Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: State Actions to Support Early Identification of Mental Health Disorders and Maintain Engagement in Treatment

May 2025

RTI International

Introduction

An estimated 59 million adults in the United States (23 percent of the adult population) have a mental health condition, and 5.5 percent have a serious mental illness.[1] Within Medicaid the percentage is higher; almost 30 percent of adults in Medicaid have reported a mental health condition, including 8 percent that have reported a serious mental illness (SMI).[2] Further, 6–10 percent of children in the United States are estimated to have serious emotional disturbance (SED).[3] Age of onset of mental health disorders is relatively young, with an estimated 62 percent of first mental health disorders occurring before age 25.[4] With onset happening in youth or early adulthood, early identification, intervention, and engagement in treatment is paramount to achieving good quality of life. The longer untreated disorders persist, the greater the likelihood for poor functioning and poor mental and physical health outcomes. However, accessing treatment for needed mental health services is difficult for individuals with Medicaid. An estimated half of Medicaid beneficiaries with SMI report that they needed treatment but did not receive it,[2] highlighting the importance of connecting individuals to needed treatment as soon as possible.

This report is part of a series of rapid cycle reports intended to share early findings and insights about section 1115 SMI/SED demonstrations. This report uses state program documents and interviews with state Medicaid agency and behavioral health agency officials to summarize the strategies states are implementing or plan to implement to improve early identification of mental health disorders, to maintain beneficiary engagement in treatment, and to identify the enabling factors and challenges states experience during implementation.

Specifically, this report addresses the following three objectives:

1. Describe state strategies to improve early identification of mental health conditions and to support engagement in treatment.
2. Describe state-reported policies, programs, and contextual factors that enable early identification of mental health conditions and engagement in treatment.
3. Describe state-reported challenges to early identification and engagement in treatment and how states are addressing or plan to address these challenges.

About Section 1115 SMI/SED Demonstrations

Improving care for Medicaid-enrolled adults with SMI and youth with SED through innovative service delivery is a priority for the Centers for Medicare & Medicaid Services (CMS). Section 12003 of the 21st Century Cures Act directed CMS to develop section 1115 demonstration projects for this population. Section 1115 SMI/SED demonstrations allow states to receive federal financial participation (i.e., federal Medicaid matching dollars) for care delivered during short-term stays in an institution for mental disease (IMD) as long as the state is taking action to ensure quality of care in IMDs and to improve access to mental health care at all levels of intensity as well as recovery support services for Medicaid beneficiaries with SMI or SED. States must also commit to maintaining funding levels for outpatient community-based mental health services and monitor and evaluate demonstration performance.

---

[1] Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health. HHS Publication No. PEP23-07-01-006. Center for Behavioral Health Statistics and Quality, SAMHSA. https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf

[2] MACPAC. (2022). Chapter 2. Access to mental health services for adults covered by Medicaid. In *Report to Congress on Medicaid and CHIP*. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf

[3] Williams, N. J., Scott, M. S. W., & Aarons, G. A. (2018). Prevalence of serious emotional disturbance among U.S. children: A meta-analysis. *Psychiatric Services, 69,* 32–40.

[4] Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., de Pablo, G. S, Shin, J. I., Kirkbride, J. B., Jones, P., Kim, J. H., Kim, J. Y., Carvalho, A. F., Seeman, M. V., Correll, C. U., & Fusar-Poli, P. (2022). Age of onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry, 27,* 281-295.

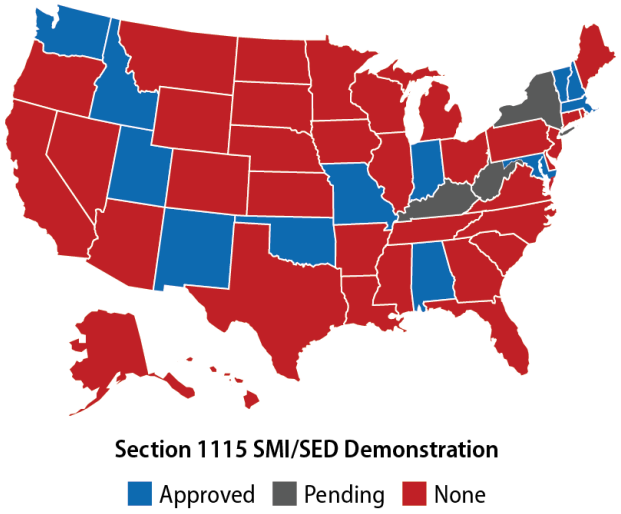
Goals of section 1115 SMI/SED demonstrations include reducing utilization and length of stay in emergency departments; reducing readmissions to acute care hospitals and residential settings; improving availability of crisis stabilization, intensive outpatient, psychiatric hospital, and residential treatment setting services; improving access to community-based services and integrated primary and behavioral health care; and improving care coordination and continuity of care after a hospitalization or residential treatment stay.

