recovery support services: recovery supports navigators and recovery coach services. The recovery supports navigators develop and monitor a recovery plan in conjunction with beneficiaries, coordinate all clinical and non-clinical services,

and participate in discharge planning from treatment programs. They also work with beneficiaries to ensure adherence to their discharge plan and assist them in pursuing their health management goals.

Recovery coach services are also offered as a form of peer support. The recovery coach is a person with lived SUD experience who acts as a guide and advocate for beneficiaries in recovery (CMS 2017).

Looking Ahead

The SUPPORT for Patients and Communities Act (P.L. 115-271) requires the U.S. Department of Health and Human Services to issue reports or guidance, or offer states technical assistance, on one aspect of recovery support-supportive housing for beneficiaries with an SUD, specifically:

- **Section 1017. Report on innovative state initiatives and strategies to provide housing-related services and supports to individuals with SUDs under Medicaid.** On or before October 24, 2019, the Secretary must issue a report to Congress on existing opportunities and state initiatives and strategies for providing housing-related services and supports in Medicaid to individuals with SUDs who are or are at risk of experiencing homelessness.
- **Section 1018. Technical assistance and support for innovative state strategies to provide housing-related supports under Medicaid.** The Secretary was required to issue a report to Congress on or before April 21, 2019, detailing a plan of action for technical assistance and support so states could develop housing-related supports and care coordination for beneficiaries with an SUD. This action plan was submitted to Congress in July 2019. The plan outlines five areas of technical support that CMS intends to carry out, beginning in fiscal year 2020: (1) offering state-specific technical assistance; (2) identifying and disseminating lessons learned under existing Medicaid SUD delivery systems; (3) developing a Medicaid state learning collaborative for approximately 10 states; (4) issuing an informational brief on the provision of housing-related supports; and (5) disseminating informational materials to states on existing options to offer housing-related supports to beneficiaries with an SUD. These technical assistance and support activities are dependent on the availability of funding.

Endnotes

[1] The project was structured in two phases. During the first phase, RTI conducted interviews with 10 subject matter experts to identify recovery support services that Medicaid programs could cover for beneficiaries with an SUD. The results of these interviews, along with additional research on state coverage policies, were used in the second phase of the project to create a scheme to classify coverage of recovery support services in all 50 states and the District of Columbia. This state-level assessment included review of Medicaid state plans, Section 1115 demonstrations, managed care waivers, home- and community-based services (HCBS) waivers, and certified community behavioral health clinic demonstrations. It also captured coverage limitations including those related to populations, settings, and provider types.

[2] The interviews sought to: define recovery support services, capture how states use Medicaid to pay for recovery support services, understand non-Medicaid funding strategies for recovery support services, and identify challenges in providing or funding recovery support services.

[3] Section 1945 of the Social Security Act.

[4] The 1915(i) SPA was created in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and updated by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

[5] Eight states are currently participating in the certified community behavioral health clinic demonstration program (Minnesota, Missouri, Nevada, New York, New Jersey, Oklahoma, Oregon and Pennsylvania). Funding for all eight states was set to expire in June 2019; however Congress is working on a funding extension for this program.

For each service category, RTI developed a broad service definitions and then reviewed Medicaid state plans, Section 1115 waivers, provider manuals, fee schedules, billing manuals, managed care documents, and other publicly available sources from July 1 - October 26, 2018. RTI noted when each of these services were provided to beneficiaries with an SUD, and collected additional information on legal authorities, eligible settings, provider restrictions, and target population. RTI was unable to determine whether certain recovery support services were being paid for in a minority of states. In those instances, RTI reached out to states directly to seek clarification about their coverage of these services (RTI 2019).

[7] For the purposes of this analysis, states that offer psychosocial rehabilitation for beneficiaries with an SUD were included in this figure (RTI 2019).

[8] Supported employment for people with severe mental illness is an evidenced-based practice that helps individuals obtain and maintain employment (Sherman et al. 2017). More recently, states have begun to offer this service to certain beneficiaries with an SUD.

References

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2016. *The use of 1915(i) Medicaid plan option for individuals with mental health and substance use disorders.* Washington, DC: ASPE. https://aspe.hhs.gov/system/files/pdf/255716/1915iSPA.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Section 223 Demonstration Program to Improve Community Mental Health Services. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/finance/223-demonstration/index.html.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. *Conditions targeted by Medicaid health homes*. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/targeted-conditions-matrix.pdf.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Section 1115 of the Social Security Act Medicaid demonstration: technical corrections to the Illinois behavioral health care transformation demonstration. Baltimore, MD:CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to the MassHealth program. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amndmnt-appvl-dec-2017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Section 1915(b) of the Social Security Act Medicaid demonstration: Community behavioral health services program (CO-03). October 22, 2015. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/Downloads/CO_Community-Mental-HealthServices-Program_CO-03.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. Chapter 4: Access to substance use disorder treatment in Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2018. https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. *Issue brief: Medicaid's role in housing.* October 2018. https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing-.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Chapter 2: Medicaid and the opioid epidemic. In *Report to Congress on Medicaid and CHIP.* June 2017. https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Behavioral health services covered under HCBS waivers and 1915(i) SPAs*. Washington, DC: MACPAC. https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-hcbs-waivers-and-spas/.

