Report to Congress:
Planning Grant Implementation
Initial Report

As Required by Section 1003 of the
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment
(SUPPORT) for Patients and Communities Act (Pub. L. 115-271)
from the
Department of Health and Human Services
Office of the Secretary

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EXHIBITS

1 EXECUTIVE SUMMARY

1.1 Background

This Initial Report to Congress is provided in accordance with section 1003 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. No. 115-271), enacted on October 24, 2018, herein referred to as the "SUPPORT Act."

Section 1003 of the SUPPORT Act amends section 1903 the Social Security Act (the Act) and directs the Secretary of the U.S. Department of Health and Human Services (HHS), in consultation with the Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA), to conduct a 54-month demonstration project (the section 1003 demonstration) designed to increase the capacity of Medicaid providers to deliver substance use disorder (SUD) treatment or recovery services.[1]

The section 1003 demonstration is comprised of two components: (1) a planning period, with planning grants awarded for an 18-month period to at least 10 states with funding of up to $50 million in aggregate,[2] and (2) a 36-month post-planning period with up to five states selected from among the planning grant states.[3] The Centers for Medicare & Medicaid Services (CMS), pursuant to section 1135(b)(5) of the Social Security Act,[a] subsequently modified the deadlines and timetables set forth in the statute due to the COVID-19 public health emergency.

Specifically, for all participating states, CMS modified the time frame of the planning period of the demonstration, which began on September 30, 2019, by extending the end date 6 months to September 30, 2021. CMS also delayed the start of the 36-month post-planning period by 6 months to September 30, 2021, to allow states to focus on immediately emergent issues related to COVID-19.

Section 1003 of the SUPPORT Act directs the Secretary to issue four Reports to Congress. This Initial Report to Congress is the first such report. It details the planning period of the section 1003 demonstration, using information available 13 months into the 24-month period. Pursuant to the

[a] When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Secretary of HHS declares a public health emergency under section 319 of the Public Health Service Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements under section 1135 of the Social Security Act. See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers for more information.

statute, this report describes (1) the criteria used for selecting the planning grant states, (2) the states that were selected, and (3) initial state activities under the planning grants.

1.1.1 Criteria for Selection

The SUPPORT Act[1] required CMS to award planning grants to at least 10 states with an approved Medicaid state plan (or waiver of the state plan), to select geographically diverse states, and to give preference to states with a prevalence of SUD (in particular opioid use disorder (OUD)) close to or above the national average prevalence, as measured by aggregate per capita drug overdoses or any other measure the Secretary deemed appropriate.[2] The *Section 1003 Demonstration Notice of Funding Opportunity* (NOFO) stipulated that the applicants must be state Medicaid agencies, and provided other standard CMS requirements including submission of a nonbinding letter of intent to apply, demonstration by the state Medicaid agency that it was collaborating with relevant state agencies, and submission of the application through Grants.gov.

The process for review of applications and selection of planning grant recipients included screening applications to determine eligibility for further review using the criteria in the NOFO and establishing an objective review committee to assess the technical merit of grant applications. The objective review of applications was used to advise the CMS approving official, who made the final award decisions.

1.1.2 States Selected to Receive Planning Grants

The 15 states selected to receive planning grants were Alabama, Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Virginia, Washington, and West Virginia. The selected states represented the different regions of the United States and were diverse in population size, rurality, and degree of reliance on Medicaid managed care in contrast to fee-for-service Medicaid. As measured by Centers for Disease Control and Prevention data on age-adjusted drug overdose deaths in 2018, all but three states selected had rates exceeding the national average. Opioid-related overdose deaths in 2018 for the 15 states ranged from 9 to 42 per age-adjusted 100,000 population (see Exhibit 4).

1.2 Initial State Activities Under Section 1003 Planning Grants

1.2.1 Activities Proposed Across Planning Grant States

In their applications, planning grant states identified their goals for the section 1003 demonstration. Overarching goals included a better understanding of SUD prevalence and needs in the state;

enhancing Medicaid SUD provider service capacity and access across the service continuum; expanding use of best practices, including medication-assisted treatment (MAT); enhancing integrated and coordinated care capacity; and improving or reforming reimbursement approaches for SUD treatment or recovery service delivery. The specific activities proposed by planning grant states to implement these goals varied (see section 4.1 *Activities Proposed Across Planning Grant States*).

Activities initially planned by states included the required needs assessment, with states having latitude to choose the approach proposed for their assessments. Typically, states proposed data analyses, surveys, stakeholder input, literature reviews, and assessments of infrastructure. States also included activities to enhance their data collection and analysis capabilities in order to conduct a satisfactory needs assessment (see Exhibit 7. *Proposed Approaches to Data Gathering in State Needs Assessments*).

All states identified activities to improve provider capacity both by provider type and by setting along the care continuum. These activities included provider outreach and recruitment, as well as training and technical assistance to enhance provider qualifications. Many states also identified telehealth or other uses of technology to extend the availability of providers of SUD treatment or recovery services. All states proposed activities aimed at increasing capacity for MAT, and many proposed activities related to expanding use of other best practices as part of Medicaid SUD service delivery. Each state's proposed activities included provider training and technical assistance. In addition, states planned to improve state oversight of providers and offer training on organizational best practices. All states proposed activities for enhancing integrated or coordinated care as part of SUD treatment or recovery service delivery under their Medicaid programs.

States included some aspect of payment reform or improvement within the Medicaid program. Activities included planning to conduct an inventory of current Medicaid payment methodologies and rates, prior authorization requirements, and administrative barriers to provider reimbursement, as well as assessing the potential impact of these factors on provider capacity.

1.2.2 State Collaboration in Planning Grant Development

States pursued a variety of planning processes in preparation for their grant applications. Every state Medicaid agency partnered formally or informally with its counterpart single state agency for substance abuse services, as part of the application process and for ongoing collaboration. Most

partnered with other state agencies as well. Some states also collaborated with other entities, including providers, and began the process of building a team to carry out planning grant activities should one be awarded. These activities continued after planning grants were awarded.

In their applications, states identified multiple avenues of planned ongoing engagement with stakeholders, including other state agencies, advisory councils, committees or working groups, health care organizations, managed care plans, community or tribal entities, and philanthropic organizations. All states identified COVID-19 as a challenge they had to overcome, with stakeholder engagement often delayed or altered from the original plan. This challenge typically related to resource constraints of the states, stakeholders, or both. In response to changing needs, some states also engaged additional partners that were not originally identified in the grant application. The new partnerships often were intended to enhance the use of telehealth in response to the pandemic and to bolster or replace team staffing affected by COVID-19.

1.2.3 Status of Proposed Activities That Were Initiated

The information on state activities in this report is limited to what was available during the first 13 months of the planning period. Many of the activities discussed are ongoing. States approached their goals flexibly, allowing them to consider the results of their needs assessments, as well as intervening events such as the pandemic, and to adapt their plans accordingly.

States that had not previously done much work to assess Medicaid SUD treatment or recovery service needs had to begin with building the capacity to do the needs assessment. A few states that already had a more developed assessment of needs or existing infrastructure were able to begin some work to increase Medicaid SUD treatment or recovery capacity during the planning period. Some of these states proposed needs assessment and demonstration activities that were meant to address specific gaps in their systems that the states had already identified. These states entered the demonstration with a clear idea of infrastructure development, reimbursement, or training and technical assistance activities that would benefit their SUD systems. However, most states relied heavily on ongoing needs assessment activities to answer key questions about their SUD infrastructure. For these states, results from the assessments led to planning activities to address barriers and gaps as these became apparent. This approach tended to produce a pre-pandemic timeline that allowed for planning, subcontracting, and data collection throughout the fall and winter of 2019 and 2020, with other activities beginning by late spring of 2020.

