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Report to Congressional Committees

January 2020

MEDICAID

States' Changes to Payment Rates for Substance Use Disorder Services

GAO-20-260

GAO Highlights

Highlights of GAO-20-260, a report to congressional committees.

January 2020

MEDICAID

States' Changes to Payment Rates for Substance Use Disorder Services

Why GAO Did This Study

SUDs—when the recurrent use of alcohol or drugs causes significant impairments—are a growing problem in the United States, affecting nearly 20 million adults in 2018. Medicaid—a joint federal-state program that finances health care coverage for low-income and medically needy individuals—is the largest source of federal funding for the services that treat SUDs. However, Medicaid beneficiaries may face challenges accessing SUD care, in part, because low percentages of SUD providers choose to participate in the program in some states. Increasing Medicaid payment rates is one option that has been suggested for improving provider participation.

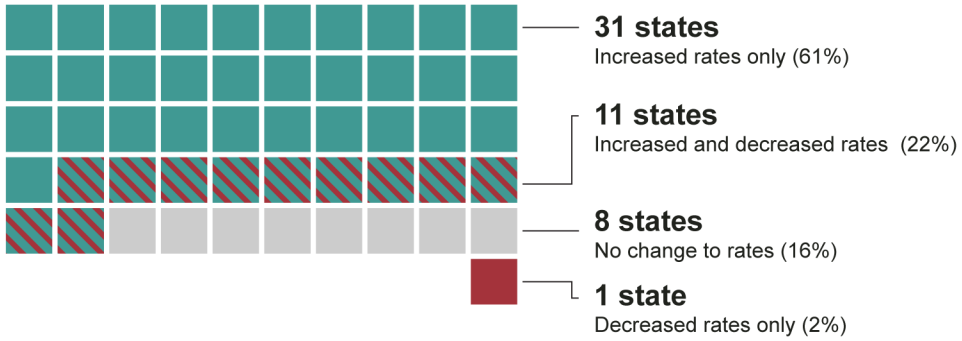
The SUPPORT for Patients and Communities Act included a provision that GAO examine how SUD services are reimbursed. This report describes (1) the extent to which states made changes to Medicaid payment rates for SUD services; (2) characteristics of rate changes selected states made; and (3) the effects of the rate changes in selected states on the availability of SUD services for Medicaid beneficiaries. GAO collected information from Medicaid programs in all 50 states and the District of Columbia about fee-for-service SUD payment rate changes from 2014 to 2019. In six states—Arizona, Montana, New Jersey, Vermont, Virginia, and Wisconsin—GAO reviewed documentation related to these rate changes and conducted interviews with state Medicaid officials and SUD providers. GAO selected states that had rate increases targeted to SUD or behavioral health services, and that varied across factors such as also having SUD rate decreases, SUD providers' participation in Medicaid, and geographic location.

View GAO-20-260. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

What GAO Found

Most state Medicaid programs reported that they increased the rates paid to physicians and other health care providers for services that treat substance use disorders (SUD), such as medication or behavioral therapy. Specifically, over 80 percent of all states increased rates for at least one SUD service from 2014 to 2019. About two-thirds of states' rate increases were targeted specifically to SUD or SUD and other behavioral health services, while the remainder were part of changes to rates for a broader set of Medicaid services. Decreases to SUD rates were less common and tended to be part of broader rate changes.

State-Reported Changes to Medicaid Substance Use Disorder Payment Rates, 2014-2019



Source: GAO analysis of information reported by state Medicaid programs. | GAO-20-260

Notes: "States" includes the District of Columbia. Percentages do not add to 100 due to rounding.

All six of the states increasing Medicaid SUD payment rates that GAO selected for closer examination reported increases for outpatient SUD services; the states varied in the extent to which they had increases for additional types of SUD services as well as other characteristics, such as the number and size of the increases. For example, Virginia increased rates for four SUD services, with increases ranging from about $50 to $350 per service, while Arizona increased rates for over 50 of these services, with all increases under $15. Montana and New Jersey also had rate decreases for a few SUD services, with the decreases in Montana accounting for most of the SUD rate changes made.

State officials and SUD providers in the selected states with larger rate changes reported greater effects on SUD service availability compared to those in states with smaller changes. For example, state officials said that larger rate increases helped increase the number of SUD providers participating in Medicaid, but did not generally note SUD service availability effects for smaller rate increases. Providers in selected states identified certain factors, such as Medicaid program requirements, that could affect how much the availability of SUD services increased or decreased following rate changes. While sometimes acknowledging provider challenges dealing with these factors, state officials said that program requirements were important to ensure quality of care, among other responses.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

Contents

Figures

Abbreviations

ASAM	American Society of Addiction Medicine
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
MACPAC	Medicaid and CHIP Payment and Access Commission
MAT	medication-assisted treatment
MCO	managed care organization
PPACA	Patient Protection and Affordable Care Act
SUD	substance use disorder

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

January 30, 2020

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Greg Walden
Republican Leader
House Committee on Energy and Commerce
House of Representatives

Substance use disorders (SUD)—when the recurrent use of alcohol, opioids, or other drugs causes significant impairments—are a growing problem in the United States, affecting nearly 20 million adults in 2018.[1] Medicaid, a joint federal-state program that finances health care coverage for low-income and medically needy individuals, is the largest source of federal funding for the services—such as medication or behavioral therapy—that treat SUDs as well as other behavioral health conditions.[2] In addition, Medicaid beneficiaries experience a higher rate of SUDs

[1]According to the Substance Abuse and Mental Health Services Administration, significant impairments include health problems, disability, and failure to meet major responsibilities at work, school, or home. Examples of common SUDs include alcohol use disorder and opioid use disorder.

[2]In addition to SUDs, behavioral health conditions include mental health conditions. Examples of common mental health conditions include anxiety disorders, such as phobias and post-traumatic stress disorder, and mood disorders, such as depression and bipolar disorder. In 2018, about 9 million adults had both a SUD and a mental health condition, referred to as co-occurring conditions.

compared to those with other forms of health care coverage. Medicaid's role—and the role of private health insurance—in financing SUD treatment has grown over time, representing a shift from payment that relied more heavily on contracts and grants administered by state and local authorities. For Medicaid, this change is in part because of the 34 states (including the District of Columbia) that have opted to expand their Medicaid programs under the Patient Protection and Affordable Care Act (PPACA).[3] State Medicaid expansions have resulted in a greater number of people being eligible for Medicaid, including those with a SUD, and, under PPACA, most of the newly eligible population must be provided certain categories of benefits, including behavioral health benefits.[4]

At the same time, Medicaid beneficiaries continue to face barriers accessing SUD treatment. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that Medicaid coverage of SUD services continues to vary widely from state to state, with significant gaps in some states.[5] Further, even in states with broad coverage of SUD services, the supply of SUD providers, such as physicians, may be limited, and Medicaid beneficiaries could also have trouble finding a provider who accepts Medicaid payment.[6] Some states, in particular, have low percentages of SUD providers who choose to participate in the

[3]Under PPACA, states have the option to expand their Medicaid programs to cover nonpregnant, nonelderly adults not eligible for Medicare whose income does not exceed 133 percent of the federal poverty level, and receive increased federal financing for the newly eligible population. PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases income eligibility to 138 percent of the federal poverty level. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively referred to as PPACA).

[4]42 U.S.C. § 1396a(k)(1).

[5]See Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP: June 2018*, (Washington, DC: June 2018).

[6]For example, in 2017, we reported wide variation in SUD treatment capacity across states, with the number of inpatient and residential beds for SUD services per 100,000 adults ranging from 28.7 in Indiana to 130.9 in Washington, and some treatment facilities having to maintain waitlists for these services. See GAO, *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652, (Washington, DC: 2017). Others have also reported on limited SUD provider availability. For example, the U.S. Surgeon General reported that in 2016, more than three-quarters of U.S. counties had severe shortages of psychiatrists and other types of health professionals needed to treat behavioral health conditions, including SUDs. U.S. Department of Health and Human Services, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, (Washington, DC: 2016).

program and stakeholders—including researchers, professional societies, and government agencies—have raised concerns that Medicaid payment rates may be too low to incentivize more providers to participate.[7] One option stakeholders have proposed for addressing concerns about the availability of SUD services within Medicaid is to increase program payment rates for these services, which some states have reported doing in recent years.

The SUPPORT for Patients and Communities Act included a provision for us to examine how SUD services are reimbursed.[8] In this report, we describe:

1. the extent to which states made changes to Medicaid payment rates for SUD services;
2. characteristics of changes selected states made to Medicaid payment rates for SUD services; and
3. what is known about the effects of Medicaid payment rate changes in selected states on the availability of SUD services for program beneficiaries.