These demonstrations require the state to submit and carry out implementation plans that set forth how the state will meet four key milestones on its path to achieving demonstration goals:

1. Ensure quality care in psychiatric hospitals and residential settings.
2. Improve care coordination and transitions to community care.
3. Increase access to a continuum of care and crisis care.
4. Support early identification and engagement in treatment.

Achieving these milestones is expected to lead to successful performance on demonstration goals.

Figure 1. Section 1115 SMI/SED demonstration status as of February 2024



As of February 2024, 12 states and the District of Columbia had received approval for section 1115 SMI/SED demonstrations; 3 states have a pending application (**Figure 1**).

Overview of Findings

Almost all states noted in their implementation plans that they had already met Milestone 4 (supporting early identification and engagement in treatment) by the time they began their section 1115 SMI/SED demonstration activities because they had already been supporting care delivery changes aimed at engaging beneficiaries in treatment as soon as possible.

Common state strategies to identify, engage, and retain beneficiaries with SMI/SED in treatment included:

- Partnering with schools to identify children with SED and provide treatment within the school.
- Implementing first episode psychosis programs to increase treatment retention, symptom reduction, and improve functioning and quality of life.
- Leveraging Medicaid reimbursement and Medicaid benefits to support treatment for SMI/SED and integration of behavioral health in non-specialty settings.
- Supporting primary care and community mental health centers to integrate physical and behavioral health.

States' demonstration documentation and interviews with state officials noted several enabling factors that facilitate these strategies, including:

- Establishing partnerships with other entities like schools to further their goals to identify and engage Medicaid beneficiaries in treatment early and often.
- Leveraging existing programs and managed care/provider requirements to improve early identification of mental health conditions or to promote engagement in treatment.
- Testing approaches to using health information technology to identify beneficiaries who need to be connected to treatment.

Few state officials noted explicit challenges with activities supporting early identification and treatment, but those that were mentioned included:

- Having poor uptake of benefits meant to improve engagement in treatment.
- Shifting to telehealth for mental health treatment during the COVID-19 pandemic, causing disruptions in treatment and less engagement in treatment because beneficiaries lacked in-person contact.
- Needing time and some trial and error to find strategies that successfully integrate primary care and behavioral health to improve access to and engagement in treatment.

Approach

Findings in this report are based on interviews and a review of state documentation submitted to CMS by ten states with approved section 1115 SMI/SED demonstrations (Alabama, the District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) as of November 2022.[5] Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, these interviews focused on planned activities and anticipated facilitators and challenges. **Appendix A** provides additional detail about the data collection methods used.

Results

Milestone 4 for the section 1115 SMI/SED demonstrations guided states to support early identification and engagement in treatment by developing new strategies or services for identification/engagement, particularly for adolescents and young adults; increasing integration of behavioral health care in non-specialty settings like schools and primary care, and improving referrals to behavioral health specialists.[6] States' demonstration documents as well as interviews with state officials noted a variety of strategies to identify, engage, and retain beneficiaries with SMI/SED in treatment (**Exhibit 1**). State officials noted that these strategies were already in place prior to the demonstration because states' approaches to delivering mental health care include engaging Medicaid beneficiaries in treatment as soon as possible; however, some states also mentioned testing new approaches.