1.2.4 Challenges That Interfered with or Prevented Initiation of Planned Activities

In the process of implementing their planned activities, states encountered two broad categories of challenges during the first 13 months of the section 1003 planning period: challenges related to the COVID-19 pandemic; and challenges concerning quantitative and qualitative data that did not originate with the pandemic.

The most frequently reported disrupter of states' initial proposed activities was the pandemic, which affected much of the United States beginning in spring 2020. Although the pandemic was almost universally depicted as a challenge by states, states also reported specific challenges and adjustments to challenges. Most commonly, states reported that data collection activities were delayed due to the pandemic. The reasons for delaying data collection activities included redirecting providers to focus on expanding telehealth capabilities; the difficulty of getting access to patients and providers; a need to invest in information technology infrastructure to allow for more online interactions with patients, providers, and other stakeholders; and a need for patients and providers to become more proficient with technology. Other states reported difficulty with staffing due to an associated hiring freeze or needing to postpone in-person interactions that were part of the demonstration.

Relatedly, although several states reported in their applications that they expected to focus on telehealth, the pandemic made the implementation of telehealth services an urgent activity for states in late spring 2020. Any states that had not initially planned to focus on telehealth services added this activity, but the pandemic more frequently expedited state plans to expand telehealth services and resulted in more needs assessment activities focused on understanding telehealth capabilities and barriers.

In addition to challenges in data collection or access due to the pandemic, states experienced other data-related impediments. States encountered difficulties related to data completeness or accuracy, the ability to link and use multiple datasets, and determining how best to use data to meet their needs. Some states also had difficulty fully identifying qualified providers, particularly ones not currently enrolled as Medicaid providers. Because states had different levels of experience working with SUD data or changed approaches over time, states often were still refining their methodology over a year into the planning period.

1.2.5 Facilitators of Initiation or Implementation

Several factors emerged over the initial 13 months of the planning grant that helped to propel implementation of grant activities. One factor commonly identified by states involved collaborative activities with other agencies or entities. Earlier work on SUD initiatives such as section 1115(a) demonstrations or work on data linkage across agencies within a state also facilitated progress for some states. Additionally, although the COVID-19 public health emergency (PHE) created challenges for states, factors associated with the pandemic such as the extended planning period provided by CMS and planning grant funding to support providers' rapid adoption of telehealth technology facilitated states' progress.

1.2.6 Activities Initiated Beyond Those in the Applications

In addition to activities identified in the planning grant applications, states altered approaches to planned activities. Some of this adjustment of activities was a natural progression based on discoveries made during the needs assessment. Many changes, such as delays in planned data collection or training activities and accelerated plans to expand telehealth services, were made in response to the COVID-19 pandemic.

1.2.7 State Subpopulations of Focus and Related Planning Grant Activities

The section 1003 demonstration NOFO encouraged states to focus their planning grant activities on target populations identified in the statute (i.e., pregnant/postpartum women and infants, infants with neonatal abstinence syndrome, adolescents and young adults, the American Indian/Alaska Native population) and others such as individuals dually eligible for Medicare and Medicaid, rural populations, or criminal justice-involved populations.[3] In response to this flexible approach, states proposed to focus on subpopulations in quite different ways, ranging from Kentucky, which focused only on pregnant and postpartum women and infants, including infants with neonatal abstinence syndrome, to Connecticut, which focused on all the target populations specified in the NOFO as well as others. Over time, states' populations of focus varied, resulting from the identification of gaps in services as the assessment progressed.

In some cases, the nature of a target population made data more difficult to gather (e.g., individuals in syringe service programs), and in all states, the presence of COVID-19 exacerbated existing challenges (e.g., lack of broadband in rural areas). States also engaged in other activities related to expanding Medicaid provider capacity for target populations, including technical assistance,

generally aimed at increasing provider qualifications to serve the identified population, and responding to identified barriers.

1.2.8 State Providers of Focus and Related Planning Grant Activities

Section 1003 aims to increase Medicaid SUD treatment or recovery provider capacity generally, as well as specifically related to target populations and to the provision of medication treatment for withdrawal management or maintenance treatment. The 15 planning grant states targeted specific provider types, individual Medicaid providers, and facilities, during their needs assessments and other planning grant activities. States focused on facility types to ensure that the appropriate continuum of care is available where needed for the provision of Medicaid SUD treatment or recovery services. Additionally, because the provision of MAT is a key part of the section 1003 demonstration, states paid particular attention to both individual and facility providers of MAT for SUD. States also explored or implemented increased use of technological approaches designed to extend providers' availability, particularly in light of the COVID-19 pandemic.

When states identified specific individual provider types as a focus of their capacity-building efforts, these providers were usually Medicaid-enrolled primary care providers and obstetricians who provide medication-assisted treatment, as well as providers who can address the needs of substance-exposed infants. States also expressed plans to ascertain the need for SUD treatment across the care continuum, hence focusing on inpatient, emergency department, residential, intensive outpatient, and outpatient services and undertaking activities to address gaps. These efforts overlapped with attention to providers of MAT. States focused on state capacity for buprenorphine prescribing and methadone dispensing and less so on prescribers of other medications used in MAT. Activities intended to increase capacity to provide MAT included technical assistance aimed at providers and efforts to understand barriers to provider willingness. Other activities related to assessing reimbursement, identifying resources for rural areas, and building treatment pathways between high-intensity and lower-intensity settings to ensure that MAT follows the person. In addition, states sought to enhance provider capacity through developing peer or community supports.

Although not a provider type, SUD services furnished through telehealth technology increasingly were used to expand provider capacity. A number of states incorporated telehealth into their planning grant applications—concentrating on provider willingness to use the technology, addressing reimbursement issues, and building infrastructure. The COVID-19 pandemic and the

flexibilities that HHS provided in the use of telehealth during the PHE facilitated rapid expansion of use and the evolution of state infrastructure to permit that expansion.

This review of planning grant states' progress 13 months into the section 1003 demonstration sets the stage for three additional Reports to Congress that will follow the demonstration over its entire duration. The AHRQ Report to Congress will summarize the experiences of states awarded planning grants and those selected for the post-planning period. The Interim Report to Congress will describe activities carried out by post-planning states, the extent to which states have achieved the goals stated in their applications, and plans for the sustainability of their SUPPORT Act project. The Final Report to Congress will provide updates on the post-planning states' activities described in the Interim Report and an evaluation of the demonstration project.[4]

2 INTRODUCTION

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was enacted on October 24, 2018. Section 1003 of the SUPPORT Act directs the Secretary of the Department of Health and Human Services (HHS) to conduct a 54-month demonstration project (the section 1003 demonstration) designed to increase the capacity of Medicaid providers to deliver substance use disorder (SUD) treatment or recovery services.[5] The section 1003 demonstration is led by the Centers for Medicare & Medicaid Services (CMS), in consultation with the Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

The section 1003 demonstration comprises (1) a planning period, with planning grants of up to $50 million, in aggregate, originally awarded for an 18-month period to at least 10 states,[6] and (2) a 36-month post-planning period, with up to five states selected from among the planning grant states.[7] Due to the COVID-19 PHE, CMS modified, through the authority of an emergency waiver under section 1135 of the Social Security Act,[b] the deadlines and timetables set forth in the statute. As a result, the entire section 1003 demonstration was extended by six months to allow states to complete planning grant activities in light of impediments from the COVID-19 pandemic and the accompanying PHE. Thus, the planning period, which began on September 30, 2019, ended on September 30, 2021. The post-planning period began on October 1, 2021, and ends on September 30, 2024.

