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Report to Congressional Committees

August 2020

SUBSTANCE USE DISORDER

Medicaid Coverage of Peer Support Services for Adults

GAO-20-616

August 2020

SUBSTANCE USE DISORDER

Medicaid Coverage of Peer Support Services for Adults

GAO Highlights

Highlights of GAO-20-616, a report to congressional committees

Why GAO Did This Study

SUD treatment can help individuals reduce or stop substance use and improve their quality of life. In 2007, the Centers for Medicare & Medicaid Services recognized that peer providers could be an important component of effective SUD treatment, and provided guidance to states on how to cover peer support services in their Medicaid programs. However, states have flexibility in how they design and implement their Medicaid programs, and coverage for peer support services is an optional benefit.

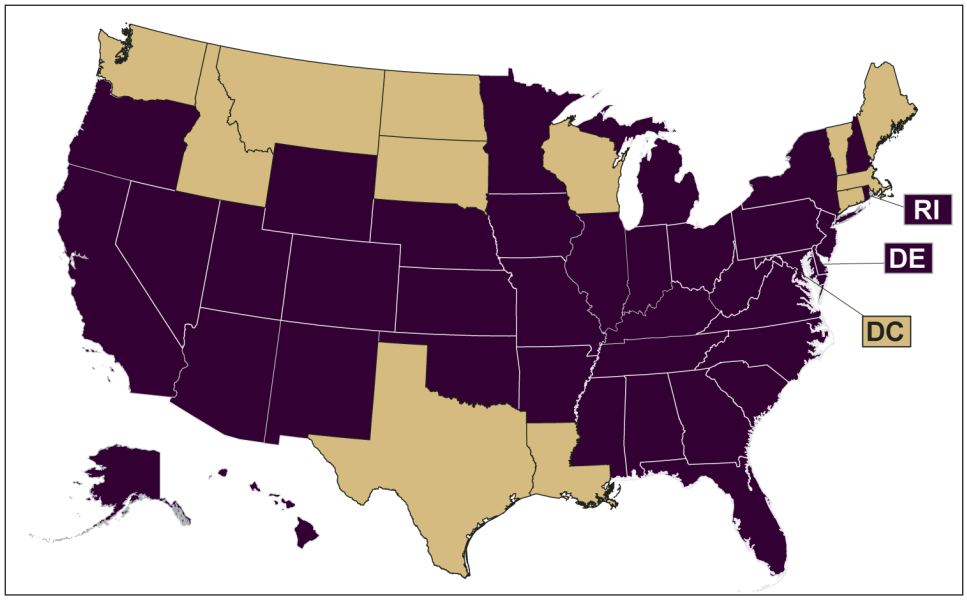
The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act included a provision for GAO to report on peer support services under Medicaid. This report describes, among other objectives, the extent to which state Medicaid programs covered peer support services for adult beneficiaries with SUDs nationwide, and how selected state Medicaid programs offered peer support services for adult beneficiaries with SUDs. GAO obtained state-by-state data from the Medicaid and CHIP Payment and Access Commission on 2018 Medicaid coverage of peer support services. GAO also reviewed information and interviewed officials from a nongeneralizable sample of three states, which GAO selected for a number of reasons, including to obtain variation in delivery systems used. The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-20-616. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Substance use disorders (SUD)—the recurrent use of alcohol or illicit drugs causing significant impairment—affected about 19.3 million adults in the United States in 2018, according to the Substance Abuse and Mental Health Services Administration. State Medicaid programs have the option to cover services offered by peer providers—individuals who use their own lived experience recovering from SUD to support others in recovery. GAO's review of Medicaid and CHIP Payment and Access Commission data found that, in 2018, 37 states covered peer support services for adults with SUDs in their Medicaid programs.

Medicaid Coverage of Peer Support Services for Adults with Substance Use Disorders, 2018



Sources: GAO analysis of Medicaid and CHIP Payment and Access Commission data; Map Resources (map). | GAO-20-616

Notes: The map shows Medicaid coverage of peer support as a standalone service for adults aged 18 or older with a primary diagnosis of substance use disorder, as of July 1 through October 26, 2018. GAO refers to the District of Columbia as a state.

Officials from the three states GAO reviewed—Colorado, Missouri, and Oregon—reported that their Medicaid programs offered peer support services as a complement, rather than as an alternative, to clinical treatment for SUD.

- Missouri officials said that peer providers did not maintain separate caseloads and were part of treatment teams, working in conjunction with doctors and other clinical staff. Similarly, officials in Colorado and Oregon said peer support services were only offered as part of a treatment plan.
- State officials reported that peer support services could be offered as an alternative to clinical treatment outside of Medicaid using state or grant funding.