Common State Strategies

Partnering with Schools to Identify Children with SED and Provide Treatment within the School. The school system is a natural locus for identifying children with SED. Medicaid funds over $3 billion per year in school-based health services,[7] and schools serve as mental health treatment settings, ensuring continuity across the continuum of care to support developmental and academic success for children. Officials from over half of states in the interviews discussed school-based strategies for identification and treatment of SED. State officials in some states (e.g., New Hampshire, Oklahoma) specifically noted payment policies that reimburse providers such as school psychologists and social workers to conduct mental health evaluations and deliver evidence-based treatment. Most states also relied heavily on partnerships with community mental health center (CMHC) staff to deliver school-based services. CMHC staff are integrated into local schools in several ways, such as providing services to children onsite or having CMHC staff serve on treatment teams for children who have an individualized education program due to a mental health condition. A few states' demonstration documentation also mentioned upstream actions focused on prevention and awareness. For example, in Vermont, Medicaid partnered with the Vermont Agency of Education on a Substance Abuse and Mental Health Services Administration (SAMSHA) grant to improve awareness of mental health issues, enhance wellness and resiliency for school-aged youth, and support system improvements for school-based mental health services.

Exhibit 1. Summary of state strategies to improve early identification of mental health conditions and to support engagement in treatment

- Partnering with schools to deliver school-based mental health services.
- Implementing first episode psychosis programs.
- Screening Medicaid managed care beneficiaries for mental health conditions and referring beneficiaries who have positive screens to treatment.
- Using Medicaid payment and benefit strategies to promote service use.
  - Promoting Early and Periodic Screening, Diagnosis, and Treatment and Medicaid health home benefits.
  - Alternative payment models to support integration of behavioral health care and primary care.
- Promoting integration of physical health screenings and services into CMHCs and behavioral health services into primary care.
  - Consultation with a psychiatrist to support primary care providers in diagnosis and treatment of psychiatric disorders.

Implementing First (or Early) Episode Psychosis Programs to Increase Treatment Retention, Symptom Reduction, and Improve Functioning and Quality of Life. In state demonstration documents, almost all states noted statewide or regional first episode psychosis programs designed to provide evidence-based treatment to individuals experiencing early psychosis, including youth and young adults who are at highest risk for first episodes. Early treatment via coordinated specialty care in the form of case management, family support and education, psychotherapy, medication management, supported education and employment, and peer

[5] For brevity, we refer to states and the District of Columbia as "states" and all respondents as "state officials."
[6] The state Medicaid Director Letter titled "Opportunities to Design Innovative Service Delivery for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" can be found here: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf
[7] MACPAP. (2018). *Medicaid in schools, Issue Brief.* https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf

support has been shown to lead to better outcomes.[8] The longer psychosis (specifically psychosis associated with schizophrenia and schizophrenia-related disorders) remains untreated, the greater the likelihood for persistent poor functioning and quality of life.[8] State Medicaid agencies partnered with their state departments of mental health, local medical schools, CMHCs, and other mental health service providers to deliver these programs.

Requiring Medicaid Managed Care Entities and Their Provider Networks to Screen and Refer Patients. States with Medicaid managed care used regulatory strategies to require managed care plans to conduct in early identification and treatment activities. Several states (e.g., New Hampshire, Indiana, Utah) with Medicaid managed care described—in interviews or in their state demonstration implementation plans—requirements to support early identification of mental health disorders and referrals to treatment. Examples of strategies to improve early identification included requirements for managed care entities to conduct health risk assessments of Medicaid members to identify potential mental health disorders; to follow-up after discharge from the emergency department, which would include emergency visits for mental health reasons; and to train providers in their networks on manifestations of mental health disorders, use of screening tools identify mental health disorders, and referral processes to mental health providers.

Leveraging Medicaid Reimbursement and Medicaid Benefits to Support Treatment for SMI/SED and Integration of Behavioral Health in Non-Specialty Settings. Reimbursement offers states a powerful lever to support treatment. Some states certified school-based providers like social workers or school psychologists as Medicaid providers, thereby allowing them to be paid for treatment services delivered to Medicaid beneficiaries in schools. A few other states have looked to federally qualified health centers (FQHCs), implementing alternative payment models for FQHCs to support integrated physical and behavioral health. Using established Medicaid benefits is another avenue to ensure beneficiaries needing treatment are connected to appropriate services. One state's implementation plan (District of Columbia) specifically mentioned that they encourage pediatric providers to use Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit to screen Medicaid youth for mental health disorders and refer youth to treatment as necessary. All demonstration states have the EPSDT benefit as required under Medicaid statute and are likely using the benefit even though they did not specifically mention it as a strategy. The Medicaid health home benefit is another benefit that could be leveraged to address the treatment needs of beneficiaries with SMI/SED. The District of Columbia and Maryland have a Medicaid health home program for beneficiaries with SMI to support delivery of coordinated, person-centered, team-based care that supports continued engagement in treatment.