This report to Congress is the first of four reports required by section 1003 and focuses on the selection of the 15 states awarded planning grants and their implementation of the planning grants over the initial 13 months of the 24-month planning period (September 30, 2019 – October 31, 2020). The AHRQ Report to Congress will provide a summary of the experiences of states awarded planning grants and those selected for the post-planning period. The Interim Report to Congress will summarize activities carried out by post-planning states, the extent to which post-planning states have achieved the goals stated in their applications, and plans for the sustainability of their SUPPORT Act projects. The Final Report to Congress will provide updates on the post-planning

[b] When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Secretary of HHS declares a public health emergency under section 319 of the Public Health Service Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements under section 1135 of the Social Security Act. See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers for more information.

grant state activities described in the Interim Report to Congress and an evaluation of the demonstration project.[8]

This report relies on extensive data submitted by the planning grant states, including (1) applications, (2) quarterly progress reports, and (3) semiannual progress reports. Together, this documentation describes state goals, partnerships, implementation processes and progress, and barriers and facilitators encountered during the first 13 months of the planning period of the demonstration.

2.1 SUD Prevalence and Treatment in the United States

The most recent National Survey on Drug Use and Health found that in 2021, an estimated 5.6 million Americans aged 12 years or older (2.0 percent) had an OUD in the past year and that an estimated 46.3 million (16.5 percent) had a type of SUD.[9] The effects of the opioid crisis in particular are pronounced throughout the United States, with opioid-related overdoses and overdose deaths growing since the early 2000s.[10] Costs associated with nonmedical use of opioids in the United States from 2015 through 2018 alone were estimated to be $631 billion or more.[11] Moreover, recent analyses found that half of the Medicaid-covered adults with OUD also had one or more additional SUDs.[12] The impact of SUD extends beyond the individual substance user, as indicated by the prevalence of neonatal abstinence syndrome,[13] fetal alcohol spectrum disorder,[14] and increased spread of infectious diseases, including HIV and hepatitis C (HCV) in some areas of the United States.

Effective treatments for SUD exist but remain highly underutilized.[15] Medication-assisted treatment (MAT) incorporates both medication treatment and psychosocial treatment and/or supports and can also be effective for treating alcohol use disorder.[16] The specific medications approved by the Food and Drug Administration (FDA) to treat OUD include buprenorphine or buprenorphine-naloxone (collectively, buprenorphine), methadone, and naltrexone. Medications approved to treat alcohol use disorder include acamprosate, disulfiram, and naltrexone. For SUDs other than opioid or alcohol use disorder, there are currently no approved medications, and treatment relies largely on psychosocial interventions.[17]

Despite the prevalence of SUD and the availability of evidence-based treatment for opioid and alcohol use disorders, significant capacity shortfalls in SUD treatment or recovery services are widespread across the United States, particularly in rural areas.[18,19] The 2019 National Survey on

Drug Use and Health found that, of the 22 million people in the United States aged 12 years or older who needed SUD treatment in the past year, only 12 percent (under 3 million people) received such treatment at a specialty facility during that period.[20] This lack of treatment availability exists across the spectrum of services, as well as across geographic locations. Thus, despite some progress, opioid treatment programs that provide methadone treatment and Drug Addiction Treatment Act (DATA)-waivered providers[c] able to prescribe buprenorphine do not meet demand for these treatments in many locations.[21, 22] In rural areas, researchers report a variety of barriers to accessing services resulting from a lack of appropriate resources in the community, including clinics and physicians.[23] One study found that 60 percent of rural counties in the United States in 2017 did not have a single physician who was waivered through DATA to prescribe buprenorphine.[24] The public health emergency declaration due to the COVID-19 pandemic led to a temporary relaxation of certain requirements related to prescribing buprenorphine, and providing take-home methadone for OUD treatment,[25] but these changes alone likely will not address all SUD treatment provider shortages over the long term.

2.2 Purpose of the Demonstration

The SUPPORT Act was enacted in response to the number of individuals in the United States with OUD and/or another SUD, high rates of fatal and nonfatal overdoses, and the other human and economic costs associated with the opioid crisis. The purpose of the *Section 1003 Demonstration Project to Increase Substance Use Provider Capacity* is to increase the treatment capacity of Medicaid providers to deliver SUD treatment or recovery services through the following activities:

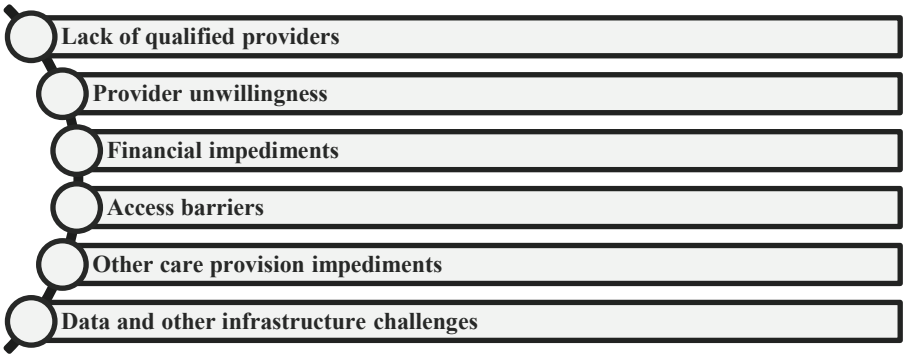
- Ongoing assessment of the state's behavioral health treatment needs;
- Activities supporting the recruitment, training, and provision of technical assistance for Medicaid providers that offer SUD treatment or recovery services;
- Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers who (1) are authorized to dispense drugs approved by the FDA for individuals with SUD who need withdrawal management or maintenance treatment; (2) have a DATA waiver to prescribe buprenorphine; and (3) are qualified under applicable state law to provide SUD treatment or recovery services; and

[c] The DATA waiver program was eliminated by Section 1262 of the Consolidated Appropriations Act, 2023.

- Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers qualified to address the treatment or recovery needs of infants with neonatal abstinence syndrome; pregnant women, postpartum women, and infants; adolescents and young adults aged 12 to 21 years; or American Indian and Alaska Native individuals.

The role of Medicaid is important in addressing SUD as a substantial percentage of adults with SUD in the United States are enrolled in Medicaid. For instance, an estimated 40 percent of adults younger than age 65 years with OUD are enrolled in Medicaid.[26] Capacity shortages in SUD services can have consequences for Medicaid beneficiaries, and states may face significant barriers in addressing these shortages. Exhibit 1 lists some of the barriers that state Medicaid programs and their associated managed care plans may need to overcome to build Medicaid SUD treatment or recovery service capacity.

Exhibit 1. Barriers to Increasing Substance Use Disorder Provider Capacity



Examples of these barriers, as identified in the *Section 1003 Demonstration Project to Increase Substance Use Provider Capacity Notice of Funding Opportunity* (NOFO), include the following:

- **Lack of qualified providers**: lack of providers trained in MAT, behavioral health services, and technical support to help primary care providers integrate SUD services;
- **Provider unwillingness**: lack of qualified providers who are willing to provide SUD treatment or to serve Medicaid beneficiaries, as well as stigma among providers about SUD treatment;
- **Financial impediments**: beneficiary cost sharing, limits on diagnosis codes for which primary care providers may receive reimbursement, low reimbursement, and burdensome provider reimbursement requirements;

- **Access barriers**: transportation, laws that limit where SUD providers can be located, and lack of providers in specific geographic areas; and
- **Other care provision impediments**: enrollment caps, prior authorization requirements, lack of care coordination between SUD providers or other providers, cultural barriers, limits on treatment duration, and step therapy criteria.[27]

2.3 Critical Context for the Demonstration

The section 1003 demonstration started a few months before the emergence of COVID-19. As the effects of COVID-19 began to be felt across the United States, the federal government declared a public health emergency, and pursuant to section 1135(b)(5) of the Social Security Act (Act), CMS modified the deadlines and timetables set forth in section 1003 of the SUPPORT Act to enable states to complete planning grant activities amid the disruption and barriers caused by the pandemic, including competing financial and resource pressures to address the spread of COVID-19. Specifically, for all participating states, CMS extended the end date of the planning period of the demonstration by 6 months, to September 29, 2021. CMS also delayed the start of the 36-month post-planning period by 6 months to September 30, 2021. The timeline updates were based on an assessment of the impact of the COVID-19 public health emergency on grantee activities.