Contents

Abbreviations

CCBHC	certified community behavioral health clinics
CMS	Centers for Medicare & Medicaid Services
MACPAC	Medicaid and CHIP Payment and Access Commission
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Social Security Act
SUD	substance use disorder

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August 6, 2020

The Honorable Charles E. 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 & Pensions
United States Senate

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

Substance use disorders (SUD)—the recurrent use of alcohol or illicit drugs causing significant impairment—affect a substantial number of adults in the United States. The most recent estimates from the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that, in 2018, about 19.3 million adults (7.8 percent) had a SUD.[1] Treatment for SUD can help individuals reduce or stop substance use, manage their symptoms, and improve their quality of life. Treatment can also help individuals avoid the potential consequences of untreated conditions, such as worsening health, loss of employment, and involvement with the justice system. One treatment option identified by SAMHSA and other experts is the use of peer providers—individuals who use their own personal, lived experience recovering from SUD to support others in their recovery.[2]

[1]SAMHSA is an agency within the Department of Health and Human Services.

[2]While there are a variety of terms that are used to describe an individual who provides peer support services, for the purposes of this report, we use the term “peer provider.”

Of the 19.3 million adults estimated to have a SUD, about 4 million were enrolled in Medicaid, a joint federal-state program that finances health care coverage for certain low-income and medically needy individuals. The Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid at the federal level, has taken some steps to incorporate peer support services into treatment for Medicaid beneficiaries with SUDs.[3] For example, in 2007, CMS recognized that the experiences of peer providers could be an important component of effective treatment and provided information on how states could cover peer support services in their Medicaid programs. However, states have flexibility within broad federal parameters in how they design and implement their Medicaid programs, and coverage for peer support services is an optional benefit.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act included a provision for GAO to report to Congress on peer support services under Medicaid.[4] This report describes the following with respect to adult Medicaid beneficiaries with SUDs:

(1) the extent to which state Medicaid programs covered peer support services nationwide,

(2) how selected state Medicaid programs offered peer support services, and

(3) the extent to which selected state Medicaid programs evaluated the effects of peer support services on beneficiaries' health and cost of care.

To describe the extent to which state Medicaid programs covered peer support services for adult beneficiaries with SUDs nationwide, we obtained state-by-state data from the Medicaid and CHIP Payment and Access Commission (MACPAC) on 2018 coverage of peer support as a standalone service for Medicaid beneficiaries with SUD as a primary

[3]CMS is an agency within the Department of Health and Human Services.

[4]Pub. L. No. 115-271, § 1008, 132 Stat. 3894, 3916 (2018).

diagnosis.[5] Based on the program descriptions in the data and additional information from CMS, we excluded nine programs in seven states, because, for example, they covered peer support services only for caregivers of beneficiaries with SUDs or other behavioral health conditions. We assessed the reliability of the MACPAC data by comparing the data with published information on state Medicaid billing for peer support services in 2017, the most current year available at the time of our review, and reviewing source documents, including Medicaid state plan amendments and waiver applications approved by CMS.[6] We also consulted with MACPAC regarding the definitions of certain data elements and changes we proposed based on our document review. Based on this work, we determined the data were sufficiently reliable for the purposes of our reporting objective.

To address how selected state Medicaid programs offered peer support services for adult beneficiaries with SUDs, as well as the extent to which states evaluated the effects of peer support services on beneficiaries' health and cost of care, we selected a nongeneralizable sample of three states: Colorado, Missouri, and Oregon.[7] We selected these states because of their variation in geographic location, delivery systems, and in the use of one or more Medicaid authorities to cover peer support services. For the selected states, we interviewed state Medicaid and behavioral health agency officials; and reviewed documentation, including state plan amendments, waiver applications, and state policy

[5]The MACPAC data describe coverage effective from July 1 through October 26, 2018, based on a one-time data collection effort by a contracted research institute. MACPAC defined a standalone service as a service that can be billed separately, rather than only as part of a bundle of services, which might include peer support services along with other clinical or nonclinical services that are billed under a single code. Throughout this report, we use the same definition. For more information on MACPAC's study, see Medicaid and CHIP Payment and Access Commission, *Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder* (Washington, D.C.: July 2019).

[6]Each state administers and operates its Medicaid program in accordance with a Medicaid state plan, which must be approved by CMS. Any changes a state wishes to make in its state plan must be submitted to CMS for review and approval as a state plan amendment. With approval from the Department of Health and Human Services, states may also administer parts of their Medicaid programs under the authority of demonstrations or waivers, which allow states to test new ways to deliver and pay for services.