To describe the extent to which states made changes to Medicaid payment rates for SUD services, we requested and received information from Medicaid officials in all 50 states and the District of Columbia (hereafter, states) regarding changes made to SUD payment rates from 2014 to 2019.[9] Specifically, we asked states to report if Medicaid payment rates in their fee-for-service (FFS) programs were increased or decreased

[7]The percentage of SUD providers accepting Medicaid varies across states, ranging from 29 percent in Hawaii to 95 percent in Delaware in 2018. See Substance Abuse and Mental Health Services Administration, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2018. Data on Substance Abuse Treatment Facilities*, (Rockville, Maryland: September 2019). Also, prior research suggests that SUD provider acceptance of Medicaid may be lower than in other specialties. For example, MACPAC found that from 2014-2015, the percentage of physicians accepting new Medicaid patients was 71 percent overall, but 36 percent for psychiatrists. See Medicaid and CHIP Payment and Access Commission, *Physician Acceptance of New Medicaid Patients,* (Washington, DC: January 2019).

[8]Pub. L. No. 115-271, § 8213, 132 Stat. 3894, 4116 (2018).

[9]In the request for information, we asked states to report information about Medicaid program payment rate changes “in the last 5 years.” As the request was distributed in June 2019 and responses collected through September 2019, individual state time frames may vary slightly. However, for the purposes of this report, we refer to the time frame as 2014 to 2019.

for at least one SUD service, and, if so, to provide information about those rate changes.[10] For example, we asked states to report on categories of services that had rate changes. These categories were different settings where services are provided—outpatient, residential, or inpatient—and medication-assisted treatment (MAT), which can be provided in a variety of settings.[11] We also asked states to report whether the rate changes were targeted specifically to SUD services or if they were part of broader changes to Medicaid covered services, as well as reasons for making the changes. States sometimes made rate changes for SUD services at the same time as changes to other behavioral health services and not all states were able to report on them separately. As a result, for our analysis, we combined states that reported making changes only to SUD services with states that reported making changes to SUD as well as other behavioral health services. Finally, in states that delivered SUD services at least in part through managed care, we asked whether Medicaid managed care organizations (MCOs) were also required to implement the rate changes.[12] We did not independently verify state-reported information, but did follow up with states to clarify inconsistencies we identified. On that basis, we determined that state-reported information was sufficiently reliable for the purposes of our reporting objectives.

To describe characteristics of changes states made to Medicaid payment rates for SUD services, we selected a non-generalizable sample of six

[10]In a FFS program, the state pays providers directly for services rendered. States may also deliver SUD services under managed care or a combination of these approaches.

[11]The categories of services we asked about were based on our background research and interviews, and we also asked states to report changes to SUD services other than these categories, if relevant. Outpatient services typically include care without an overnight stay in settings such as hospital outpatient and emergency departments or offices and clinics of physicians and other medical professionals; residential services typically include 24-hour care provided in non-hospital settings; and inpatient services typically include 24-hour care provided in hospital settings. MAT typically involves the use of medications approved by the Food and Drug Administration in combination with counseling or behavioral therapies. While community-based services was a separate category in the information request for states, we included it under outpatient services for the purposes of this report, as some states used these terms interchangeably.

[12]For the purposes of this report, managed care refers to comprehensive, risk-based managed care provided through MCOs, which is the most common managed care arrangement. However, state Medicaid programs may deliver SUD services through other types of managed care arrangements, such as prepaid inpatient health plans, which provide a limited benefit package to beneficiaries and may or may not assume financial risk for the services provided.

states—Arizona, Montana, New Jersey, Vermont, Virginia, and Wisconsin—that implemented changes to FFS payment rates targeting SUD or SUD and other behavioral health services from 2014 to 2019.[13] We identified these states based on interviews we conducted with stakeholders, as well as through state Medicaid agencies' responses to our request for information. We selected states that had increased Medicaid SUD payment rates, because we found that decreases to Medicaid SUD payment rates were infrequent and generally not targeted to SUD or behavioral health services. In addition, we selected states that varied across factors, including: (1) also implementing SUD rate decreases; (2) delivering SUD services to Medicaid beneficiaries through FFS or managed care; (3) the percentage of SUD providers participating in Medicaid; and (4) geographic location. We also prioritized states that had a higher prevalence of individuals with a SUD when possible. For the selected states, we reviewed relevant documentation, including state Medicaid policy documents, Medicaid fee schedules, and Medicaid provider manuals. We also interviewed officials from each state's Medicaid agency about the rate changes, including states' reasons for making the changes, the methodology used to determine the size of the changes, and the extent to which rate changes were implemented by MCOs.

To describe what is known about the effects of Medicaid payment rate changes in our selected states on the availability of SUD services for program beneficiaries, we interviewed state Medicaid officials and reviewed related documentation, such as data on SUD provider participation in Medicaid, when available. We also interviewed at least two separate SUD providers or SUD provider groups in each selected state. To identify providers to interview, we contacted the American Society of Addiction Medicine (ASAM) chapter in each state and obtained recommendations from state Medicaid agencies and other interviewees.[14] In selecting among providers or provider groups, we prioritized those with specific SUD or behavioral health experience, and also those that represented a variety of provider types, such as some that practiced in outpatient settings as well as some that practiced in residential settings.

[13]For the purposes of our work, we included changes states implemented from January 2014 through September 2019.

[14]ASAM is a professional medical society representing over 6,000 professionals in the field of addiction medicine across the United States.

We conducted this performance audit from February 2019 to February 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

SUD Treatment in the United States

SUD treatment aims to help people stop or reduce harmful substance misuse, improve health and social functioning, and manage the risk of relapse. SUD treatment generally involves diagnostic services to determine the nature and extent of the condition and may include a combination of medication, behavioral therapy, and recovery support services. Based on a person's needs, treatment may occur in a variety of settings—including outpatient, inpatient, and residential—and the intensity of treatment can also vary both within and across setting types. ASAM has recommended that SUD treatment be categorized into five broad levels of intensity—early intervention, outpatient, intensive outpatient and partial hospitalization, residential, and medically managed intensive inpatient—with further gradations of intensity within these levels.[15]

A variety of providers may be involved in SUD treatment. For example, treatment could include care by medical professionals, such as a psychiatrist, primary care physician, or nurse; counselors, such as an addiction counselor or clinical social worker; support staff, such as a peer recovery specialist or patient navigator; or some combination of these types of staff.

Medicaid Payment and Coverage for SUD Treatment

The Centers for Medicare & Medicaid Services (CMS) oversees Medicaid at the federal level, and states administer their respective Medicaid programs' day-to-day operations. In order to receive federal funding for Medicaid expenditures, states must comply with a broad set of federal requirements. However, states have significant flexibility in designing and

[15]For example, ASAM Level 1 Outpatient Services typically consists of less than 9 hours of care per week, while ASAM Level 4, Medically Managed Intensive Inpatient Services, typically consists of 24-hour care. For more information, see ASAM, *What Are the ASAM Levels of Care?* (May 13, 2015), accessed November 5, 2019, https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/.

administering their programs, including setting Medicaid eligibility standards; establishing provider payment rates and billing requirements; determining the amount, scope, and duration of covered benefits; and deciding how Medicaid-covered services provided to beneficiaries will be delivered.

States typically use either FFS or managed care to deliver services in their Medicaid programs. Under FFS, states determine payment rates and billing requirements for health care providers and pay them directly for services rendered. For example, some states may require that providers bill a service in 15-minute increments, and others, that providers bill the service per event (regardless of length). Also, some states may choose to pay providers separately for each individual service, while others may bundle payments by paying providers one rate for all services during a single episode of care. Under managed care, states contract with MCOs to provide a specific set of Medicaid-covered services to beneficiaries. While states establish requirements for MCOs and pay them a certain amount per beneficiary, MCOs contract with health care providers and, in turn, determine their own provider payment rates and billing requirements. Most states use both FFS and managed care, and the percentage of Medicaid beneficiaries served through MCOs has grown in recent years, representing nearly 70 percent of all beneficiaries in 2017.[16]

PPACA made changes to Medicaid eligibility and benefit requirements that increased the role of Medicaid in financing SUD and other behavioral health treatment. Prior to PPACA, few states provided Medicaid coverage to childless nonelderly adults without disabilities, and many states provided only limited coverage of SUD services in their Medicaid programs. As a result of PPACA, 34 states have expanded Medicaid eligibility to nonpregnant, nonelderly adults who are not eligible for Medicare and who have incomes not exceeding 138 percent of the federal poverty level.[17] Additionally, state Medicaid programs must

[16]See Centers for Medicare & Medicaid Services, Division of Managed Care Plans, *Medicaid Managed Care Enrollment and Program Characteristics, 2017* (Baltimore, MD: 2019).

[17]Idaho, Nebraska, and Utah have submitted Medicaid expansion proposals to CMS, but as of November 2019, had not received approval to implement them. See Kaiser Family Foundation and National Association of Medicaid Directors, "A View from the States."