This public health crisis corresponded with an increase in the incidence of opioid-related overdoses in many parts of the United States.[28] Thus, just as need increased, the states' intended section 1003 planning grant activities were curtailed by public health considerations related to the pandemic, which may have had a substantial impact on the demonstration. Specific examples of how the pandemic affected planning grant states' planned and implemented activities are discussed throughout this report.

Other state initiatives underway may also affect Medicaid SUD treatment or recovery service provider capacity. Examples included the CMS Comprehensive Primary Care Plus Model, Accountable Health Communities Model, State Innovation Model, Maternal Opioid Misuse Model, and Integrated Care for Kids Model, as well as section 1115(a) SUD demonstrations and SAMHSA State Targeted Response and State Opioid Response grants. Participation in any of these initiatives may overlap with or complement section 1003 demonstration activities and influence outcomes. The section 1003 demonstration NOFO required applicants to identify other programs and funding sources at the local, state, and federal levels that are related to the applicants' proposed section 1003

project and address how they will ensure that funding for section 1003 will not duplicate those other services or funding. Applicants were also asked to identify how they will monitor potential duplication and include mitigation strategies if duplication is identified.[29]

3 CRITERIA USED FOR SELECTION OF SECTION 1003 PLANNING GRANT STATES

3.1 Eligibility and Ineligibility Criteria for Planning Grant Awards

The SUPPORT Act[30] required CMS to award planning grants to at least 10 states with an approved Medicaid state plan (or waiver of the state plan), to select geographically diverse states, and to give preference to states with a prevalence of SUD (in particular OUD) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses or any other measure the Secretary deemed appropriate.

The section 1003 demonstration NOFO described the eligibility requirements for the planning grant awards: any state Medicaid agency could apply, with one application per state; and applications had to be submitted by a 6 week deadline.[31] The NOFO included other standard CMS requirements, such as submission of a nonbinding letter of intent to apply[32]; demonstration by the state Medicaid agency that it was collaborating with relevant state agencies[33]; and submission through Grants.gov in accordance with other CMS standard grant requirements.[34] Cost sharing or a state match was not required for the planning grants.[35]

The NOFO also described ineligibility criteria that CMS would consider as potential reasons for applicant disqualification for award:

- Insufficient detail of the state's approach to achieving program goals and milestones;
- Inability or unwillingness to collect and share monitoring and evaluation data with CMS or its contractors;
- Program integrity concerns regarding the organization, community partners, or any other relevant individuals or entities;
- Late submission of an application (which was due August 9, 2019); and
- Overlap with another model, demonstration, or program, including a Center for Medicare & Medicaid Innovation model, that may result in duplication.[36]

3.2 Selection Criteria for Planning Grant Awards

The section 1003 demonstration NOFO also described selection criteria that CMS would use to score the applications and requirements for what the applications should contain. It specified that CMS would have sole discretion to select recipients and that such selection would not be subject to administrative or judicial review. In addition to the criteria for selection included in the statute, the

NOFO indicated that selection preference would be given to applicants that identified measurable outcomes.[37] Each application could be assigned a maximum of 100 points. Applicants were required to address the following elements in their application: staffing (15 points); budget (20 points); state infrastructure, data sharing, and reporting (15 points); organizational structure (10 points); and a project narrative (40 points). The project narrative was required to address (1) assessment of the mental health and SUD treatment needs of the state to determine the extent to which providers are needed, (2) proposed activities to develop state infrastructure, and (3) analysis of SUD prevalence.[38] Per standard grant requirements, CMS also considered any information about the applicant that is in the designated integrity and performance system accessible through the System for Award Management.[39]

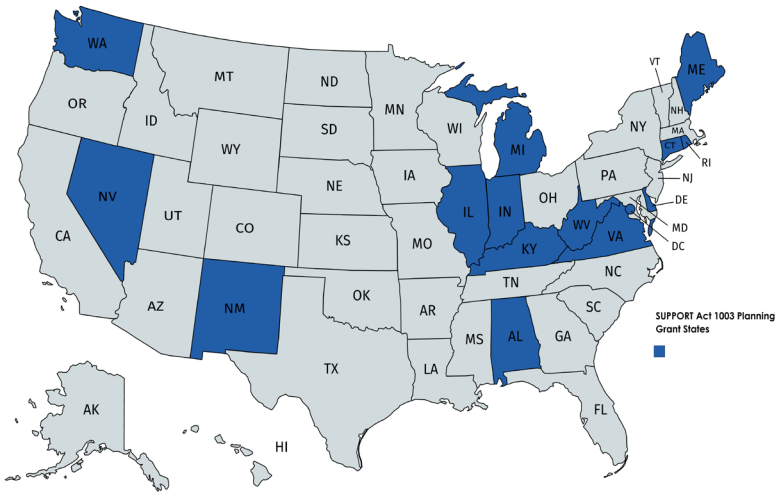
3.3 Review and Selection Process for Planning Grant Awards

The section 1003 demonstration NOFO described in detail the process for review of applications and selection of planning grant recipients. The process included screening applications to determine eligibility for further review using the criteria in the NOFO and establishing an objective review committee to assess the technical merit of the grant applications. The objective review of applications was used to advise the CMS approving official, who made the final award decisions. The CMS approving official considered (1) review panel recommendations, (2) readiness of the applicant to conduct the work, (3) projected impact on aims and quality of the proposal, (4) programmatic and grant management compliance, (5) reasonableness of the estimated cost to the government, and (6) the likelihood that the proposed project will result in the benefits expected. The approving official gave preference to state applicants with a prevalence of SUD that is comparable to or higher than the national average and, finally, conducted a review of risks posed by applicants prior to award.[40] Appendix A includes the selection scoring instrument used by the objective review committee.

4 STATES AWARDED SECTION 1003 PLANNING GRANTS

In September 2019, 15 state Medicaid agencies (shown in Exhibit 2) were awarded $48.4 million in aggregate, for 18-month planning grants. CMS opted to make available supplemental funding to the 15 state Medicaid agencies with the remaining $1.6 million, from the original $50 million appropriation. Each of the 15 state Medicaid agencies was able to request a 3.3% increase in the amount of their grant award.

Exhibit 2. Section 1003 Planning Grant States, Map and Award Amounts



State	Original Award	Supplemental Award
Alabama	$5,000,000	$160,581
Connecticut	$2,881,404	$92,540
Delaware	$3,579,864	$114,000
District of Columbia	$4,616,075	$148,251
Illinois	$4,559,743	$146,441
Indiana	$2,760,638	$88,661
Kentucky	$833,701	$—[a]
Maine	$2,077,599	$66,725
Michigan	$3,448,066	$110,739
Nevada	$1,684,013	$—[a]
New Mexico	$2,451,656	$78,738
Rhode Island	$3,482,368	$111,840
Virginia	$4,831,341	$160,328
Washington	$3,872,766	$124,378
West Virginia	$2,204,124	$—[a]

Abbreviation: SUPPORT Act, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271).

[a] States without a supplemental award did not request additional funding.

Exhibit 3 identifies selected characteristics of the planning grant states, including census region, state population, percentage of the population in rural areas, number of Medicaid enrollees, and Medicaid managed care penetration. The planning grant states were distributed across the United States and included states with a broad range of population sizes and Medicaid enrollment. The percentage of the population living in rural areas in 2010 ranged from 0 percent (the District of Columbia) to 61 percent (Maine). As of mid-2018, seven of the 15 planning grant states had a percentage of Medicaid enrollees in managed care greater than the percentage for the United States as a whole (83 percent), including Washington and Michigan (both 100 percent).