[7]We also reviewed information from New Hampshire, but ultimately did not select this state because the state's government operations were affected by the Coronavirus Disease 2019 at the time of our review.

documents.[8] We interviewed state officials between February and April 2020, and information on states' provision of peer support services was current as of that time. We also reviewed CMS's guidance for states on covering peer support services under Medicaid and interviewed representatives from two mental health organizations.[9]

We conducted this performance audit from October 2019 to August 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

Peer Support Services

According to SAMHSA, peer support services encompass a range of activities and interactions between individuals who share similar experiences of being diagnosed with a SUD. Peer providers share their own lived experience of recovery along with practical guidance to assist others to initiate and maintain recovery and enhance their quality of life. Peer support services may include goal-setting, developing coping and problem solving strategies, and linking individuals to resources like transportation or volunteer opportunities. Peer support can be provided both in clinical settings, such as community mental health centers; and in nonclinical settings, such as homes, workplaces, and peer-run organizations. Peer providers are not intended to duplicate or replace therapists, case managers, or other members of a treatment team; instead, peer providers can complement clinical treatment by offering nonclinical services to support recovery from SUD. SAMHSA has stated that peer support services may also serve as an alternative, rather than as a complement, to clinical treatment for SUD.[10]

[8]We use the term behavioral health to encompass mental health and substance use.

[9]See Centers for Medicare & Medicaid Services, State Medicaid Director Letter #07-011 (Baltimore, Md.: Aug. 15, 2007).

[10]For example, peer support services may function as an alternative for individuals who decline clinical treatment for SUD. The Office of National Drug Control Policy's National Drug Control Strategy noted that when peer providers stay engaged with individuals who decline treatment, it can maintain the possibility of future treatment engagement.

According to SAMHSA, individuals who receive peer support may show reductions in substance use, improvements on a range of recovery outcomes, or both. However, SAMHSA officials have noted that the agency considers peer support services for adults with SUDs to be a promising practice or emerging best practice that is in need of continued research, as opposed to an evidence-based practice. A report from the National Academies of Sciences, Engineering, and Medicine also noted that while peer support services have promising potential to increase engagement in treatment and to reduce substance use, there are no data from well-controlled trials evaluating peer support and more research is needed.[11] Three systematic reviews of peer support for individuals with SUDs have also shown benefits of peer support services, while noting methodological concerns, such as lack of appropriate comparison groups.[12]

Medicaid

States that choose to cover peer support services in their Medicaid programs have a number of different options. States may choose to include coverage for peer support services under their state Medicaid plans, which must be approved by CMS in order for states to receive the federal share of the Medicaid payments they make.[13] In addition, states may seek permission from CMS to provide peer support services under waivers or demonstrations, which allow states to set aside certain, otherwise applicable, federal Medicaid requirements.[14] Table 1 summarizes key characteristics of state plan, waiver, and demonstration authorities states can use to provide peer support services.

[11]See National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives* (Washington, D.C.: 2019).

[12]See (1) S. Reif et al., "Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence," *Psychiatric Services*, vol. 65, no. 7 (2014); (2) E. Bassuk et al., "Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review," *Journal of Substance Abuse Treatment*, vol. 63 (2016); and (3) D. Eddie et al., "Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching," *Frontiers in Psychology*, vol. 10 (2019).

[13]A Medicaid state plan defines how the state will operate its Medicaid program, including which populations and services are covered. Among other things, services provided through state plan benefits must generally be comparable in availability among different groups of beneficiaries and be offered statewide.

[14]For example, under the Medicaid statute, states may not exclude enrollees or providers because of where they live or work in the state, but states can use waiver or demonstration authority to waive this "statewideness" requirement in order to target beneficiaries in a specific geographic region.

Table 1: Optional Medicaid Funding Authorities Available to States for Providing Peer Support Services

Title	Authorizing statute	Description
State plan rehabilitative services	Social Security Act (SSA) 1905(a)(13)	Allows a state to cover, under its state plan, medical or remedial services recommended by a physician or other licensed health care provider, to reduce physical or mental disability, and restore a Medicaid beneficiary to the best possible functional level.
State plan home- and community-based services	SSA 1915(i)	Allows a state to offer a comprehensive package of home- and community-based services under its state plan.
Non-Medicaid services waiver	SSA 1915(b)(3)	Allows a state to use savings it achieves by providing cost effective care through a Medicaid managed care program to furnish additional services to beneficiaries over and above those in its state plan.[a]
Home- and community-based services waiver	SSA 1915(c)	Allows a state to provide a broad range of home- and community-based services to beneficiaries who would otherwise require services in an institutional setting, such as a nursing facility.
Medicaid demonstration	SSA 1115	Allows the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.
Certified community behavioral health clinics (CCBHC) demonstration	Protecting Access to Medicare Act of 2014 Section 223 as amended[b]	Authorizes funding for eight states for a 2-year demonstration or through November 30, 2020, whichever is longer, to certify and reimburse CCBHCs, which must provide access to a comprehensive range of treatment and recovery support services, including peer support services.[c]