While the income level under PPACA was set to 133 percent of the federal poverty level, PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases income eligibility to 138 percent of the federal poverty level. See 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), (e)(14)(I).

provide certain categories of benefits—including behavioral health benefits—for most individuals who are newly eligible under the expansions.[18] These benefits must also comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires that coverage of mental health and substance use benefits cannot be more restrictive than coverage of most medical or surgical benefits.[19]

Despite these changes, in June 2018, MACPAC reported wide variation in state Medicaid programs coverage of SUD services, with significant gaps in the types of services covered in some states.[20] Specifically, it found that the services most commonly not covered were partial hospitalization and residential treatment. MACPAC noted that the lack of coverage for residential treatment likely occurred in part because Medicaid has historically excluded federal payments for services provided to beneficiaries in institutions for mental diseases.[21] Since the time of MACPAC's report, Medicaid programs' coverage of SUD services has continued to increase. In response to an annual survey, 13 states reported enhancing or adding new mental health or SUD service benefits in 2019, and 20 states reported planning to do so in 2020.[22]

[18]Most newly eligible beneficiaries must be covered by alternative benefit plans. Alternative benefit plans generally provide the same level of benefits as those provided to individuals enrolling in plans offered in health insurance exchanges—marketplaces established by PPACA where individuals can compare and select among plans that meet certain standards—and must include behavioral health treatment as one of 10 essential health benefits.

[19]See Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765, 3881–93. In March 2016, CMS issued a final rule that addresses the application of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requirements to certain types of Medicaid coverage, including Medicaid alternative benefit plans. 81 Fed. Reg. 18,390 (March 30, 2016). We recently reported on state and federal oversight of compliance with mental health parity requirements. See GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, GAO-20-150 (Washington, D.C.: Dec. 13, 2019).

[20]See Medicaid and CHIP Payment and Access Commission, "Report to Congress, June 2018."

[21]Institutions for mental diseases are generally facilities larger than 16 beds that primarily provide inpatient, residential, or other services to individuals with behavioral health conditions, including SUDs. See 42 U.S.C. § 1396d(i).

[22]See Kaiser Family Foundation and National Association of Medicaid Directors, "A View from the States."

CMS has implemented initiatives aimed at improving the availability and quality of SUD treatment within the Medicaid program. For example, in July 2015, CMS issued a State Medicaid Director Letter informing states that they could seek approval of section 1115 demonstrations to undertake comprehensive SUD service reforms, including coverage of short-term residential treatment services in institutions for mental diseases.[23] In November 2017, CMS issued another State Medicaid Director Letter that modified and streamlined the policy for these section 1115 demonstrations and allowed more flexibility for interested states.[24] According to CMS, as of November 2019, 27 states had received approval for SUD 1115 demonstration projects. Among other things, CMS reported that the purpose of these demonstrations is to encourage states to expand access to the full continuum of SUD services for Medicaid beneficiaries, while also improving the quality of care, particularly in residential treatment settings. CMS also noted that states are required to report certain data to track the effects of the demonstrations on such outcomes. In addition to the 1115 demonstrations, in September 2019, CMS awarded $50 million in planning grants to 15 states as part of demonstration projects to increase SUD provider capacity in Medicaid.[25] According to CMS, these grants are intended to assess a state's needs for SUD treatment; pay for recruitment, training, and technical assistance for Medicaid SUD providers; and improve Medicaid payment rates for SUD services.

[23]Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives. See 42 U.S.C. § 1315(a).

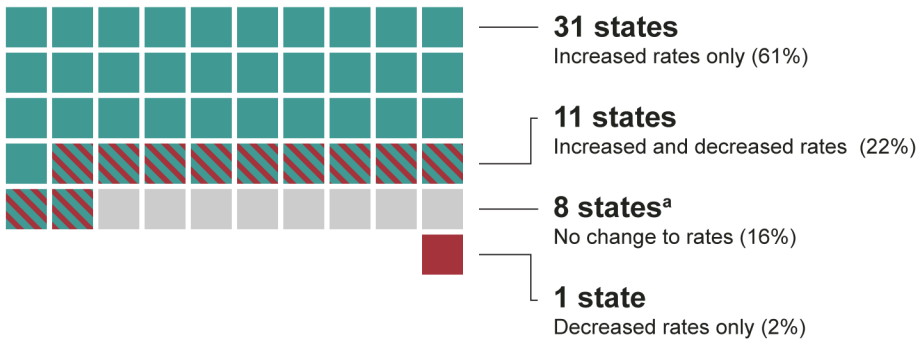
[24]See, CMS, *State Medicaid Director Letter, Strategies to Address the Opioid Epidemic*, SMD: 17-003 (Baltimore, MD: November 1, 2017).

[25]Section 1003 of the SUPPORT for Patients and Communities Act required CMS to award these grants to at least 10 states. Pub. L. No. 115-271, § 1003, 132 Stat. 3894, 3903 (2018). The following 15 states were awarded the grants: Alabama, Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Washington, Virginia, and West Virginia.

Forty-two States Increased Some Medicaid SUD Payment Rates; In about Two-thirds, Changes Were Targeted to SUD or Behavioral Health Services

In responding to our information request, Medicaid programs in 42 states (82 percent) reported increasing the FFS rate they paid providers for at least one SUD service from 2014 to 2019.[26] Twelve states—including 11 of the 42 with increases—reported decreasing these rates for at least one SUD service. (See fig. 1.) Most of the states increasing or decreasing rates also delivered SUD services through managed care, and just over half of them reported that they required MCOs to increase the payment rates for these services as well.[27] Eight states reported that they had not changed any FFS payment rates for SUD services during this time period. Medicaid officials from four of the states that did not change any rates—Hawaii, Michigan, Pennsylvania, and Tennessee—explained that their states do not use FFS for SUD services, and instead deliver all SUD services through managed care. Therefore, according to the officials, it is the responsibility of MCOs, and not the state, to set the rates they pay providers.

Figure 1: State-Reported Changes to Medicaid Substance Use Disorder (SUD) Payment Rates, 2014-2019



Source: GAO analysis of information reported by state Medicaid programs. | GAO-20-260

Notes: Percentages do not add to 100 due to rounding. SUD payment rate changes refer to those made by state Medicaid agencies in their fee-for-service programs. Thirty-one of the 43 states that made rate changes also used managed care to deliver SUD services, and 17 of these reported requiring managed care organizations to make the changes as well.

[26]While we did not ask states to report on the number or size of rate increases made, a few states reported such details, indicating wide variation. For example, one state reported that small rate increases were made to all SUD services to account for inflation, while another reported a significant rate increase to a single SUD service.

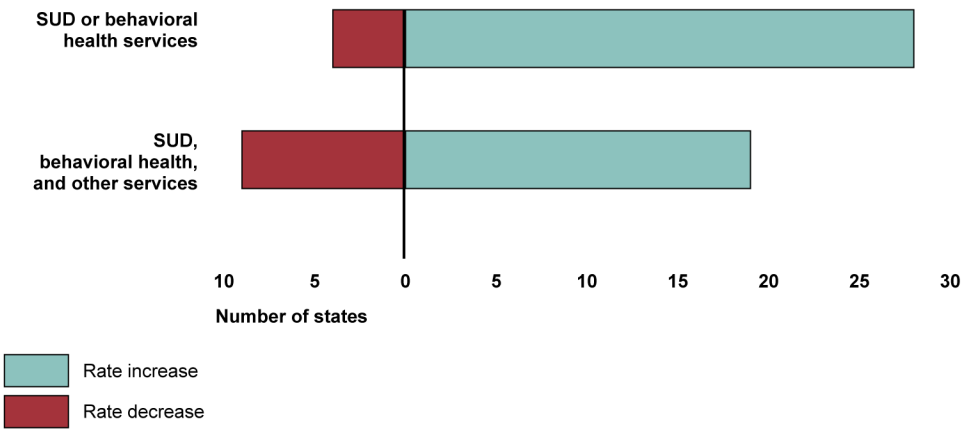
[27]Information from interviews in our selected states suggests that, when not required, MCOs may make separate decisions regarding rate increases, but also that, in some cases, MCOs' rates may be higher than FFS rates regardless of whether they choose to implement the changes.

[a]Among the eight states that reported not changing any payment rates for SUD services, four states reported that all SUD services are delivered through managed care rather than through their fee-for-service programs, and that the state does not set the rates managed care organizations pay to providers.

Twenty-eight of the 42 states with SUD payment rate increases reported increases that were targeted specifically to SUD services, or SUD and other behavioral health services. (See fig. 2.) For example, officials reported that Ohio's rate increases were part of a specific rate restructuring effort to change how Medicaid paid for behavioral health services, including SUD services, by setting rates that accounted for such things as the type of provider delivering care. The remaining 14 states that reported increases in rates for SUD services said the increases were part of changes to a broader set of Medicaid services in their states.[28] Reported decreases to SUD payment rates were more likely to be part of decreases to a broader set of Medicaid services. For example, according to state Medicaid officials, Wyoming reduced rates for all Medicaid services, including SUD services, after the program's budget was reduced, and Missouri decreased certain SUD payment rates as part of more general changes to Medicaid payments for physicians.