Exhibit 3. Planning Grant State Characteristics

State	Census Region	Population Estimate[a]	Rural Population, %[b]	Medicaid Enrollees[c]	Enrollees in Any Managed Care, %[d]
United States	—	327,167,434	19	70,587,631	83
Alabama	South	4,887,871	41	809,149	63
Connecticut	Northeast	3,572,665	12	881,308	0
Delaware	South	967,171	17	235,645	88
DC	South	702,455	0	238,919	72
Illinois	Midwest	12,741,080	12	2,787,617	70
Indiana	Midwest	6,691,878	28	1,568,595	77
Kentucky	South	4,468,402	42	1,429,312	91
Maine	Northeast	1,338,404	61	226,056	87
Michigan	Midwest	9,995,915	25	2,476,774	100
Nevada	West	3,034,392	6	684,413	88
New Mexico	West	2,095,428	23	755,665	79
Rhode Island	Northeast	1,057,315	9	285,201	97
Virginia	South	8,517,685	25	1,399,566	82
Washington	West	7,535,591	16	1,779,628	100
West Virginia	South	1,805,832	51	507,421	68

[a] As of July 1, 2018. Source: U.S. Census Bureau. 2018 national and state population estimates. Table 1. Annual estimates of the resident population for the United States, regions, states, and Puerto Rico: April 1, 2010 to July 1, 2018 (NST-EST2018-01). December 19, 2018. https://www.census.gov/newsroom/press-kits/2018/pop-estimates-national-state.html

[b] As of 2010. Source: U.S. Census Bureau. 2010 census urban and rural classification and urban area criteria. Percent urban and rural in 2010 by state. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html

[c] As of September 2020. Source: Centers for Medicare & Medicaid Services. September 2020 Medicaid & CHIP enrollment data highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[d] As of July 1, 2018. Source: Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics, 2018.* Winter 2020. https://www.medicaid.gov/Medicaid/downloads/medicaid-mc-enrollment-report.pdf

Drug overdoses were an important statutory criterion for the selection of planning grant states. Exhibit 4 identifies the prevalence of per capita fatal drug overdoses and fatal opioid-related drug overdoses for each planning grant state and for the nation as a whole in 2018, which is the baseline year for assessments related to the demonstration. In 2018, age-adjusted rates of opioid-related deaths ranged from nine in Washington to 42 in West Virginia per 100,000 population. The rate of age-adjusted drug overdose deaths for the country as a whole in 2018 was 21 per 100,000 population, and among the 15 planning grant states, only Alabama (17), Virginia (17), and Washington (15) had lower rates for all drug overdose deaths. Rates for all other planning grant states were equal to or exceeded the national average.

Exhibit 4. Prevalence of Age-Adjusted per Capita Drug Overdoses Nationally and by Section 1003 Planning Grant State, 2018

Jurisdiction	Age-Adjusted Rate (per 100,000 population)	
	Drug Overdose Deaths[a]	Opioid-Related Drug Overdose Deaths[b]
United States	21	—
Alabama	17	11
Connecticut	31	28
Delaware	44	34
DC	35	27
Illinois	21	17
Indiana	26	18
Kentucky	31	23
Maine	28	23
Michigan	27	21
Nevada	21	12
New Mexico	27	17
Rhode Island	30	26
Virginia	17	14
Washington	15	9
West Virginia	52	42

[a] Source for data in this column: Centers for Disease Control and Prevention. Drug overdose deaths (2018). Page last reviewed March 19, 2020. https://www.cdc.gov/nchs/data/databriefs/db356_tables-508.pdf#2

[b] Source for data in this column, excluding Alabama and Delaware: National Institute on Drug Abuse. Opioid summaries by state (2018). Page last reviewed April 16, 2020. https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state. Source for Alabama and Delaware data: NORC. Opioid overdose deaths in the United States (2014–2018). https://opioidmisusetool.norc.org/

Although the statute specifies drug overdoses as an indicator of SUD prevalence in the planning grant states, the number of individuals who experience an overdose is less than the number with a SUD. Actual SUD prevalence is difficult to ascertain, but Medicaid claims data can be used to capture the number of Medicaid beneficiaries who receive treatment for SUD or specifically OUD. As required by section 1015(a)(1) of the SUPPORT Act, HHS publishes a compendium of the

number of Medicaid enrollees treated for SUD based on Transformed Medicaid Statistical Information System (T-MSIS) data. This compendium, the SUD Data Book, was initially published in 2019 and will be updated annually through 2024.

Using data from the SUD Data Book, Exhibit 5 presents the percentage of Medicaid enrollees treated for SUD (including OUD), the percentage treated for SUD (including OUD) who were dually eligible for Medicaid and Medicare, and the percentage treated specifically for OUD in 2018. All planning grant states except the District of Columbia, Illinois, and Virginia (data were not available for Rhode Island) had greater percentages of their Medicaid enrollees receiving treatment for SUD compared with the national percentage of enrollees receiving SUD treatment in 2018 (8 percent). In contrast, the national percentage of treatment for SUD among Medicaid enrollees who were dually eligible for Medicare (8 percent) was equal to or exceeded by all planning grant states except Michigan and Virginia. The national percentage of Medicaid enrollees receiving treatment for OUD in 2018 (3 percent) was exceeded by all planning grant states other than Alabama, the District of Columbia, Illinois, Michigan, and Nevada.

Exhibit 5. Section 1003 Planning Grant State SUD and OUD Treatment, 2018

State	SUD Treatment in Medicaid Enrollees, %	SUD Treatment in Dually Eligible Enrollees, %	OUD Treatment in Medicaid Enrollees, %
United States	8	8	3
Alabama	9	11	2
Connecticut	13	11	5
Delaware	13	9	6
DC	7	11	2
Illinois	7	8	2
Indiana	10	9	3
Kentucky	13	11	5
Maine	12	14	6
Michigan	10	6	2
Nevada	9	12	2
New Mexico	10	10	4
Rhode Island[a]	—	—	—
Virginia	7	7	3
Washington	10	11	4
West Virginia	11	11	6

Abbreviations: OUD, opioid use disorder; SUD, substance use disorder.

[a] The 2018 figures are missing due to data quality issues.

Source: U.S. Department of Health and Human Services. *Report to Congress: T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2018*. Tables A.1.i and A.7. January 19, 2021. https://www.medicaid.gov/sites/default/files/2021-01/2018-sud-data-book_0.pdf

Data from the SUD Data Book provide additional information on the service setting in which Medicaid enrollees received treatment for SUD in the planning grant states in 2018. Those percentages are shown in Exhibit 6 for the following categories, excluding Rhode Island: inpatient (20–55 percent), outpatient (66–92 percent), residential (1–15 percent), home based (1–3 percent), community based (0–3 percent), and unknown setting (<1–32 percent). These differences indicate the extent to which the states rely on a different balance of service settings.

Exhibit 6. Percentage[a] of Planning Grant State Medicaid Enrollees Receiving Treatment for SUD, by Service Setting, 2018

State	Inpatient	Outpatient	Residential	Home Based	Community Based	Unknown Setting
United States	43	77	6	2	2	8
Alabama	52	77	3	1	1	<1
Connecticut	33	87	2	2	<1	32
Delaware	35	85	15	1	1	1
DC	55	66	9	1	<1	1
Illinois	54	67	6	1	1	14
Indiana	51	70	2	1	<1	2
Kentucky	38	83	6	1	1	1
Maine	20	92	1	1	1	3
Michigan	37	80	11	3	3	8
Nevada	52	72	2	2	1	15
New Mexico	36	84	3	1	2	1
Rhode Island[b]	—	—	—	—	—	—
Virginia	48	70	2	1	1	1
Washington	30	86	12	1	3	3
West Virginia	42	76	3	3	0	1

Abbreviations: SUD, substance use disorder.