Source: GAO analysis of the Social Security Act, Protecting Access to Medicare Act of 2014 and information from the Centers for Medicare & Medicaid Services. | GAO-20-616

[a]Under a managed care service delivery model, states pay managed care organizations a capitation payment, which is a fixed periodic payment per beneficiary enrolled in a managed care plan—typically, per member per month.

[b]Pub. L. No. 113-93, § 223, 128 Stat. 1040, 1077 (codified, as amended, at 42 U.S.C. §1396a note).

[c]The Coronavirus Aid, Relief and Economic Security Act, enacted March 27, 2020, directed the Secretary of Health and Human Services to select two additional states from among those that previously received CCBHC planning grants and applied, but were not selected for the demonstration in 2016, to participate in the 2-year demonstration program, starting in 2020. Pub. L. No. 116-136, § 3814, 134 Stat. 281, 430 (2020).

In 2007, CMS issued guidance for states on covering peer support services in Medicaid.[15] This guidance not only outlined the funding authorities states could use, but also included other requirements for states seeking federal Medicaid reimbursement for peer support services, including the following:

[15]See CMS, State Medicaid Director Letter #07-011.

- States must identify the Medicaid authority to be used for coverage and payment, as well as describe the service, the provider of the service and their qualifications, and all applicable utilization review and reimbursement methodologies.[16]
- Peer providers must complete a training and certification program as defined by the state.[17]
- Peer providers must receive supervision from a "competent mental health professional." Such supervision may be provided through direct oversight or periodic care consultation.[18]
- Reimbursement must be based on an identified unit of service and be provided by a single peer provider, based on an approved plan of care.

States electing to cover peer support services under their Medicaid programs may choose different delivery systems to provide these benefits, such as fee-for-service or managed care. Under a fee-for-service model, states pay providers for each covered service for which the providers bill the state. Under a managed care service delivery model, states pay managed care organizations a capitation payment, which is a fixed periodic payment per beneficiary enrolled in a managed care plan—typically, per member per month. Some states with managed care delivery systems may elect to "carve out" certain benefits; i.e., pay for or contract for them separately from other health care benefits. For example, some states choose to carve out SUD-related services from their managed care contracts and pay for them on a fee-for-service basis.

[16]Utilization review refers to the evaluation of the medical necessity and appropriateness of the use of individual health care services. For example, state Medicaid programs may require prior authorization for certain services, which requires health care providers to demonstrate compliance with coverage and payment rules before services are provided to patients, rather than after the services have been provided.

[17]For more information on state certification programs for peer providers, see GAO, *Mental Health: Leading Practices for State Programs to Certify Peer Support Specialists*, GAO-19-41 (Washington, D.C.: Nov. 13, 2018).

[18]The state may define the amount, scope, and duration of the supervision, as well as who is considered a competent mental health professional.