[28]Some states changed rates for multiple types of services or made multiple changes over the 5-year period. As a result, states may be represented in more than one category of changes. For example, five of the 28 states that had increases targeted to SUD or behavioral health services, also had increases to these services that were part of changes to a broader set of Medicaid services, for a total of 19 states with increases to SUD services that were part broader changes.

Figure 2: Services States Reported Targeting for Medicaid Substance Use Disorder (SUD) Payment Rate Changes, by Direction of Change, 2014-2019

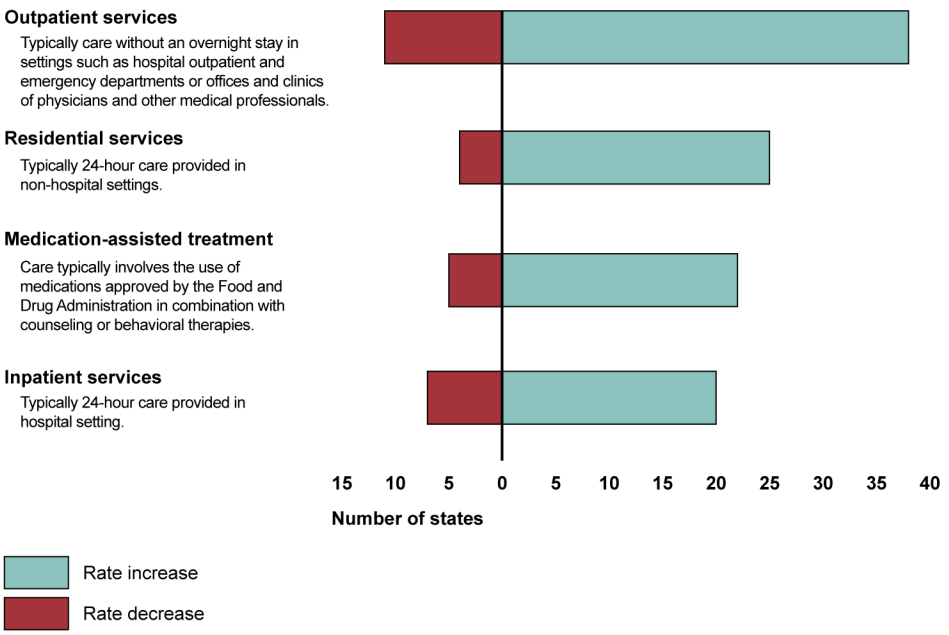


Source: GAO analysis of information reported by state Medicaid programs. | GAO-20-260

Notes: SUD payment rate changes refer to those made by state Medicaid agencies in their fee-for-service programs. Thirty-one of the 43 states that made rate changes also used managed care to deliver SUD services, and 17 of these reported requiring managed care organizations to make the changes as well. States sometimes reported multiple rate changes over the 5-year period that included both types of changes (targeted and not targeted to SUD or behavioral health services). As a result, totals are greater than the number of states.

Nearly all of the 42 states with rate increases reported changes to rates for outpatient SUD services. However, states also increased rates for other SUD service categories, with close to half reporting increases for inpatient, residential, or MAT services. Rate decreases followed a similar pattern, with reported decreases most common for outpatient SUD services (See fig. 3.)

Figure 3: State-Reported Medicaid Substance Use Disorder (SUD) Payment Rate Changes, by Type of Service and Direction of Change, 2014-2019



Source: GAO analysis of information reported by state Medicaid programs. | GAO-20-260

Notes: SUD payment rate changes refer to those made by state Medicaid agencies in their fee-for-service programs. Thirty-one of the 43 states that made rate changes also used managed care to deliver SUD services, and 17 of these reported requiring managed care organizations to make the changes as well. States sometimes reported rate changes for multiple types of services. As a result, totals are greater than the number of states.

States with rate increases most commonly reported that their decisions were based on analyses of payment rates, though the types of analyses varied across states. [29] For example, some rate analyses, such as those in Iowa, Idaho, and Texas, were part of the state Medicaid programs' periodic rate review processes. Other analyses were one-time reviews conducted after a potential problem was identified. For example, in Alabama, the Medicaid agency found that Medicaid FFS rates for MAT were lower than rates paid by other insurers, and conducted an analysis as a result. States with rate decreases reported different reasons depending on whether the decrease was targeted to SUD or behavioral

[29]Other reasons states reported for increasing rates included, to sustain or improve access to SUD services, rate restructuring efforts, or state legislative requirements.

health services. Specifically, states with targeted decreases reported that they were either due to rate analyses or rate restructuring efforts, while states with broader decreases most often reported that they were in response to state legislative requirements.

Selected States' Medicaid Payment Rate Changes Were Most Often for Outpatient SUD Services, and Varied in Number and Size

Similar to what was reported by all states, Medicaid FFS payment rate increases from 2014 to 2019 in all of our six selected states were most common for outpatient SUD services; states varied in the number of these services affected by the increases and the size of the increases. For example, Virginia raised rates for three outpatient services, one of which increased by over $350. In contrast, Arizona increased rates for over 30 outpatient services, but none were increased more than $7.[30] In addition to increases, two of the selected states also had rate decreases for a few outpatient services, with decreases ranging from $6 to nearly $200. Most selected states also implemented rate increases to at least one other category of SUD services—including inpatient, residential, or MAT services—again with variation in the number and size of the changes made.

While selected states sometimes made substantial changes to payment rates, no state made changes to payment rates across the entire spectrum of Medicaid SUD services that each reported covering. In addition, for SUD services that experienced rate changes, how states delivered the services sometimes affected the extent to which the changes were implemented for providers. Specifically, Arizona, New Jersey, Virginia, and Wisconsin all delivered SUD services at least in part through managed care, and there was variation across these states in the extent to which MCOs implemented the FFS changes; Virginia was the only state that told us they required MCOs to do so.[31] Table 1

[30]While some selected states had more substantial rate changes than others, the number and size of specific rate changes may not be fully comparable across the states in part due to variation in their billing requirements.

[31]In Wisconsin, SUD services are mostly delivered through managed care, and state Medicaid officials told us that most MCOs reported implementing the SUD payment rate increases. In Arizona, SUD services are delivered through managed care except for one subpopulation. While providers in Arizona said MCO implementation of increases varied, state Medicaid officials noted that all MCOs in the state had higher SUD payment rates than FFS prior to increases. In New Jersey, SUD services are delivered through managed care only for certain populations, but providers reported that MCOs did not implement the increases despite their rates generally being lower than the FFS rates. Wisconsin officials also noted that Medicaid beneficiaries may also receive SUD treatment through a county-based program, which negotiates its own rates with providers. The counties are then reimbursed at 100 percent of their Medicaid allowable costs.

summarizes our selected states' Medicaid FFS payment rate changes (see appendix II for more details on each state's payment rate changes).

Table 1: Summary of Medicaid Substance Use Disorder (SUD) Payment Rate Changes in Six Selected States, 2014 to 2019

State	Year	Direction	Service categories changed	Number and size of changes[a]
Arizona[b]	2014	Increased	Outpatient, inpatient, and medication assisted treatment (MAT)	Rates for over 50 services within these three categories increased, ranging from 5 cents to $13; median was $2
	2018	Increased	Residential	Rate for one service within this category increased by $6
Montana	2018	Increased	Outpatient	Rate for one service within this category increased by $5
		Decreased		Rate for two services within this category decreased by $7 and $193, respectively
New Jersey	2016	Increased	Outpatient, residential, and MAT	Rates for 13 services within these three categories increased, ranging from $4 to $270; median was $52
		Decreased	Inpatient	Rate for one service within this category decreased by $6
Vermont[c]	2016	Increased	Outpatient, residential, and MAT	Rates for all nine services in these three categories increased, ranging from 50 cents to $10; median was $1
Virginia	2017	Increased	Outpatient and residential	Rates for four services within these two categories increased, ranging from $55 to $356; median was $178
Wisconsin	2017	Increased	Outpatient	Rate for six services within this category increased, ranging from $1 to $63; median was $7

Source: GAO analysis of information from selected state Medicaid agencies. | GAO-20-260

Notes: This table describes the SUD payment rate changes selected states implemented in their Medicaid fee-for-service (FFS) programs, but does not include the entire spectrum of Medicaid SUD services each reported covering. Additionally, Arizona, New Jersey, Virginia, and Wisconsin delivered SUD services at least in part through managed care, and there was variation in the extent to which managed care organizations implemented the changes.

[a]In general, changes have been rounded to the nearest dollar. The number and size of services changed may not be fully comparable across states because of differences in state billing requirements. State billing requirements may also mean that rate change amounts do not always reflect the effective rate change for providers. For example, while Montana had a rate decrease for group therapy of about $7 following the move to Common Procedural Terminology Codes for the service, according to providers, the effective rate went from about $25 per hour—which meant a payment of $50-$75 for a 2-3 hour session—to about $17.50 per session regardless of length.

[b]While not within the time frame of our review, officials told us that, effective October 1, 2019, the state again increased most Medicaid FFS payment rates for outpatient SUD services by an average of 23.1 percent.