Supporting Primary Care and CMHCs to Integrate Physical and Behavioral Health. Recognizing the role of integrated care in delivering person-centered, comprehensive health care to individuals with mental disorders, every state documented in its implementation plan at least one effort to integrate behavioral health into primary care or primary care into behavioral health. Approaches varied, with some states highlighting pilot programs or grant-funded (e.g., through a SAMSHA grant) initiatives. Some programs are focused on youth at risk for developing SED, while others focus on beneficiaries of all ages. Some are regionally based; others are statewide. Some programs focus on integration of behavioral health into FQHCs or other primary care providers via referral arrangement or co-location. Others have or are considering pursuing the Certified Community Behavioral Health Clinic program to transform CMHCs into coordinated comprehensive health providers that also provide or refer patients to outpatient primary care screenings and physical health monitoring. More than half of states' implementation plans also noted that consultation programs via telephone or telehealth whereby primary care providers receive diagnosis and treatment advice from psychiatrists to help them manage their patients' mental disorders in the primary care setting.

State-Reported Policies, Programs, and Context That Enable Early Identification of Mental Health Disorders and Support Engagement in Treatment

Leveraging Existing Partnerships. Recognizing the multiple spheres in which individuals with mental health disorders live, work, and play, every state leveraged partnerships to further their goals to identify and engage Medicaid beneficiaries early and often in treatment. State Medicaid agencies do not have sole responsibility for many programs in place to address mental health, so Medicaid agencies work with the lead organizations that do have responsibility to ensure that Medicaid beneficiaries are included in these efforts. Almost every state mentioned partnerships with schools, school districts, and/or their state departments of education to support initiatives aimed at primary prevention of mental illness, screening, referrals for treatment, and delivery of mental health care within the school. Recognizing the role that primary care plays in diagnosis and treatment of mental illness, officials from almost every state also mentioned partnerships with FQHCs and other primary care providers. Some states (e.g., Alabama, Maryland) also reported – in interviews and in state documentation -- testing payment and care delivery strategies for health risk screenings, referral programs to behavioral health, and even co-location with a mental health practitioner to improve the delivery of holistic, comprehensive primary care.

[8] Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., … Heinssen, R. K. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, 173*(4), 363-372. https://doi.org/10.1176/appi.ajp.2015.15050632

Relying on Existing Care Management Programs. The section 1115 SMI/SED demonstrations are built upon systems of mental health care already in place for Medicaid beneficiaries, and officials from every state interviewed for this report mentioned relying on existing care management programs to improve early identification and help beneficiaries remain in treatment. For example, almost all states mentioned, in their implementation plans, the care management functions within their first episode psychosis programs. States also relied on existing policies that require providers and Medicaid managed care plans to deliver care management to high-needs beneficiaries, including those with SMI. Care managers were viewed as a critical resource because they follow-up with clients who routinely miss treatment appointments and try to re-engage them in treatment.

> *"… we're providing better access to those folks [for] care and ensuring better coordination across the continuum over time, which was not always there before so things used to be more discontinuous, especially from inpatient care to community-based care, but I think things are more integrated now, coordinated."*
>
> -State official

Piloting New Health Information Technology Initiatives. State officials in several states mentioned, in interviews and in implementation plans, the promise of health information technology (IT) for identification and treatment. For example, officials in one state mentioned an event notification system that the state is developing that would notify care teams when a targeted event happens, such as an individual entering the emergency room with a primary diagnosis of a mental health disorder. The expectation is that early notification can lead to early intervention by a care manager and beneficiaries can be brought in for treatment. Another state is exploring how to operationalize portable mental health advance directives so that care teams can continue to provide necessary care should a beneficiary become incapacitated by a mental health crisis.

State-Reported Challenges to Improving Early Identification of Mental Health Disorders and Supporting Engagement in Treatment

Few state officials noted explicit challenges to activities supporting early identification and treatment. Those that were mentioned are noted here, with the acknowledgment that these should not be interpreted as generalizable to all states given the limited response to this line of inquiry.