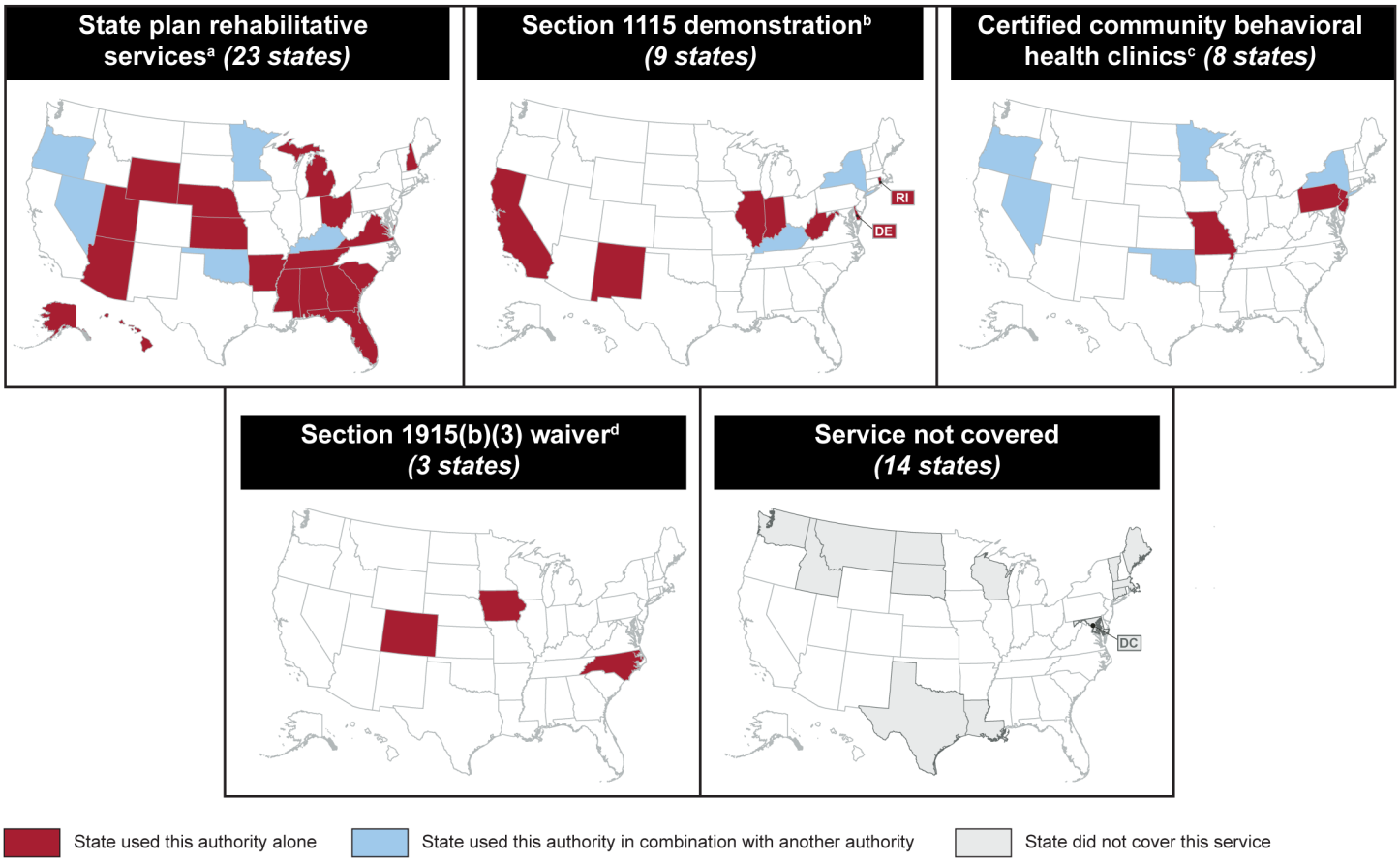
Thirty-Seven State Medicaid Programs Covered Peer Support for Adults with Substance Use Disorders in 2018, Most Commonly as a Rehabilitative Service

Thirty-seven states covered peer support for adults with SUDs during 2018, according to data gathered by MACPAC.[19] As shown in figure 1, the majority of these states (23) covered peer support services under state plan authority using the rehabilitative services option, either alone (18 states) or in combination with other authorities (five states). Nine states covered peer support services under Section 1115 demonstrations.[20] Demonstration authority allowed these states greater flexibility than state plan authority to determine the populations served, services covered, and service delivery arrangements. (See app. I for a state-by-state tabulation of the Medicaid authorities used to cover peer support services for adults with SUDs in 2018.)

[19]The MACPAC data describe coverage effective from July 1 through October 26, 2018. Of the 37 states that covered peer support for adults with SUDs, 31 covered peer support services under a single Medicaid authority and six did so under two authorities.

[20]Since MACPAC gathered its data, many more states have sought approval for demonstrations to cover SUD treatment services. As of May 2020, 28 states had been approved by CMS to operate Section 1115 demonstrations for SUD treatment, which can include peer support services.

Figure 1: Medicaid Authorities Used by States to Cover Peer Support Services for Adults with Substance Use Disorders, 2018



Sources: GAO analysis of Medicaid and CHIP Payment and Access Commission data; Map Resources (map). | GAO-20-616

Notes: The maps show the Medicaid authorities, if any, that states used to cover peer support as a standalone service for adults aged 18 or older with a primary diagnosis of substance use disorder (SUD), as of July 1 through October 26, 2018. While 37 states covered peer support services for adults with SUDs, the numbers in the first four maps total 43, because six states used two authorities to cover these services. According to the Centers for Medicare & Medicaid Services, states can use 1915(c) waiver and 1915(i) state plan authorities to cover peer support services; however, MACPAC did not identify any states that were using these authorities to cover peer support for adults with a primary diagnosis of SUD at the time of its data collection. We refer to the District of Columbia as a state.