[c]In 2015, the state also implemented a 0.2 percent rate increase to the same outpatient and residential SUD services. Officials said the increases were specific to the state's preferred provider network, in which providers must comply with additional requirements and oversight.

Selected states also varied in the reasons and methods used for determining the number and size of the rate changes. Specifically,

- Arizona officials said they increased rates for SUD services in 2014 in response to the enactment of state legislation that provided an increase in funding for certain SUD services. Specifically, officials said that the rate increase was 2 percent for over 50 SUD and mental health services.[32] Then, in 2018, they said that following enactment of state legislation providing for a 3 percent rate increase for nursing home facilities, they implemented a 3 percent rate increase for a SUD residential service, given the similarities in providers delivering both types of services.[33] In addition to payment rate changes, Arizona officials said that during this time period, they implemented temporary incentive payments for behavioral health services, including SUD services, in order to encourage certain outcomes.[34]
- Montana officials said the state changed rates for three outpatient SUD services in 2018 to align them with provider payment rates for similar mental health services. Specifically, the state moved from using Healthcare Common Procedure Coding System codes for the SUD services to corresponding Current Procedural Terminology codes that were being used for the mental health services.[35] These

[32]State officials said they could not report SUD services separately from mental health services, as the state does not differentiate between them since dual diagnoses are common.

[33]While not within the time frame of our review, Arizona officials told us that, effective October, 1, 2019, the state again increased most Medicaid fee-for-service payment rates for outpatient SUD services by an average of 23.1 percent. The increases were implemented to align FFS rates for these services with the rates paid under managed care, after an analysis identified the FFS rates were adequate, but less than the rates paid by MCOs.

[34]At the time of our review, officials said that the state's temporary incentive payments related to SUDs and other behavioral health conditions were a 1 percent payment rate increase for all services provided by behavioral health outpatient clinics that partnered with a school district, a 10 percent payment increase for physical health services provided at behavioral health outpatient clinics or integrated clinics, a 3 percent payment increase for behavioral health outpatient clinics identified as Autism Centers of Excellence, and up to a 4 percent increase for inpatient psychiatric hospitals that met certain criteria. They also said that incentive payments are implemented for 1 year at a time, after which the state may decide to continue them or implement new temporary payment incentives.

[35]The Current Procedural Terminology codes are maintained by the American Medical Association and are the standard codes used by physicians and other providers in the United States to bill for services. Healthcare Common Procedure Coding System codes are maintained by CMS and used for items and services billed in Medicare and Medicaid that are not covered by Current Procedural Terminology codes.

changes resulted in a rate increase for one of the SUD services, and a rate decrease for the other two services.

- New Jersey officials said the state increased rates for 13 outpatient, residential, and MAT SUD services in 2016 in response to provider feedback that rates for these services were not sufficient, and that the state needed to better account for the direct cost to providers in order to, among other things, attract and retain SUD providers participating in Medicaid. To determine the size of the rate increases, officials said they constructed the costs for the services, based on wage data and the costs of benefits and overhead, among other factors.[36]
- Vermont officials said that in 2015 and 2016, they increased rates for nine outpatient, residential, and MAT SUD services by 0.2 percent and 2 percent, respectively, in response to the enactment of state legislation that provided increases in funding for these services. They said that the increase in 2016 was essentially to adjust for increases in cost-of-living in the state.[37]
- Virginia officials said that the rate increases implemented for four outpatient and residential SUD services in 2017 were part of a larger effort to redesign the delivery of SUD services and that, prior to this time, the state had almost no utilization of SUD services in its Medicaid program. As part of the redesign, officials said they expanded the SUD services covered by Medicaid and also determined that rate increases for certain existing SUD services were necessary to build a provider network and meet beneficiary needs. Officials also said they increased rates to make them more supportive of evidence-based care. To determine the size of the increases,

[36]According to state officials, a rate decrease for one inpatient service occurred because the service is aligned with Medicare rates, which can result in periodic increases or decreases based on changes in Medicare payment.

[37]Officials said that the rate increases were for the state's preferred provider network, in which providers must comply with additional requirements and oversight.

One service for one provider in the state was increased by 8 percent as opposed to 2 percent. Officials said the service was for individuals under the age of 18, and the provider was the only one in the state to provide the service. They explained that rates for those under 18 are set separately, which accounts for the different percentage increase.

officials said, among other things, they reviewed rate information from commercial payers.[38]

- Wisconsin officials said they increased rates for six outpatient SUD services in 2017 primarily in response to provider feedback that payment rates for these services were inadequate. Officials said they supplemented this feedback by conducting analyses of behavioral health providers' participation in Medicaid and health trends in the community, and by comparing Medicaid rates for behavioral health services to the rates of other payers. As a result of all these efforts, they decided increases were needed to improve provider participation in Medicaid and beneficiary access to SUD services. Officials said the state targeted outpatient services for rate increases in part because they are understood to be the most cost effective way to treat SUDs. They also said they used the Medicare physician fee schedule as a benchmark to determine the size of the rate increases.[39]

Half of the selected states also reported plans to make additional increases to Medicaid SUD payment rates. Specifically, Vermont officials said that they were in the first year of a multi-year payment reform process to determine rates for residential services based on clinical complexity. Likewise, officials from New Jersey said they were considering changing rates for long-term residential services based on provider feedback that the current rates are inadequate. Wisconsin officials said that they were in the process of setting Medicaid payment rates for newly covered residential SUD services and were also considering rate changes for other higher-intensity SUD services, such as intensive outpatient services—which were not part of the 2017 outpatient rate changes—at the same time.

[38]For partial hospitalization and intensive outpatient services, state officials said they conducted a survey of SUD treatment programs in the state to determine commercial rates and matched the Medicaid rates for these services with the commercial rates. For case management, state officials said they used the rate for this service in other Medicaid programs. For SUD group home, officials said they increased the rate by 50 percent.

[39]Officials told us that, in aligning the Medicaid rates for SUD services to those in Medicare, they also adopted Medicare's rate structure. This resulted in shifting the Medicaid rates from a four-rate structure to a two-rate structure based on the licensure and credentials of the provider of the service; generally, the higher of the two rates is paid to physicians, psychiatrists, and nurse practitioners and the lower rate is paid to other licensed or credentialed professionals.

Stakeholders in Selected States Reported that Medicaid Payment Rate Changes and Other Factors Affected Availability of SUD Services

State officials and SUD providers in selected states with larger Medicaid FFS payment rate changes reported greater effects on SUD service availability for program beneficiaries, compared to those in states with smaller changes. Providers in selected states identified certain factors, including Medicaid program requirements, that tempered the effects of rate increases or heightened the effects of decreases. While sometimes acknowledging provider challenges dealing with these factors, state Medicaid officials told us that program requirements were important to ensure quality of care and proper payments, and that budgetary constraints limit the extent to which they can increase rates.

Stakeholders in Three States with Larger Rate Changes Reported Greater Effects on SUD Service Availability

In the three selected states with larger Medicaid FFS payment rate changes from 2014 to 2019—Virginia, New Jersey, and Montana—state officials and SUD providers we interviewed often reported that the changes resulted in corresponding increases or decreases in the availability of SUD services for program beneficiaries. For example,

- In Virginia, state officials said that the SUD rate increases—which were generally over $100 per service—contributed to more SUD providers participating in Medicaid. Specifically, an evaluation prepared for the state found that the number of individual outpatient SUD providers billing Medicaid more than doubled—from 1,087 to 2,965—in the year following the increases, and beneficiaries' utilization of SUD services also grew, with more beneficiaries with a SUD receiving treatment than before.[40]
- In New Jersey, state officials said that the number of SUD providers applying to participate in Medicaid rose following rate increases. They also provided data showing that, for certain services affected by the increases, the number of SUD providers billing Medicaid went up by about 100 from the time the increases were implemented in 2016 to 2018, and utilization of the services also generally grew.[41] Providers we interviewed in the state agreed that SUD service availability had improved for Medicaid beneficiaries, with some particularly noting

[40]Cunningham, P. et al, *An Evaluation Report Prepared for the Virginia Department of Medical Assistance Services,* "*Addiction and Recovery Treatment Services Access and Utilization during the First Year (April 2017 – March 2018*), Virginia Commonwealth University, (Richmond, VA: August 2018).

[41]Virginia and New Jersey were the only selected states that provided data on changes in SUD service availability before and after the rate increases.

increases in availability for service types with larger rate increases, such as detoxification services, where the rate increase was over $200.[42]

- In Montana, where rates for group therapy and assessment and placement were decreased in 2018 following the move to Common Procedural Terminology Codes for the services, providers reported reductions in service availability. In particular, they explained that the group therapy rate changed from about $25 per hour—which meant a payment of $50 to $75 for a 2-3 hour therapy session—to about $17.50 per session regardless of length. As a result, the providers identified at least two of their peers providing intensive outpatient services that went out of business, one of which had multiple clinics in the state.[43] Providers said such closures have made it more difficult for Medicaid beneficiaries, and others seeking SUD treatment, to obtain these services, particularly in areas of the state where SUD providers were already limited. According to Montana Medicaid officials, in 2019, they implemented a bundled payment option for intensive outpatient services. Officials said this change was partially in response to provider feedback that the 2018 rate decrease made it challenging to provide these services. Providers said that they were hopeful this change will be an improvement, but it was too soon to tell.