[a] The denominator of the percentages presented is total Medicaid enrollees in a given state (or nationally, for the United States) who received treatment for SUD.

[b] The most recent SUD Data Book identified data quality issues for Rhode Island in 2018.

Source: U.S. Department of Health and Human Services. *Report to Congress: T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2018*. Table C.2. January 19, 2021. https://www.medicaid.gov/sites/default/files/2021-01/2018-sud-data-book_0.pdf

5 STATE ACTIVITIES UNDER SECTION 1003 PLANNING GRANTS

5.1 Activities Proposed Across Planning Grant States

In their applications, planning grant states identified their major goals for the section 1003 demonstration. Commonly listed goals included a better understanding of SUD prevalence and needs in the state, including by population; enhancing Medicaid SUD provider capacity and access across the service continuum to meet identified needs; expanding use of best practices, including MAT; enhancing integrated and coordinated care capacity; and improving or reforming payment or reimbursement approaches for SUD service delivery. The specific activities proposed by planning grant states to accomplish these goals, however, varied. This section summarizes some of the proposed activities identified in the applications. Appendix B also provides links to state profiles with snapshots of each state's approach to its planning grant.

5.1.1 Understanding Medicaid SUD Prevalence and Service Needs, Including by Population

Capacity needs assessment. A key component of each state's planning grant was the development of a needs assessment to identify which Medicaid SUD treatment or recovery service providers, populations, and activities to target during the post-planning period. Section 1003 of the SUPPORT Act requires that, among other activities, planning grant states plan and undertake the following[41]:

> (i) Activities that support the development of an initial assessment of the behavioral health treatment needs of the State to determine the extent to which providers are needed (including the types of such providers and geographic area of need) to improve the network of providers that treat substance use disorders under the State plan (or waiver), including the following:
>
> > (I) An estimate of the number of individuals enrolled under the State plan (or a waiver of such plan) who have a substance use disorder.
> >
> > (II) Information on the capacity of providers to provide substance use disorder treatment or recovery services to individuals enrolled under the State plan (or waiver), including information on providers who provide such services and their participation under the State plan (or waiver).

(III) Information on the gap in substance use disorder treatment or recovery services under the State plan (or waiver) based on the information described in subclauses (I) and (II).

(IV) Projections regarding the extent to which the State participating under the demonstration project would increase the number of providers offering substance use disorder treatment or recovery services under the State plan (or waiver) during the period of the demonstration project.

Continuation of an ongoing statewide needs assessment is required for the post-planning period.[42]

The section 1003 demonstration NOFO expands on the statutory requirements for the initial needs assessment.[43] It requires states to conduct an initial assessment of the behavioral health treatment needs of the state, including the types of providers needed and the geographic areas of need, to address the SUD treatment and recovery needs of Medicaid beneficiaries. The assessment is to include:

- The number and percentage of individuals enrolled in Medicaid who have SUD;
- Data on the capacity, qualifications, and willingness of Medicaid providers to deliver SUD treatment and/or recovery services to Medicaid-eligible individuals;
- Information on the gap in Medicaid-covered SUD treatment and recovery services relative to the estimated need of individuals enrolled in Medicaid who have SUD; and
- The level and amount of coordination between primary care, mental health care, and SUD treatment and recovery services for Medicaid beneficiaries.

Grantees are required to use the assessment to determine activities for improving the network of Medicaid-participating providers of SUD treatment or recovery services.

Although states were required to gather the information listed above, the specific activities they proposed for their needs assessments varied (Exhibit 7). Typically, states proposed research on their specific Medicaid systems to inform their plans. States commonly proposed data analysis (11 states); surveys or focus groups of beneficiaries, providers, or other stakeholders (12 states and 10 states, respectively); and/or a formal mechanism for obtaining stakeholder input (11 states) as part of their assessment process. Nine states proposed an assessment of their infrastructure, which included activities such as reviewing state licensing laws or inventorying other administrative requirements.

Exhibit 7. Proposed Approaches to Data Gathering in State Needs Assessments

State	Data Analysis	Surveys	Focus Groups	Stakeholder Input	Review Literature/ Prior NA	Infrastructure Assessment
Alabama	✓	B	B	✓	—	—
Connecticut	✓	B	—	✓	—	✓
Delaware	✓	P	✓	✓	✓	✓
DC	✓	✓	✓	✓	✓	✓
Illinois	✓	✓	—	—	—	—
Indiana	—	P	B, P	—	—	✓
Kentucky	✓	✓	—	✓	—	—
Maine	✓	✓	✓	✓	✓	✓
Michigan	—	P	✓	✓	✓	✓
Nevada	—	—	✓	✓	✓	✓
New Mexico	✓	—	✓	—	✓	—
Rhode Island	✓	✓	—	✓	—	—
Virginia	✓	B, P	B	✓	✓	✓
Washington	✓	P	S	—	—	✓
West Virginia	—	—	—	✓	✓	—
Total	11	12	10	11	8	9

Abbreviation: NA, needs assessment.

Note: Some states specified that they would survey or hold focus groups with beneficiaries (B), providers (P), or other groups of stakeholders (including unspecified stakeholders) (S).

Proposed data-gathering activities and approaches were diverse. A sample of state-proposed activities shown in Exhibit 8 demonstrates differing aspects of the proposed needs assessments and does not represent a complete summary of each state's approach. Some examples of data gathering approaches include using "World Cafes" to assemble stakeholders for input, compiling existing needs assessment data, creating a dashboard of SUD/OUD prevalence, using geospatial analysis, focusing on areas with limited public transportation, using workforce data (including licensure information), determining gaps in the continuum of care and capacity to serve identified subpopulations, assessing provider willingness to serve Medicaid enrollees with SUD, and creating infrastructure for ongoing analysis.

Exhibit 8. State Planning Grant Activities Related to Assessment of Needs

State	Needs Assessment-Related Activities in Planning Grant Applications
Alabama	Determine number of DATA-waivered providers actively providing Medicaid SUD/MAT services; survey those not engaged to determine reasons. Assess number of telehealth providers, providers in rural areas, and providers in areas with limited public transportation.

State	Needs Assessment-Related Activities in Planning Grant Applications
Connecticut	Assess the unique needs of Medicaid subpopulations, including soliciting input for age- and gender-appropriate, and culturally relevant SUD and OUD treatment or recovery service needs. Survey providers to understand (1) their competence in treating special populations, (2) the number of slots in each level of care reserved for SUD patients, (3) the availability of key recovery support services in their organization, and (4) willingness to treat patients with SUD. Identify areas where providers need training to be considered competent to treat a given subpopulation.
Delaware	Create an assessment steering committee representing agencies and individuals engaged in the OUD and SUD treatment or recovery system. Inventory available data sources, establish data-sharing MOUs with key state and private entities, and analyze available data to estimate the number and percentage of Medicaid beneficiaries with SUD/OUD. Interview providers across the care continuum. Analyze workforce data (e.g., professional licensure, Medicaid provider data). Survey providers on capacity, willingness, barriers, and opportunities to provide treatment or recovery services, including MAT, to Medicaid beneficiaries.
District of Columbia	Conduct a comprehensive needs assessment of Medicaid provider capacity to diagnose and treat SUD that aligns with the state Medicaid agency's perspective on data governance, care delivery, and reimbursement strategies that can sustainably improve SUD provider capacity in the District of Columbia.
Illinois	Conduct a data-driven assessment of current treatment needs among Medicaid members. Identify trends from hospital, emergency department, and death certificate data, and pinpoint counties/municipalities at higher risk of opioid-involved painkiller and benzodiazepine overprescribing. Prepare an environmental scan/asset map of SUD counseling and treatment providers and agencies. Conduct a gap analysis of the SUD continuum of care. Conduct status and gap identification of referral processes and professional workforce needs. Determine patient barriers to care.
Indiana	Implement a community-engaged planning process for assessing Medicaid provider capacity. Implement an assessment that includes (1) a gap/resource analysis of mental health and SUD treatment needs among Medicaid-enrolled individuals, (2) creation of a provider network inventory and taxonomy of Medicaid-covered SUD treatment or recovery services, and (3) a comprehensive assessment of care coordination capacity between different SUD treatment or recovery provider types. Improve intra- and interagency infrastructure for future monitoring, evaluation, and planning.
Kentucky	Conduct an epidemiological health care gap analysis using administrative claims data and survey data from Medicaid-enrolled and non-Medicaid-enrolled providers. Use geospatial analyses to help ascertain geographic centers of need within the state. Determine evidence-based needs across the state for the targeted population.