[a]This authority allows states to cover under their state plan medical or remedial services recommended by a physician or other licensed practitioner, to reduce physical or mental disability and restore a Medicaid beneficiary to the best possible functional level.

[b]This authority allows states to cover services and populations not included in the Medicaid state plan. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.

[c]This authority allows selected states to certify and reimburse clinics that provide a comprehensive range of treatment and recovery services, including peer support services. Section 223 of the

Protecting Access to Medicare Act of 2014, as amended, authorized funding for eight states for a 2-year demonstration, or through November 30, 2020, whichever is longer, to operate certified community behavioral health clinics. Pub. L. No. 113-93, 128 Stat. 1040, 1077 (codified, as amended, at 42 U.S.C. §1396a note).

[d]This authority allows states to use savings achieved by providing cost-effective care through managed care programs to furnish additional services to beneficiaries over and above those in the state plan.

Six of the 37 states used two authorities to cover peer support services for adults with SUDs. Combining demonstration authority with state plan authority allowed these states to cover services for individuals who would otherwise be ineligible, or to provide enhanced services to certain subpopulations. For example, according to the MACPAC data, Kentucky used

- Section 1115 demonstration authority to cover peer support for beneficiaries with SUDs residing in institutions for mental disease who were not otherwise eligible for Medicaid coverage; and
- state plan authority under the rehabilitative services option to cover peer support services for all other beneficiaries.[21]

The most common combination of authorities, used by four states to cover adults with SUDs, was state plan authority under the rehabilitative services option in conjunction with certified community behavioral health clinics (CCBHC) demonstration authority. With CCBHC demonstration authority, states were able to certify and reimburse certain behavioral health clinics to provide a comprehensive range of treatment and recovery services, including peer support services, to individuals with SUDs. By also covering peer support services under state plan authority, states were able to provide peer support services to individuals with SUDs in additional settings and parts of the state outside CCBHCs' service areas.

Where adults with SUDs were able to receive Medicaid-covered peer support services varied among the 25 states for which information was available in the MACPAC data. Of the 25 states, at least 19 covered peer

[21]In 2015 and 2017, CMS announced a new Section 1115 demonstration initiative to allow states to receive federal financial participation for the continuum of SUD treatment services, including those provided in residential treatment facilities. Ordinarily, Medicaid excludes payments for beneficiaries aged 21-64 residing in facilities of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. For more information on this exclusion, see GAO, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652 (Washington, D.C: Aug. 9, 2017).

support in multiple settings. Depending on the state, these could include both clinical settings, such as behavioral health clinics, residential treatment facilities, and hospital emergency departments; and nonclinical settings, such as homes, workplaces, places of worship, and parks. The most frequently cited settings for peer support were outpatient provider sites, such as behavioral health clinics and substance use treatment centers. In addition, while peer support was frequently provided to beneficiaries on a one-to-one basis, the MACPAC data indicate that at least 16 states covered peer support services provided to groups, including either other adults with SUDs or members of the beneficiary's family or support network.

Selected States Offered Peer Support Services for Adults with Substance Use Disorders as a Complement to Clinical Treatment

All three selected states in our review—Colorado, Missouri, and Oregon—currently offered peer support services as a complement, rather than as an alternative, to clinical treatment for SUD, according to state officials.[22] For example, officials in Missouri said that peer providers did not maintain separate caseloads and were part of a treatment team, working in conjunction with doctors, nurses, therapists, and case managers. Similarly, officials in Colorado and Oregon said peer support services were offered only as part of a treatment plan.

State officials also reported other similarities, including the following:

- All three states covered peer support services for Medicaid beneficiaries with SUDs as a standalone service, typically in 15-minute increments.[23] State officials said peer support services were generally billed by the clinics where peer providers worked, since

[22]According to state officials, peer support services could be offered as an alternative, rather than as a complement, to clinical treatment outside of Medicaid. State officials in Missouri said they used state or grant funding to provide peer support services to individuals who were not undergoing clinical treatment for SUD; for example, to help maintain their recovery. Similarly, officials in Oregon said that outside of Medicaid, there are peer-run organizations that offer peer support services regardless of an individual's diagnosis or length of time in recovery.

[23]Standalone refers to services that can be billed separately, rather than only as part of a bundle of services. In addition to standalone services, Colorado offered peer support as part of certain bundled services that were billed on a per diem basis, which involves paying a fixed rate for all services provided on a single day of service. While Missouri and Oregon do not include peer support services in bundled services, CCBHCs in those states are paid on a per diem basis for services beneficiaries receive, which may include peer support services.

none of the states allowed peer providers to bill Medicaid independently.