Mee-Lee, D., G.D. Shulman, M.J. Fishman, D.R. Gastfriend, and M.M. Miller. 2013. *The ASAM Criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions. Third edition.* Carson City, NV: The Change Companies. https://www.asam.org/resources/the-ASAM-criteria/text.

RTI, International (RTI). 2019. Analysis for MACPAC of recovery support services.

RTI, International (RTI). 2018. Analysis for MACPAC, coverage of recovery support services interview summary findings.

Sherman, L., S.Lynch, J. Reich, and W. Hudock. 2017. *Availability of supported employment in specialty mental health treatment facilities and facility characteristics: 2014. National mental health services study.* Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA). https://www.samhsa.gov/data/sites/default/files/report_3071/ShortReport-3071.html.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2018. Recovery support tools and resources: peers. Rockville, MD: SAMHSA. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2015. *Core competencies for peer workers in behavioral health services.* Rockville, MD: SAMHSA. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2000. *Comprehensive case management for substance abuse treatment. Treatment improvement protocol series, no. 27.* Rockville, MD: SAMHSA. https://store.samhsa.gov/system/files/sma15-4215.pdf.

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Appendix: State Coverage of Substance Use Disorder Recovery Support Services and Case Management

TABLE A-1. Medicaid State Plan, Section 1115 Demonstrations, and Other Medicaid Authorities Used to Pay for Recovery Support Services, 2018

State	Peer support			Supportive housing			Skills training and development			Comprehensive community support			Supported employment		
	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority
Total	**24**	**8**	**10**	**2**	**1**	**1**	**9**	**1**	**4**	**25**	**1**	**4**	**6**	**3**	**4**
Alabama	✓	–	–	–	–	–	–	–	–	✓	–	–	✓	–	–
Alaska	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Arizona	✓	–	–	–	–	–	✓	–	–	✓	–	–	✓	–	–
Arkansas	✓	–	–	✓	–	–	✓	–	–	✓	–	–	✓	–	–
California	–	✓	–	–	–	–	–	✓	–	–	–	–	–	–	–
Colorado	–	–	✓	–	–	✓	–	–	✓	–	–	✓	–	–	✓
Connecticut	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Delaware	–	✓	–	–	–	–	–	–	–	–	–	–	–	✓	–
District of Columbia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Florida	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Georgia	✓	–	–	–	–	–	✓	–	–	✓	–	–	–	–	–
Hawaii	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–

TABLE A-1. (continued)

State	Peer support			Supportive housing			Skills training and development			Comprehensive community support			Supported employment		
	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority
Idaho	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Illinois	–	✓	–	–	–	–	–	–	–	–	–	–	–	✓	–
Indiana	–	✓	–	–	–	–	✓	–	–	–	–	–	–	–	–
Iowa	–	–	✓	–	–	–	✓	–	–	–	–	–	–	–	–
Kansas	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Kentucky	✓	✓	–	–	–	–	–	–	–	–	–	–	–	–	–
Louisiana	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Maine	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Maryland	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Massachusetts	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–
Michigan	✓	–	–	–	–	–	–	–	✓	✓	–	–	✓	–	–
Minnesota	✓	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
Mississippi	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Missouri	–	–	✓	–	–	–	–	–	–	✓	–	–	–	–	–
Montana	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska	✓	–	–	–	–	–	–	–	–	–	–	✓	–	–	–
Nevada	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	✓
New Hampshire	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	✓
New Mexico	–	✓	–	–	–	–	–	–	–	✓	–	–	–	–	–
New York	✓	–	✓	–	–	–	–	–	✓	–	–	–	–	–	✓
North Carolina	–	–	✓	–	–	–	–	–	–	✓	–	✓	–	–	–

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TABLE A-1. (continued)

State	Peer support			Supportive housing			Skills training and development			Comprehensive community support			Supported employment		
	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority	State plan	§ 1115	Other authority
North Dakota	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ohio	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Oklahoma	✓	–	–	–	–	–	✓	–	–	✓	–	–	–	–	–
Oregon	✓	–	✓	–	–	–	–	–	✓	–	–	✓	✓	–	–
Pennsylvania	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
Rhode Island	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–
South Carolina	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
South Dakota	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Tennessee	✓	–	–	✓	–	–	–	–	–	✓	–	–	✓	–	–
Texas	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Utah	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Vermont	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Virginia	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Washington	–	–	–	–	✓	–	–	–	–	✓	–	–	–	✓	–
West Virginia	–	✓	–	–	–	–	✓	–	–	–	–	–	–	–	–
Wisconsin	–	–	–	–	–	–	✓	–	–	✓	–	–	–	–	–
Wyoming	✓	–	–	–	–	–	✓	–	–	–	–	–	–	–	–

Notes: State plan authority includes the Medicaid rehabilitative services state plan option, the Section 1915(i) state plan option, and the health home state plan option. § 1115 is Section 1115 demonstration. Other Medicaid authorities include Section 1915(b) waivers, home-and-community-based waivers and certified community behavioral health clinic demonstrations.