State	Needs Assessment-Related Activities in Planning Grant Applications
Maine	Conduct gap analyses following these steps: (1) determine how gaps will be measured and assessed, (2) collect data to fill in gaps in existing data, and (3) create reports describing gaps in the number and capacity of providers, reporting types, and range and intensity of services while comparing the gaps in SUD treatment among beneficiaries and the entire state population. For the gap analyses, use a multipronged, comprehensive data collection approach, including secondary data analysis of administrative data from a variety of sources, provider focus groups and key informant interviews with health systems as well as hospital and residential program leadership, and listening sessions with individuals, family members, and caregivers with lived SUD experience.
Michigan	Create a dashboard of prevalence for Medicaid enrollees with SUD/OUD, including by subpopulation. Analyze volume and levels of SUD/OUD services by enrollee using claims/encounter data. Create an inventory of SUD treatment or recovery service provider capacity for Michigan's Medicaid program. Conduct qualitative research to understand provider perspectives on SUD/OUD treatment or recovery service capacity. Integrate perspectives into inventory for gap analysis. Create an algorithm to determine the effect of various policy levers on SUD provider capacity.
Nevada	Provide baseline assessments and epidemiological data that are available on a county-by-county basis in one comprehensive document.
New Mexico	Integrate data from the needs assessment with previous needs assessments and state strategic plans to address OUD and SUD, while building infrastructure for ongoing assessment. Review recent state documents related to SUD strategic planning and needs assessments. Analyze baseline Medicaid utilization data. Create infrastructure for ongoing analysis and reporting of Medicaid utilization data to track workforce and network growth. Analyze Medicaid billing data for American Indian/Alaska Native providers. Summarize findings from focus groups and key informant interviews. Develop a dissemination strategy to inform stakeholders of baseline data and changes in data during the project.
Rhode Island	Assess service capacity gaps among Medicaid providers, including levels of care for substance use and co-occurring disorders, integration of substance use and mental health services, and geographic disparities in access to care. Assess the need for increased capacity across the American Society of Addiction Medicine levels of residential service. Assess factors affecting wait times for residential level of care and willingness of residential providers to provide care for SUD.
Virginia	Solicit input from enrollees, providers, and other stakeholders on assessment development and need through six regional "World Cafes." To determine need quantitatively, analyze Medicaid data alone and with Department of Corrections data. To determine capacity, analyze data from N-SSATS, the DEA list of DATA-waivered prescribers with Medicaid data, and peer support specialists using Medicaid behavioral health agency data. Determine gaps relative to prevalence, and use qualitative data to understand gaps.

State	Needs Assessment-Related Activities in Planning Grant Applications
Washington	Conduct initial quantitative and qualitative assessment activities to determine the state's mental health and SUD treatment or recovery support service needs for Medicaid beneficiaries. Survey providers and hold focus groups with stakeholders to examine capacity, qualifications, and willingness of Medicaid-enrolled providers to offer SUD treatment or recovery services, including all forms of MAT, across a continuum of settings. Determine gaps in Medicaid-covered SUD treatment or recovery services related to financial barriers. Identify perceived access to care barriers (e.g., transportation, geographic barriers).
West Virginia	Conduct a comprehensive and systematic needs assessment of SUD and mental health treatment in all regions of the state. Identify epidemiologists and data analysts for the SUD Needs Assessment Data Workgroup. Examine similar needs assessment reports to identify models and ensure best practices. Review past assessments of the state's behavioral health activities and workforce needs. Assess gaps and barriers in services, including behavioral and physical health integration, care transitions, care quality, and willingness of providers. Identify relevant workgroups and key contacts/collaborators in each region. Convene regional meetings to obtain community input.

Abbreviations: DATA, Drug Addiction Treatment Act; DEA, Drug Enforcement Administration; MAT, medication-assisted treatment; MOU, memorandum of understanding; N-SSATS, National Survey of Substance Abuse Treatment Services; OUD, opioid use disorder; SUD, substance use disorder.

Data enhancement. As part of the needs assessment process, states proposed to use an assortment of data and planned to assess or enhance their data capabilities. Fourteen states (all but West Virginia) specifically noted in their proposals the importance of having accurate and up-to-date T-MSIS data files. Some states, such as Delaware and Washington, also discussed accessing linked data from different sources. Delaware, for example, has a Drug Monitoring Initiative which established data sharing memoranda of understanding across state agencies. Other states, such as Alabama, planned to create a process of data sharing across state agencies to establish a statewide data repository related to the opioid crisis. Other Medicaid agencies anticipated accessing data from partner agencies, such as the Connecticut bed-tracking system administered by the state's Department of Mental Health and Addiction Services. States also proposed technological advances, such as development of a data dashboard (e.g., Indiana) or a treatment locator tool (e.g., Maine), as an infrastructure outgrowth of the needs assessment.

States recognized some of the data hurdles they likely would encounter in conducting their needs assessment. For instance, Illinois understood that it could not rely exclusively on fee-for-service claims data and would need to access encounter data from the state's managed care plans. Illinois also recognized that use of the SAMHSA list of buprenorphine providers would not identify all DATA-waivered providers, because the list contains only the names of those providers who wish to

be publicly identified. Indiana, as another example, recognized that it can be difficult to associate individual mid-level providers with service and claims delivery. Maine knew that obtaining accurate ethnicity data was difficult and planned to work with tribes in the state to better understand the SUD treatment or recovery service needs of that population. Rhode Island recognized that claims and encounter data do not capture those who are undiagnosed and not engaged in services.

5.1.2 Enhancing Medicaid SUD Provider Service Capacity and Access Across the Service Continuum

States identified activities to improve provider capacity both by provider type and by setting in the care continuum. Provider outreach and recruitment activities, as well as training and technical assistance to enhance provider qualifications were planned by all planning grant states. Many states also identified telehealth or other uses of technology to expand the availability of providers of SUD treatment or recovery services.

Provider outreach, recruitment, training, and technical assistance. Provider outreach and recruitment are a significant part of capacity-building activities by planning grant states. These activities include recruitment to enroll Medicaid providers, outreach to encourage enrolled providers to increase their provision of SUD treatment or recovery services to Medicaid enrollees, and training and technical assistance to ensure that Medicaid-enrolled providers are qualified to provide needed services. Because the activities proposed were extensive and varied, examples are used to provide an overview of different state approaches to planning grant activities. Exhibit 9 provides examples of recruitment activities from each state, including addressing barriers to capacity associated with provider attitudes toward patients with SUD, ensuring competency and capacity for serving target subpopulations, expanding the number of providers qualified to prescribe buprenorphine, ensuring that licensing or credentialing requirements do not impede capacity development, developing supports for providers to alleviate burden and increase capacity, marketing to recruit providers, and developing systems of care that support qualified capacity where needed.