- None of the states required prior authorization before Medicaid beneficiaries could receive peer support services. According to the state officials, if peer support services were determined to be appropriate for a Medicaid beneficiary and peer providers were available, these services could be incorporated into the beneficiary's treatment plan.[24]

The selected states used a variety of Medicaid authorities and delivery systems to provide peer support services. Specifically:

- **Colorado.** Colorado paid five Medicaid managed care entities, called regional accountable entities, a capitated monthly payment to coordinate care and administer behavioral health services, including peer support services, under a 1915(b)(3) waiver. According to state officials, peer support services were part of the benefit package for all regional accountable entities, and these entities were responsible for determining the needs of the regions they serve. Officials said that there were no incentives in their contracts with regional accountable entities to encourage the use of peer support services, and they were not required to contract with facilities that had peer providers on staff. However, officials said there might be an inherent incentive for regional accountable entities to provide peer support services since they are paid a capitated rate and these services might prevent individuals from escalating to higher, more expensive levels of care.

- **Missouri.** Under Missouri's CCBHC demonstration and rehabilitative services state plan option, peer support services for Medicaid beneficiaries with SUDs were generally paid for through the state's fee-for-service system, because SUD services were carved out of managed care contracts. State officials said Missouri's rehabilitative services state plan option is effectively a continuation of its CCHBC demonstration, because it adds CCBHC services to Missouri's state plan.[25] Under an 1115 demonstration, peer support services were covered under a capitated benefit at specific community health

[24]Officials from the three states said Medicaid beneficiaries did not always have access to peer providers, because there were not enough peer providers available.

[25]The CCBHC demonstration is time-limited. States participating in the demonstration were initially limited to participation for a 2-year period; however, the law was amended to allow for participation for 2 years, or through November 30, 2020, whichever is longer.

centers in St. Louis City and St. Louis County involved in the demonstration.[26] As of May 2020, Missouri had also applied for an 1115 demonstration, which would expand SUD and mental health treatment benefits, including peer support services, for women for 12 months following the end of their pregnancy benefits.[27]

- **Oregon.** Oregon paid 15 Medicaid managed care entities, called coordinated care organizations, a capitated payment to deliver physical and behavioral health services, including peer support services, under its rehabilitative services state plan option and CCBHC demonstration. State officials said that coordinated care organizations should endeavor to have peer providers available. They also said that, although the contracts with coordinated care organizations contain no specific incentives to encourage the use of peer support services, doing so might help the coordinated care organizations meet certain performance expectations, such as reducing emergency department use. As of December 2019, Oregon was in the process of applying for an 1115 demonstration that would, among other things, allow peer support services to be provided in community-based peer-run organizations, which are led by individuals with lived experience of mental health conditions or SUDs.[28] Oregon's draft 1115 application notes that peer-run organizations would expand the network of available providers and more effectively engage individuals who may be reluctant to access care in clinical settings.

[26]This 1115 demonstration was approved in July 2010, and according to state officials, the substance use treatment benefit was added in February 2019. Enrollment for this demonstration is capped at 16,000 enrollees. Officials said they added SUD benefits to the 1115 demonstration to respond to the opioid crisis in the St. Louis region. As of March 2020, officials said peer support services had not been provided under this demonstration.

[27]Medicaid coverage for pregnant women who do not qualify for coverage under another eligibility group continues until the last day of the month in which the woman reaches 60 days postpartum at a minimum, and states have discretion to extend coverage further. 42 U.S.C. § 1396a(a)(10)(A)(i)(IV).

[28]These peer-run organizations would be established and certified by the state as a provider type, and would be independent from outpatient treatment providers.

Selected States Have Not Evaluated the Effects of Peer Support Services, Citing Challenges that Hamper Such Efforts

Officials we interviewed from the three selected states in our review—Colorado, Missouri, and Oregon—said they had not evaluated the effects of peer support services on Medicaid beneficiaries' health or cost of care. The officials said that they have generally relied on findings from the research literature that support the use of peer support services for adults with SUDs. For example, an official from Missouri said that a SAMHSA publication that describes peer support services and summarizes the results of studies on the effectiveness of peer support was helpful and that they used it in discussions with the state legislature when discussing budget needs.

CMS officials told us that states are generally not required to evaluate individual services, such as peer support services, provided in their Medicaid programs. Specifically:

- With regard to state plan services, CMS officials said that the agency does not examine whether services that states seek to add to their state plans are evidence-based during their review of state plan amendments.[29]
- Although some waiver and demonstration authorities do require evaluations, CMS officials said these evaluations are generally not conducted at the level of individual services. Officials said states were not likely to study peer support services as a specific part of waiver or demonstration evaluations if these services were offered as part of a range of services for treating SUD.