However, we found that the reported effects of SUD rate changes in these states were sometimes complicated by other changes these states made to the provision of SUD services around the same time. For example, while Virginia reported increases in SUD service availability for Medicaid beneficiaries in the years following the rate increases, the state made a number of other changes at or around the same time that could have also affected SUD service availability. In particular, providers noted that the state's Medicaid expansion and redesign of SUD service delivery had increased the availability of SUD services under Medicaid, including

[42]Detoxification services aim to stabilize patients who are addicted to a substance by withdrawing them from the substance in a controlled manner.

[43]ASAM defines intensive outpatient services as an organized outpatient service that delivers 9 or more hours of SUD treatment services per week. See ASAM, *What are the ASAM Levels of Care?,* accessed November 5, 2019, https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/. Among others, services include individual and group therapy.

by adding newly covered SUD services.[44] In Montana, providers reported that rate decreases led to a reduction in service availability for intensive outpatient services. However, state officials noted that, overall, the number of outpatient SUD providers participating in Medicaid had more than doubled in the last few years due to statutory changes to the state's approval process for SUD providers, which were aimed at increasing the number of such providers in the state.[45]

In states where rate changes were smaller, most providers reported that, rather than expanding SUD service availability for program beneficiaries, Medicaid rate increases allowed them to maintain services with less financial strain, or avoid scaling back services. For example, one provider in Arizona noted that a $6 increase for a residential service allowed it to no longer operate at a loss for the service. Likewise, providers in Vermont said that the state's increases to Medicaid payment rates for SUD outpatient and residential services—all of which were under $10—have most likely prevented reductions in SUD service availability in the state, particularly given increases in cost of living as well as the demand for the services with the opioid epidemic. However, in certain cases, smaller increases may not have been enough to prevent decreases in service availability. For example, in Wisconsin—where the median rate increase was $7—one provider reported that Medicaid SUD rates had not been adjusted in many years and, while the increases had helped it break even on certain services, they were not enough to stop some small clinics in the Northern part of the state from closing. Medicaid officials in states with smaller rate increases were either unable to report their effect on SUD service availability for program beneficiaries or reported that any improvement was probably because of other state efforts rather than the increases. For example, in Vermont, rather than cite the 2 percent rate increases for SUD services, state officials said that greater availability of MAT was because of other state efforts, including the reform of its

[44]In 2017, Virginia's Medicaid agency launched the Addiction and Recovery Treatment Services program, an enhanced SUD treatment benefit for Medicaid beneficiaries that, among other things, added newly covered SUD services to conform to ASAM recommendations for the continuum of SUD care, increased rates for existing SUD services, and included training, technical assistance and outreach to providers. Virginia's Medicaid expansion took effect on January 1, 2019.

[45]State officials reported that under Montana law, SUD providers must be approved by the state and, as of 2017, no longer need to demonstrate that they will not duplicate existing local services, allowing for more than one provider in a location.

delivery system for opioid providers with the creation of a “Hub and Spoke” model.[46]

The extent to which providers reported effects of Medicaid rate changes may have depended on a variety of factors specific to each provider. For example, in Wisconsin, while two providers that primarily served Medicaid patients did not note any improvements to service availability following the rate increases, another provider told us that the increases might have helped some providers that accepted few Medicaid patients to accept more. This provider also noted that the rate increases helped more clinics offering MAT to open in the state. In Montana, one provider offering a wide range of SUD services said that it had lost a significant amount of money due to the rate decreases that were implemented in 2018. As a result, it had to implement pay freezes and ask administrative staff to take days off, which had resulted in staff attrition. However, another provider in the state that mainly offered MAT services did not report similar financial challenges following the rate decreases.

State officials and providers generally did not cite the rate changes they reported as having other effects on the provision of SUD services for Medicaid beneficiaries, such as quality of care. For example, when asked whether Medicaid rate increases had affected the quality of SUD care, providers in Arizona tended to instead discuss how other efforts, including the state’s temporary incentive payment programs had improved care quality. One provider noted that an incentive program offering additional payments to providers to integrate physical and behavioral health services had increased the proportion of people getting both types of services at their sites. Another provider said that, with the additional money from the incentive programs, it has been able to offer payment bonuses to staff with good patient outcomes. In New Jersey, state officials said that new Medicaid requirements—such as having a patient navigator to help coordinate care—helped to improve the quality of SUD services for program beneficiaries in the state, but did not cite rate increases as leading to quality improvements. Similarly, in Wisconsin, one provider noted that quality of SUD care had improved with increased use of peer support, but said this was likely the result of the state implementing a training program to certify SUD peer specialists, rather than the result of the rate increases.

[46]Hubs are regional centers that offer more intensive SUD treatment for patients with opioid use disorder. Spokes are doctors, nurses, and counselors that offer comprehensive treatment for the disorder fully integrated with general healthcare and wellness services.

Providers Identified Certain Factors that Tempered Effects of Rate Increases; State Officials Cited Importance of Some for Ensuring Quality, Among Other Responses

Providers in our selected states identified certain factors that tempered the effects of Medicaid payment rate increases for SUD services—and, in the case of Montana, heightened the effects of rate decreases—including effects on SUD service availability for Medicaid beneficiaries. While sometimes acknowledging provider challenges dealing with these factors, state Medicaid officials told us that program requirements were important to ensure quality of care and proper payments, and that budgetary constraints limit the extent to which they can increase rates.

See below for the factors providers noted, with state-specific examples of provider comments and state Medicaid officials' responses.

Medicaid requirements for delivering SUD services

Some New Jersey providers said that while the rate for intensive outpatient services increased, they often lose about 20 percent of Medicaid payments for these services as a result of a state requirement for delivering the services. Providers explained that the rate for these services is bundled and paid by the week, and that for payment, the state requires that patients attend their individual therapy sessions. Providers said these sessions may not happen for a variety of reasons, and in these cases, providers are not paid for the other services in the bundle that were performed that week. State Medicaid officials said that they are aware of provider challenges meeting the individual therapy requirement, but that it is necessary to meet standards of care for such services. Officials said they are working to find a way to ensure quality care without penalizing providers, such as by a regulatory change to create a separate payment for individual therapy.

Some Montana providers said the Medicaid rate decrease for group therapy was compounded by a new state requirement that limits group therapy sessions to a maximum of 16 patients. As a result, providers must use more staff to perform the same services at the lower payment rate, making it more difficult for providers to continue to offer the service. State Medicaid officials said they changed the group therapy maximum to better align the service with best practices for quality care. They said that, previously, there was a financial incentive for providers to hold large, long group therapy sessions to maximize payment, and that providers were sometimes holding groups of over 30 people, which is not a best practice and does not allow for individualized treatment, which the state is trying to encourage.

Hiring staff to fill vacant positions

An Arizona provider said that while the state implemented some rate increases, SUD workforce shortages make it difficult to fill vacant positions and retain staff. The provider said that the issue was particularly

acute for psychiatrists where a shortage of providers has led to salary expectations of $200,000 or more. The provider said that SUD providers find it challenging to meet that expectation, particularly if they rely on Medicaid payment rates. State Medicaid officials said in setting rates, their priority is to ensure that Medicaid beneficiaries have access to the services they need at least to the extent that such services are available to the general population. They also noted that they recently commissioned a behavioral health rate adequacy report, which concluded that the state's current Medicaid rates appear to be adequate.

Providers in Vermont mentioned similar SUD workforce challenges, which they said were intensified by a high cost of living and an aging provider population in the state. These providers noted that additional rate increases would help them better compete for employees. State Medicaid officials said that program budgets limit the extent to which rate increases can be implemented beyond those that the state legislature mandates or for which it provides a specific appropriation, which was the case for the 2 percent increase implemented in 2016.

Medicaid paperwork requirements and audit processes

Some New Jersey providers said that completing the paperwork required for Medicaid payment is labor-intensive and that Medicaid's payment rates—even with increases—were not sufficient to cover this time investment. They said that as a result, some SUD providers, particularly those that are smaller, choose not to participate in the program. These providers also noted that some SUD providers are hesitant to join Medicaid because requirements are confusing, getting clarification is difficult, and the program has a reputation for conducting intensive audits. As a result, among other things, providers fear they will misunderstand requirements and not get paid for services performed. State Medicaid officials said that the SUD provider population is continuing to grow in the state and that, as Medicaid is government funded, providers should expect monitoring—including to identify and recover improper payments—at both the state and federal level.[47]

[47]We have also emphasized the importance of monitoring the Medicaid program, which has been on GAO's high risk list since 2003. Specifically, we have said that the size, growth, and diversity of the program present oversight challenges. In particular, our recent work has highlighted oversight challenges in three areas: improper payments, appropriate use of program dollars, and data. See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP, (Washington, D.C. Mar. 6, 2019).