Having Poor Uptake of Benefits Meant to Improve Engagement in Treatment. Officials from one state noted poor uptake in a new service designed to reimburse transition planning for fee-for-service beneficiaries leaving inpatient care for community-based care. Transition planning helps connect beneficiaries to the right community-based treatment providers so that beneficiaries with SMI can continue receiving needed care for their mental health disorders. The state decided to cover this service for fee-for-service beneficiaries after most of this state's beneficiaries enrolled in managed care, which has its own discharge and transition planning requirements. The state Medicaid agency will be assessing challenges with uptake and brainstorming how to improve use of the benefit.

Relying on Telehealth during the COVID-19 Pandemic for High-Intensity Mental Health Treatment. During the COVID-19 pandemic, telehealth became prominent as Medicaid providers shifted to delivering more care remotely, including mental health care. Officials in one state noted several challenges transitioning high-intensity therapy services to telehealth during the pandemic. First, disruptions in service occurred as providers worked to get the right technology and billing procedures in place to provide virtual therapy. Second, state officials wondered if high-needs beneficiaries with SMI were less engaged in virtual treatment because they lacked in-person contact with their mental health providers.

Identifying the Right Strategies to Integrate Behavioral Health into Primary Care. Officials in one state specifically noted that supporting primary care providers to integrate behavioral health to improve identification, referral, and treatment is challenging. Primary care providers need to establish strong relationships with behavioral health providers to ensure that referred patients are seen by the behavioral health providers, and they need the right information exchange systems in place to share care plans. As mentioned in the section above, several states experimented with payment and care delivery policies and pilot programs to achieve better behavioral health/primary care integration.

> *"Our FQHCs are safety net providers, and they see lots of people who could potentially be walking wounded [with mental illness but not yet seriously mentally ill]. We are looking into some of these other periphery strategies in order to have a better continuum and care coordination model."*
>
> -State official

Conclusions

This report summarizes the strategies states are implementing or plan to implement to identify, engage, and retain Medicaid beneficiaries with SMI/SED in treatment (section 1115 SMI/SED demonstration Milestone 4) and the enabling factors and challenges states experience in doing so. Demonstration states pursued different strategies to address this milestone, but common themes around state strategies emerged, including partnering with schools, implementing first episode psychosis programs, requiring Medicaid managed care organizations to screen and refer patients for treatment, utilizing Medicaid reimbursement and benefits to support treatment, and supporting primary care providers and CMHCs to integrate physical and behavioral health. In both state documentation and in interviews, state officials often stated that they advanced demonstration goals through partnerships, in particular with school entities and primary care. The focus on partnerships spoke to states' awareness that identifying and treating mental health disorders

will happen inside and outside the system of mental health providers, so there needs to be opportunities for touch points for screening and treatment across a variety of settings. Almost all demonstration states also addressed this milestone through their ability to require Medicaid managed care entities and/or their providers to conduct health risk assessments to identify mental health disorders and to deliver case management activities, such as referring beneficiaries to needed services and following-up when beneficiaries are not routinely engaging in treatment.

All states began demonstration activities during the COVID-19 pandemic. Three demonstrations were approved in early 2020, several months before the start of the pandemic, and the rest were approved after. Even though COVID-19 was an unprecedented shock to the U.S. health system and states had to grapple with service delivery while resources were diverted to the pandemic, it did not surface as a major implementation challenge across all states; only one state mentioned the pandemic as a challenge, specifically its impact on use of telehealth for delivering mental health services.

Section 1115 SMI/SED demonstration implementation is still relatively early, yet almost all states noted in their implementation plans that they had already met Milestone 4 by the time they began their demonstration activities because they had already been supporting care delivery changes aimed at engaging beneficiaries in treatment as soon as possible. As a result, states plan to continue their pre-demonstration strategies and may consider testing new approaches to address any identified areas for improvement in their continuum of care for beneficiaries with SMI or SED. For example, several states mentioned building out new health IT offerings to support early identification and continuation of treatment; others mentioned exploring how best to implement the Certified Community Behavioral Health Clinic program for CMHCs. Notably, state officials discussed very few challenges with implementing strategies. Reasons for this may include the fact that most state strategies were already in place at the time of the interview so implementation challenges were no longer a key concern and that state officials did not always have detailed knowledge of how strategies were implemented. If future interviews are conducted with providers more familiar with these strategies, challenges will be assessed then.