✓ Check indicates that the state is covering this service.
– Dash indicates that the state is not covering this service.

Source: RTI 2019.

TABLE A-2. Medicaid State Plan, Section 1115 Demonstrations, and Other Medicaid Authorities Used to Pay for Case Management Services, 2018

State	Transitional case management			Targeted case management			Recovery management		
	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority
Total	**15**	**2**	**0**	**38**	**4**	**5**	**3**	**4**	**3**
Alabama	✓	–	–	✓	–	–	–	–	–
Alaska	–	–	–	✓	–	–	–	–	–
Arizona	–	–	–	✓	–	✓	–	–	–
Arkansas	–	–	–	✓	–	–	–	–	–
California	–	✓	–	✓	✓	–	–	✓	–
Colorado	–	–	–	✓	–	–	–	–	✓
Connecticut	–	–	–	✓	–	–	–	–	–
Delaware	–	–	–	✓	✓	–	–	–	–
District of Columbia	–	–	–	–	–	–	–	–	–
Florida	–	–	–	–	–	–	–	–	–
Georgia	–	–	–	✓	–	–	–	–	–
Hawaii	–	–	–	–	–	–	–	–	–
Idaho	–	–	–	✓	–	–	–	–	–
Illinois	✓	–	–	✓	✓	–	–	–	–
Indiana	–	–	–	–	–	–	–	✓	–
Iowa	✓	–	–	✓	–	–	–	–	–
Kansas	–	–	–	✓	–	–	–	–	–
Kentucky	–	–	–	✓	–	–	–	–	–
Louisiana	–	–	–	–	–	–	–	–	–
Maine	✓	–	–	✓	–	–	–	–	–
Maryland	✓	–	–	–	–	–	–	–	–

TABLE A-2. (continued)

State	Transitional case management			Targeted case management			Recovery management		
	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority
Massachusetts	–	✓	–	–	✓	–	–	✓	–
Michigan	✓	–	–	✓	–	–	–	–	✓
Minnesota	✓	–	–	✓	–	–	–	–	✓
Mississippi	–	–	–	✓	–	–	–	–	–
Missouri	✓	–	–	✓	–	–	–	–	–
Montana	–	–	–	✓	–	–	–	–	–
Nebraska	–	–	–	–	–	–	–	–	–
Nevada	–	–	–	✓	–	✓	–	–	–
New Hampshire	–	–	–	✓	–	–	✓	–	–
New Jersey	–	–	–	–	–	–	–	–	–
New Mexico	✓	–	–	✓	–	–	–	–	–
New York	✓	–	–	–	–	✓	✓	–	–
North Carolina	–	–	–	✓	–	–	–	–	–
North Dakota	–	–	–	–	–	–	–	–	–
Ohio	–	–	–	✓	–	–	–	–	–
Oklahoma	–	–	–	✓	–	–	–	–	–
Oregon	–	–	–	✓	–	✓	–	–	–
Pennsylvania	–	–	–	–	–	✓	–	–	–
Rhode Island	✓	–	–	✓	–	–	–	✓	–
South Carolina	–	–	–	✓	–	–	–	–	–
South Dakota	✓	–	–	✓	–	–	–	–	–
Tennessee	✓	–	–	✓	–	–	–	–	–
Texas	–	–	–	✓	–	–	–	–	–
Utah	–	–	–	✓	–	–	–	–	–

TABLE A-2. (continued)

State	Transitional case management			Targeted case management			Recovery management		
	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority	State plan	Section 1115 demonstration	Other authority
Vermont	✓	–	–	–	–	–	✓	–	–
Virginia	–	–	–	✓	–	–	–	–	–
Washington	–	–	–	✓	–	–	–	–	–
West Virginia	–	–	–	✓	–	–	–	–	–
Wisconsin	–	–	–	✓	–	–	–	–	–
Wyoming	✓	–	–	✓	–	–	–	–	–

Notes: For the purposes of this analysis, covered case management services are those paid for under the state plan, including the health home state plan option and the rehabilitative services state plan option. With the exception of Minnesota and Wyoming, states paying for transitional case management through the state plan are limiting this service to beneficiaries enrolled in the state's health home. Other authorities include Section 1915(b) waivers and certified community behavioral health clinic demonstrations.

- ✓ Check indicates that the state is covering this service.
- – Dash indicates that the state is not covering this service.

Source: RTI 2019.