Variation in Medicaid MCOs' processes

In Virginia, SUD providers transitioned from FFS billing to contracting with multiple MCOs at the same time as the rate increases, and some said that variation in MCO processes has increased administrative burdens and associated costs. According to the providers, such burdens have detracted from clinical time, and some organizations have needed to hire extra staff to focus on MCO payment, particularly related to prior authorization for services.[48] For example, providers said that they faced challenges resolving variation in the length of stay MCOs will authorize for the same residential SUD service, and noted that some do not initially authorize the entire length of stay typical for the service. State Medicaid officials said that in regard to prior authorization, it is necessary to ensure appropriate treatment. They also said that they do not require MCOs to approve a specific length of stay for SUD services, as these decisions may be based on individual needs. However, they said that MCOs are required to respond to prior authorization requests within 1 day for residential or inpatient services and 3 days for outpatient services.

Arizona, New Jersey, and Wisconsin providers also noted difficulties with variation in MCOs' processes, including prior authorization practices, which, among other things, they said, can be a barrier to Medicaid beneficiaries receiving care. For example, providers in Arizona noted that prior authorizations can sometimes take a few days to receive, which can disrupt treatment. According to these providers, it is particularly important to start SUD treatment as soon as an individual is ready, because some patients do not return for care after delays. State Medicaid officials in all three states said that prior authorization is necessary to ensure MCOs can judge the appropriateness and medical necessity of treatment for each beneficiary. However, New Jersey officials acknowledged the challenges providers may face working with multiple MCOs, and, in Arizona, officials said that as of October 1, 2019, they revised MCO guidance to specify that prior authorization for behavioral health residential facilities should be expedited relative to other authorization requests in recognition of the time-sensitive nature of the services. Likewise, state officials in Wisconsin said they were considering

[48]Prior authorization is a payment approach that requires certain conditions are met before services can be provided to patients, in part to control utilization and prevent improper payments. We recently reported on challenges prior authorization may present for Medicaid beneficiaries trying access MAT services. See, *GAO, Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications*, GAO-20-233 (Washington, D.C.: Jan. 24, 2020).

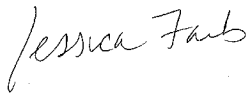
examining MCOs' SUD prior authorization process to see if changes were needed.

Agency Comments

We provided a draft of this product to the Department of Health and Human Services for comment. The department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



Jessica Farb
Director, Health Care

Appendix I: State-Reported Information on Changes to Medicaid Payment Rates for Substance Use Disorder Services

We requested and received information from Medicaid officials in all 50 states and the District of Columbia (hereafter, "states") regarding changes made to the rates they paid providers for services that treat substance use disorders (SUD) from 2014 to 2019. Specifically, we asked states to report if Medicaid payment rates were increased or decreased in their fee-for-service programs for at least one SUD service, and, if so, to provide information about those rate changes, including whether the changes were targeted to SUD services or part of changes to a broader set of Medicaid services, whether the changes applied to certain categories of services identified through our background research, and whether the state also required Medicaid managed care organizations to make the changes.[1] States sometimes reported multiple rate changes over the 5-year period. Table 2 below summarizes the information states reported.

[1]In addition to fee-for-service, where the state pays providers directly for services rendered, states may deliver SUD services under managed care, including by contracting with managed care organizations to provide the services to Medicaid beneficiaries. Most states use both fee-for-service and managed care for their Medicaid programs.

Table 2: Summary of State-Reported Information on Changes to Medicaid Payment Rates for Substance Use Disorder (SUD) Services, 2014 to 2019[a]

	Rate increases			Rate decreases		Rate change requirements for managed care organizations[d]
State	Direction of rate changes	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	
Alabama	Increased rates	Yes	Outpatient; Medication-assisted Treatment (MAT)	N/A	N/A	N/A
Alaska	Increased and decreased rates	No	Outpatient; Residential; Inpatient	No	Outpatient	N/A
Arizona	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Not required to implement rate changes
Arkansas	Increased rates	Yes	Outpatient	N/A	N/A	N/A
California	Increased and decreased rates	Yes	Outpatient; Residential; Inpatient; MAT	Yes	Outpatient; MAT	N/A
Colorado	Increased rates	Yes; No[e]	Outpatient; Residential	N/A	N/A	Not required to implement rate changes
Connecticut	Increased rates	Yes	MAT	N/A	N/A	N/A
Delaware	Did not change rates	N/A	N/A	N/A	N/A	Unknown
District of Columbia	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Not required to implement rate changes
Florida	Increased and decreased rates	No	Outpatient; Residential; Inpatient	No	Outpatient; Inpatient	Not required to implement rate changes
Georgia	Increased and decreased rates	Yes	Residential; Inpatient	Yes	Residential; Inpatient	Required to implement rate changes
Hawaii	Did not change rates	N/A	N/A	N/A	N/A	Unknown
Idaho	Increased rates	No	Outpatient	N/A	N/A	Required to implement rate changes
Illinois	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Required to implement rate changes
Indiana	Increased rates	Yes	Outpatient; Residential; MAT	N/A	N/A	Required to implement rate changes
Iowa	Increased rates	No	Inpatient	N/A	N/A	Required to implement rate changes

	Rate increases			Rate decreases		Rate change requirements for managed care organizations[d]
State	Direction of rate changes	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	
Kansas	Increased rates	Yes	Outpatient	N/A	N/A	Required to implement rate changes
Kentucky	Increased Rates	No	Outpatient	N/A	N/A	Not required to implement rate changes
Louisiana	Did not change rates	N/A	N/A	N/A	N/A	Unknown
Maine	Increased rates	Yes; No[e]	Outpatient; Residential; MAT	N/A	N/A	N/A
Maryland	Increased rates	Yes; No[e]	Outpatient; Residential; Inpatient; MAT	N/A	N/A	N/A
Massachusetts	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Required to implement rate changes
Michigan	Did not change rates	N/A	N/A	N/A	N/A	Unknown
Minnesota	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Required to implement rate changes
Mississippi	Increased and decreased rates	No	Outpatient	No	Outpatient; MAT	Required to implement rate changes
Missouri	Increased and decreased rates	No	Outpatient; Residential; Inpatient; MAT	No	Outpatient; Residential; Inpatient; MAT	Required to implement rate changes
Montana	Increased and decreased rates	Yes; No[e]	Outpatient; Residential; Inpatient; MAT	Yes; No[e]	Outpatient; Residential; Inpatient; MAT	N/A
Nebraska	Increased rates	No	Outpatient; Residential; Inpatient	N/A	N/A	Required to implement rate changes
Nevada	Did not change rates	N/A	N/A	N/A	N/A	Unknown
New Hampshire	Increased rates	Yes	Outpatient; Residential; Inpatient; MAT	N/A	N/A	Required to implement rate changes
New Jersey	Increased and decreased rates	Yes	Outpatient; Residential; MAT	No	Outpatient; Residential; Inpatient	Not required to implement rate changes

	Rate increases			Rate decreases		Rate change requirements for managed care organizations[d]
State	Direction of rate changes	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	
New Mexico	Increased rates	Yes	Outpatient; Inpatient; MAT	N/A	N/A	Required to implement rate changes
New York	Increased rates	Yes	Outpatient; Residential; MAT	N/A	N/A	Required to implement rate changes
North Carolina	Did not change rates	N/A	N/A	N/A	N/A	Unknown
North Dakota	Increased rates	No	Outpatient	N/A	N/A	Not required to implement rate changes
Ohio	Increased and decreased rates	Yes	Outpatient; Inpatient	Yes	Outpatient	Required to implement rate changes
Oklahoma	Increased and decreased rates	No	Outpatient; Inpatient	No	Outpatient; Inpatient	N/A
Oregon	Increased rates	Yes	Outpatient; Residential	N/A	N/A	Not required to implement rate changes
Pennsylvania	Did not change rates	N/A	N/A	N/A	N/A	Unknown
Rhode Island	Increased and decreased rates	No	Outpatient; MAT	No	Outpatient; MAT	Required to implement rate changes
South Carolina	Increased rates	No	Inpatient	N/A	N/A	Required to implement rate changes
South Dakota	Increased rates	No	Outpatient; Residential; Inpatient; MAT	N/A	N/A	N/A
Tennessee	Did not change rates	N/A	N/A	N/A	N/A	Unknown
Texas	Increased rates	No	Outpatient; Residential; MAT	N/A	N/A	Not required to implement rate changes
Utah	Increased rates	Yes	Outpatient	N/A	N/A	Not required to implement rate changes
Vermont	Increased rates	Yes	Outpatient	N/A	N/A	N/A
Virginia	Increased rates	Yes; No[e]	Outpatient; Residential; MAT	N/A	N/A	Required to implement rate changes
Washington	Increased rates	Yes	Outpatient; Residential; MAT	N/A	N/A	Not required to implement rate changes
West Virginia	Increased rates	Yes	Outpatient; Residential	N/A	N/A	Required to implement rate changes
Wisconsin	Increased rates	Yes	Outpatient	N/A	N/A	Not required to implement rate changes

	Rate increases			Rate decreases		Rate change requirements for managed care organizations[d]
State	Direction of rate changes	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	Targeted to SUD or behavioral health services[b]	SUD service categories included[c]	
Wyoming	Decreased rates	N/A	N/A	No	Outpatient; Inpatient	N/A

Source: GAO analysis of information reported by state Medicaid programs. | GAO-20-260

[a]Changes to payment rates refer to those made by state Medicaid agencies in their fee-for-service programs.