This report is meant to share early insights about states' section 1115 SMI/SED demonstration efforts to identify beneficiaries with SMI or SED in need of treatment and engage beneficiaries in treatment. As part of the meta-evaluation effort, we will continue to monitor changes in service delivery as the demonstrations mature. The findings from these interviews may help to contextualize state-specific results from the impact analysis and meta-analysis or may support operationalization of new variables for those analyses.

Authors and Acknowledgments

This rapid cycle report was authored by Melissa Romaire, PhD; Madeline Britvec, MPH; Chelsea Katz, PhD; Marque Long, MPH; Heather Kane, PhD; Donna Spencer, PhD; Susan Haber, ScD; and Anupa Bir, ScD of RTI International. The authors would like to express appreciation to state officials for their time and informed perspectives. The authors acknowledge Nathan Yates for editorial assistance. The authors also acknowledge the contribution of CMS staff who reviewed drafts of this report: Kirsten Beronio, Christopher Carroll, Allen Ma, Deborah Steinbach, and Danielle Daly.

The Federal Meta-Analysis Support Contract

In 2018, the Centers for Medicare & Medicaid Services (CMS) commissioned the Federal Meta-Analysis Support contract (HHSM-500-2014-00037I) to learn from each Medicaid section 1115 demonstration and the groups of such demonstrations with similar features. Under this contract, RTI International is conducting meta-evaluations of selected groups of Medicaid section 1115 demonstrations.

Rapid cycle reporting is central to the Federal Meta-Analysis Support contract, providing CMS with timely, practical findings, and supporting dissemination of findings to key stakeholder audiences. This report is one of several rapid cycle reports prepared by RTI International under the contract.

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews with 10 states (Alabama, District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) and a review of the 10 states' implementation plans, of midpoint assessments for two states (District of Columbia and Vermont), and of quarterly monitoring reports for five states (District of Columbia, Idaho, Oklahoma, Utah, and Washington). Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Respondents included state Medicaid directors, state Medicaid program staff, and state behavioral health agency staff familiar with the section 1115 SMI/SED demonstration. One interview was conducted per state, and almost all states had multiple program staff attending the interview.

Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, interviews in these states focused on planned activities, enabling factors, and challenges.

Interviews used a common, semi-structured protocol that covered multiple topics, including perspectives on the state's most important demonstration activities and activities around section 1115 SMI/SED demonstration Milestones 1 through 4. This report drew upon interview questions and responses related to implementation of Milestone 4, early identification and engagement in treatment. Interviews were 60 minutes in length.

Interviews were audio recorded with state officials' permission and transcribed. RTI analyzed the transcripts using NVivo 12.0. The initial analysis phase entailed a deductive coding process with prescribed codes for topics that aligned with the interview protocol. After this initial phase, the analysis team initiated an inductive coding process to identify and synthesize strategies, enabling factors, and challenges across states. The team held regular coding reviews and debriefings and conducted intercoder reliability assessments to ensure quality control.

In the report, we use quantifying language (e.g., "all state officials" or "some state officials") to give readers a sense of the number of state officials who mentioned a topic during an interview and therefore the prevalence of topics that state officials raised or addressed. We do not provide exact counts of state officials who mentioned a topic because the interviews were semi-structured in nature. Unlike the case of a structured survey with identical questions and response sets, we cannot conclude from semi-structured interviews that a particular topic was or was not relevant or meaningful to state officials who did not mention a particular topic. Also, when data come from publicly available documents, we provide state names and counts, as well as note the document source. We avoid naming states when data come solely from interviews to minimize risk to confidentiality.

This analysis has several limitations. State officials may report strategies; state-reported policies, programs, and contextual factors; and challenges that are most important to them—as such, there may be some inherent bias in the information they report. Additionally, states' perspectives may have varied depending on how far along they were in implementation. At the time our interviews were conducted, some states had been engaged in demonstration implementation for close to two years while others were only recently approved to begin demonstration activities. Perspectives about the importance of a strategy in meeting a demonstration milestone may reasonably be expected to change over time. Moreover, this report is not designed to provide an exhaustive list of strategies, enabling factors, and challenges; we present those that were frequently mentioned. Interviews lasted 60 minutes and covered multiple topics, which limited in-depth discussion on any one topic. Finally, identification of challenges related to early identification and engagement in treatment was infrequent, which limits the generalizability of the challenges discussed in this report.