Officials from Colorado and Oregon and representatives from mental health organizations we interviewed cited challenges that make studying the effects of peer support difficult. Specifically:

- Colorado officials said that it can be difficult to determine which Medicaid beneficiaries received peer support services, because peer providers may participate in bundled services where their involvement would not be recorded in the encounter data.
- Oregon officials noted that it is always difficult to measure the value of community supports within a clinical system, and that most evidence for the benefits on an individual's health is anecdotal. Officials said it can be hard to quantify the deep, meaningful connection that

[29]CMS officials said that they review the services included in state plan amendments to ensure that they meet federal requirements for the specific benefit, as well as for state plan amendments in general.

develops between a peer provider and a beneficiary. They also noted that there can be resistance among peer support advocates to collecting data on peer support, because of traumatic experiences individuals may have had in clinical settings.

- Representatives from mental health organizations we spoke with said that it can be difficult to isolate the effects of peer support on outcomes; for example, because individuals receiving peer support services are often receiving clinical treatment at the same time. In addition, following up with individuals who have received peer support services to see what their longer-term outcomes have been can be difficult, because of changes in contact information over time.

Agency Comments

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

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human 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 yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other major contributors to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

Appendix I: State Medicaid Coverage of Peer Support Services in 2018

Table 2: Medicaid Authorities Used by States to Cover Peer Support Services for Adults with Substance Use Disorders (SUD), 2018

State	State plan rehabilitative services[a]	Section 1115 demonstration[b]	Certified community behavioral health clinics demonstration[c]	1915(b)(3) waiver[d]
Alabama	X			
Alaska	X			
Arizona	X			
Arkansas	X			
California		X		
Colorado				X
Connecticut				
Delaware		X		
District of Columbia				
Florida	X			
Georgia	X			
Hawaii	X			
Idaho				
Illinois		X		
Indiana		X		
Iowa				X
Kansas	X			
Kentucky	X	X		
Louisiana				
Maine				
Maryland				
Massachusetts				
Michigan	X			
Minnesota	X		X	
Mississippi	X			
Missouri			X	
Montana				
Nebraska	X			
Nevada	X		X	
New Hampshire	X			
New Jersey			X	
New Mexico		X		
New York		X	X	

State	State plan rehabilitative services[a]	Section 1115 demonstration[b]	Certified community behavioral health clinics demonstration[c]	1915(b)(3) waiver[d]
North Carolina				X
North Dakota				
Ohio	X			
Oklahoma	X		X	
Oregon	X		X	
Pennsylvania			X	
Rhode Island		X		
South Carolina	X			
South Dakota				
Tennessee	X			
Texas				
Utah	X			
Vermont				
Virginia	X			
Washington				
West Virginia		X		
Wisconsin				
Wyoming	X			
Total	**23**	**9**	**8**	**3**

Legend:

X = state used this authority to cover peer support as a standalone service for adults aged 18 years or older with a primary diagnosis of SUD, as of July 1 through October 26, 2018.

= state did not cover peer support services for adults with SUDs.

Source: GAO analysis of data from the Medicaid and CHIP Payment and Access Commission. | GAO-20-616

Notes: We refer to the District of Columbia as a state. According to the Centers for Medicare & Medicaid Services, states can use 1915(c) waiver and 1915(i) state plan authorities to cover peer support services; however, MACPAC did not identify any states that were using these authorities to cover peer support for adults with a primary diagnosis of SUD at the time of its data collection.

[a]Authority allows states to cover under their state plan medical or remedial services recommended by a physician or other licensed practitioner, to reduce physical or mental disability and restore a Medicaid beneficiary to the best possible functional level.

[b]Authority allows states to cover services and populations not included in the Medicaid state plan. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.

[c]Authority allows selected states to certify and reimburse clinics that provide a comprehensive range of treatment and recovery services, including peer support services. Section 223 of the *Protecting Access to Medicare Act of 2014*, as amended, authorized funding for eight states for a 2-year demonstration, or through November 30, 2020, whichever is longer, to operate certified community behavioral health clinics. Pub. L. No. 113-93, 128 Stat. 1040, 1077 (codified, as amended, at 42 U.S.C. §1396a note).

[d]Authority allows states to use savings achieved by providing cost-effective care through managed care programs to furnish additional services to beneficiaries over and above those in the state plan.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Tim Bushfield (Assistant Director), Hannah Locke (Analyst-in-Charge), Sonia Chakrabarty, Kaitlin Dunn, Nancy Fasciano, Sandra George, Drew Long, Vikki Porter, and Jenny Rudisill made key contributions to this report.