[b]N/A is for not applicable, as the state did not make this type of rate change. As not all states were able to report on changes to rates for SUD services separately from changes to rates for other behavioral health services, for our analysis, we combined states that reported making changes only to SUD services with states that reported making changes to SUD as well as other behavioral health services.

[c]N/A is for not applicable, as the state did not make this type of rate change. Outpatient services typically include care without an overnight stay in settings such as hospital outpatient and emergency departments or offices and clinics of physicians and other medical professionals; residential services typically include 24-hour care provided in non-hospital settings; and inpatient services typically include 24-hour care provided in hospital settings. MAT typically involves the use of medications approved by the Food and Drug Administration in combination with counseling or behavioral therapies. While community-based services was a separate category in the information request for states, for the purposes of this report, we included community-based services under outpatient services, as some states used these terms interchangeably.

[d]N/A is for not applicable, as the state's Medicaid program does not provide SUD services through managed care; Unknown is for states that reported not making rate changes, as these states were not asked about their requirements for managed care organizations.

[e]States could make multiple changes over the 5-year period. As a result, some states may have rate increases and/or decreases that were both targeted and not targeted to SUD or behavioral health services.

Appendix II: Medicaid Payment Rate Changes for Substance Use Disorder Services in Selected States

The six selected state Medicaid programs we reviewed all reported covering a broad spectrum of services to treat substance use disorders (SUD), and implemented changes to at least a few Medicaid fee-for-service (FFS) payment rates for these services from 2014 to 2019.[1] Two of the selected states, Arizona and Vermont, implemented set percentage increases to FFS rates for certain SUD services. Specifically, in 2014, Arizona implemented a 2 percent increase to over 50 SUD and mental health services.[2] In 2018, the state also implemented a 3 percent increase to a single rate for SUD residential treatment facilities.[3] In 2015 and 2016, Vermont raised rates for nine SUD outpatient and residential services by 0.2 and 2 percent, respectively. The size of the changes in the other four selected states varied among the services changed. Table 3 below details the SUD payment rate changes in these four states.

Table 3: Medicaid Payment Rates Changes to Substance Use Disorder (SUD) Services in Four Selected States, 2014 to 2019

SUD service (billing unit, when applicable)	Year	Amount of change (in dollars)	Percentage change
Montana	**2018**		
Assessment and placement		-192.79	-68
Individual therapy (15 minutes)[a]		4.78	28
Group therapy up to 16 people (1 event)[b]		-6.72	-28
New Jersey	**2016**		
Psychiatric diagnostic evaluation without medical services		90.19	133
Psychiatric diagnostic evaluation with medical services		270.20	493
Individual therapy (20-30 minutes)		39.59	138
Individual therapy concurrent with evaluation and management services (20-30 minutes)		41.02	140
Individual therapy (45-50 minutes)		41.26	84

[1]States may deliver Medicaid SUD services through FFS, where the state pays providers directly for services rendered, under managed care, or a combination of these approaches.

For the purposes of our work, we included changes states implemented from January 2014 through September 2019.

[2]State officials said they could not report SUD services separately from mental health services, as the state does not differentiate between them since dual diagnoses are common.

[3]While after the time frame of our review, officials told us that, effective October 1, 2019, the state again increased most Medicaid fee-for-service payment rates for outpatient SUD services by an average 23.1 percent.

SUD service (billing unit, when applicable)	Year	Amount of change (in dollars)	Percentage change
Individual therapy concurrent with evaluation and management services (45-50 minutes)		52.31	142
Family counseling / education in substance abuse facility (1 hour)		67.94	148
Group therapy up to 12 people in substance abuse facility (90 minutes per person)		4.50	20
Family conference (25 minutes)		3.91	21
Intensive outpatient treatment in substance abuse facility (per day)		38.48	54
Partial care treatment in substance abuse facility (per day)		-5.69	-7
Detoxification outpatient or residential (per day)		204.08	100
Short-term residential (per day)		54.60	37
Opioid treatment methadone (per week)		77.60	573
Virginia	**2017**		
Partial hospitalization (per day for a minimum of 5 hrs.)		356	247
Intensive outpatient (per day for a minimum of 3 hrs.)		178	247
Case management (per month)		227	1419[c]
SUD group home (per day)		55/67[d]	146/162
Wisconsin[e]	**2017**		
Group counseling[f]			
Rate 1 (15 minutes per person with psychologist)		1.89	81
Rate 1 (15 minutes per person with licensed or certified therapist)		2.31	122
Rate 1 (15 minutes per person with psychiatrist, advanced practice nurse)		0.80	23
Rate 2 (15 minutes per person with SUD counselor)		1.74	123
Alcohol and/or drug intervention service[f]			
Rate 1 (15 minutes with Licensed or certified therapist, counselor, SW)		7.00	50
Rate 1 (15 minutes with psychologist)		4.48	27
Rate 1 (15 minutes with psychiatrist, advanced practice nurse)		0.66	3
Rate 2 (15 minutes with SUD counselor)		7.60	94
Alcohol and/or other drug abuse services, not otherwise specified[f]			
Rate 1 (15 minutes with licensed or certified therapist)		7.00	50
Rate 1 (15 minutes with psychologist)		4.48	27
Rate 1 (15 minutes with psychiatrist, advanced practice nurse)		0.66	3
Alcohol and/or substance abuse services, family/couples counseling[f]			
Rate 1 (15 minutes with licensed or certified therapist)		12.34	89
Rate 1 (15 minutes with psychologist)		9.82	60
Rate 1 (15 minutes with psychiatrist, advanced practice nurse)		6.00	30

SUD service (billing unit, when applicable)	Year	Amount of change (in dollars)	Percentage change
Rate 2 (15 minutes with SUD counselor)		11.60	144
Diagnostic evaluation			
Rate 1 with medical services (60 minutes with psychiatrist, advanced practice nurse; maximum 8 times in 12 months)		17.68	14
Rate 1 (60 minutes with psychologist; maximum 8 times in 12 months)		63.38	97
Rate 1 (60 minutes with psychiatrist; maximum 8 times in 12 months)		32.87	34
Rate 2 (60 minutes with licensed or certified therapist; maximum 8 times in 12 months)		41.22	74
Rate 2 (60 minutes with qualified treatment trainee; maximum 8 times in 12 months)		52.33	118
Rate 2 (60 minutes with advanced practice nurse; maximum 8 hours in 12 months)		32.87	34

Source: GAO analysis of information from selected state Medicaid agencies. | GAO-20-260

Note: This table describes the payment rate changes selected states implemented in their Medicaid fee-for-service programs, but does not represent the entire spectrum of Medicaid SUD services each reported covering. New Jersey, Virginia, and Wisconsin also delivered SUD services at least in part through managed care, and there was variation in the extent to which managed care organizations implemented the changes. The number and size of services changed may not be fully comparable across states, because of differences in state billing requirements.

[a]Individual therapy in Montana may be billed at 30, 45, or a maximum of 60 minutes.

[b]The previous rate for group therapy in Montana was paid by the hour and could be billed multiple times per session versus the current event-based rate. As a result, the rate decrease may appear smaller than the effective decrease for providers.

[c]The previous rate for case management was set for 15 minutes in Virginia and could be billed by a provider multiple times in a month versus the current monthly rate. As a result, the rate increase may appear larger than the effective increase for providers.

[d]For SUD group home service, there is currently one rate in Virginia. There were previously multiple rates—based on geography—for this service, and thus we present increases resulting from each of the prior rates.

[e]Wisconsin established two rates for each service. Different types of providers can provide each service and are paid at one of the two rates based on the Medicare physician fee schedule. The state previously paid providers with a four-rate structure and thus, the changes in the table include the increase made for each type of provider to reach the new two-rate structure.

[f]While the state does not set billing limits for these services, officials said its claims system is configured to include National Correct Coding Initiative edits, which all state Medicaid programs must follow. Among other things, the initiative sets billing limits at what a provider would report under most circumstances for a single beneficiary on a single date of service.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov.

Staff Acknowledgments

In addition to the contact named above, William Hadley (Assistant Director), Rachel Svoboda, (Analyst-in-Charge), Jennifer Lucado, and Jessica L. Preston and made key contributions to this report. Also contributing were Samuel Amrhein, Julianne Flowers, Carla Miller, Jennifer Rudisill, and Ethiene Salgado-Rodriguez.

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