Exhibit 9. State Planning Grant Activities Related to Recruitment of Qualified Providers for Medicaid SUD Treatment or Recovery Services

State	Recruitment-Related Activities in Planning Grant Applications
Alabama	Modify and expand existing approach for training physicians, physician assistants, registered nurses, and others regarding addiction treatment. Provide training for physicians to improve patient care by maintaining or improving knowledge, skills, and attitudes toward SUD.
Connecticut	Recruit and train providers with specialized expertise and competence in serving members of the identified Medicaid subpopulation groups. Collaborate with local agencies serving older adults to develop an implementation plan for training primary care physicians on recognizing SUD/OUD in the older adult population and on SBIRT. Expand training and technical assistance to inpatient psychiatric programs to improve screening, MAT induction on the inpatient unit, and warm transfer to continuing care. Plan for recruitment, credentialing, Medicaid reimbursement, and training of peer support providers to deliver SUD/OUD services.
Delaware	Provide training to attain DATA waiver. Increase the number of Medicaid providers participating in the Department of Substance Abuse and Mental Health learning collaboratives. Increase provider supports to meet needs of high-risk populations.
District of Columbia	Develop data-driven strategies to recruit prospective providers and design training and technical assistance activities to support those strategies. Include focus on provider workflow and perspectives in training and technical assistance activities.
Illinois	Provide technical assistance by (1) establishing networks connecting MAT providers of services to patients, (2) starting a fellowship program that includes weekend immersion training for practitioners followed by ongoing coaching and mentoring, and (3) coordinating other technical assistance opportunities available through support from SAMHSA, ASAM, and the Illinois Department of Public Health.
Indiana	Review sections of Indiana Administrative Code specific to SUD service delivery and provider monitoring, and develop recommendations for edits and enhancements to licensure and certification standards.
Kentucky	Assess scope of practice laws to expand role of nurse practitioners, including to prescribe MAT; identify key stakeholders to consider expanding scope of practice for nurse practitioners; and consider the potential for legislation to expand scope of practice. Recruit providers to provide complex services (particularly for targeted subpopulations), identify barriers to providing services, and examine potential to incentivize provision of certain services.
Maine	Use specialized workflow consultation to address lack of support to help primary care providers integrate SUD services. Review any licensing and MaineCare policy misalignment to address lack of cross-trained behavioral health providers. Address lack of information about provider capacity for referrals by evaluating options and piloting a real-time treatment locator.

State	Recruitment-Related Activities in Planning Grant Applications
Michigan	Capacity-building activities could include (1) implementing statewide recruitment efforts to develop/increase capacity for opioid treatment programs, SUD residential programs, buprenorphine prescribers, SUD counselors and therapists, and Opioid Health Home providers and (2) providing statewide technical assistance and training for the federal DATA waiver process, state SUD licensing and certification processes, and evidence-based practices for screening, assessment, and coordination.
Nevada	Expand eligible providers, increase current providers' provision of SUD services, develop a comprehensive MAT policy and Medicaid Service Manual chapter, provide services and staff training through Project ECHO (Extension for Community Healthcare Outcomes), advance an integrated care system, and expand the education and delivery program for pregnant women with OUD and their infants with neonatal abstinence syndrome.
New Mexico	Increase workforce capacity through (1) training on the use of ASAM criteria, SBIRT, MAT, and screening for withdrawal management; (2) individualized technical support to providers on licensing, certification, and billing expectations for Medicaid SUD services; (3) guidance documents to clarify pathways to licensure and certification for SUD treatment; (4) identification of a national certification process to be used for peer support workers; and (5) development of a marketing campaign to recruit new providers into the workforce.
Rhode Island	Investigate approaches to recruit SUD providers in rural areas and providers with cultural competency to reduce disparities. Increase willingness to deliver MAT, with a particular focus on addressing stigma, lack of confidence and training, and the need for on-site support staff among mid-level providers in primary care and emergency departments. Improve partnerships between managed care plans and providers.
Virginia	Identify at least one OBOT and health system per high-need community to develop linkages of care. In areas without an OBOT, provide technical assistance to health systems to establish an OBOT. Collaborate with selected OBOTs to identify support services, with a focus on meeting needs for pregnant/postpartum and justice-involved members, including through nontraditional methods such as telehealth or physician hotlines.
Washington	Identify and arrange for needed training and technical assistance, including training for DATA-waivered providers, community recovery support services, and use of naloxone. Remove barriers to training for prescribers and dispensers of MAT. Offset or eliminate training and licensing costs to providers, including chemical dependency professionals. Evaluate provider shortages in tribal areas.
West Virginia	Design a Center of Excellence for Substance Use Disorder model[a] capable of providing the recruitment, training, technical assistance, and practice transformation support necessary to create treatment programs that deliver care aligned with the evidence base and meet the needs of beneficiaries with SUD. Develop a planning group to identify what type of Center of Excellence would work best for the state.

Abbreviations: ASAM, American Society of Addiction Medicine; DATA, Drug Addiction Treatment Act; ECHO, Extension for Community Healthcare Outcomes; MAT, medication-assisted treatment; OBOT, office-based opioid treatment; OUD, opioid use disorder; SAMHSA, Substance Abuse and Mental Health Services Administration; SBIRT, Screening, Brief Intervention, and Referral to Treatment; SUD, substance use disorder.

[a] West Virginia's Center of Excellence for Substance Use Disorder model would be based on similar programs in Rhode Island (https://bhddh.ri.gov/substance-useaddiction/individual-and-family-information/help-opioid-dependence/centers-excellence) and Pennsylvania (https://www.dhs.pa.gov/about/Documents/Find%20COEs/c_291267.pdf).

Telehealth and technology. Use of telehealth and other technologies is key to many states' proposed approaches to increasing Medicaid SUD treatment and/or recovery service provider capacity. Exhibit 10 provides examples of how states proposed to integrate technology into their planning grant activities, including increased use of (1) telehealth or new applications of telehealth; (2) technology for practice supports such as consent management tools or patient engagement applications; (3) e-consulting (remote communication between patients and clinicians) or distance learning for training and technical assistance; and (4) health information exchanges.

Exhibit 10. State Planning Grant Capacity-Building Activities Related to Technology and Medicaid SUD Treatment or Recovery Services

State	Technology-Related Capacity-Building Activities in Planning Grant Applications
Alabama	Assess the number of telehealth providers and increase use of telehealth. Leverage telehealth technologies to include tele-psychiatry, OUD services, and community wrap-around services. Increase use of distance learning for training and technical assistance.
Connecticut	Work with partners on implementing targeted recruitment of telehealth providers of MAT services to meet the needs of counties with the highest member-to-provider ratios.
District of Columbia	Pilot the selection and implementation of e-consult and tele-MAT supports to assess ways providers can use these tools to transform practice. Develop and implement consent management tools to facilitate appropriate exchange of 42 CFR Part 2 information via the District's designated health information exchange.
Illinois	Expand technical assistance for prescribers through in-person and web-based platforms. Examine mechanisms that may allow the state to reimburse technology-based treatment or recovery support tools, because these tools can be critical in improving access to care in rural areas with few MAT providers.
Indiana	Engage state health information technology staff to consider SUD provider health information technology and health information exchange readiness as well as challenges for future electronic sharing and meaningful use of patient data by community providers.
Maine	Conduct provider telehealth readiness assessments. Provide licenses and technical assistance to support implementation of telehealth for MAT, behavioral counseling, and integrated care. Secure and operationalize a treatment locator.
Michigan	Provide training and technical assistance to rural communities on the use of telehealth for SUD treatment or recovery services.

State	Technology-Related Capacity-Building Activities in Planning Grant Applications
Nevada	Consider telehealth for patients requiring psychotherapy as part of behavioral health services.
Rhode Island	Integrate technology to improve quality of outcomes by providing agencies with specific telemedicine tools and an evidence-based patient engagement application to increase participation in treatment.
Virginia	Provide technical assistance on reimbursement for underutilized services such as telehealth and care coordination through virtual trainings provided via the Virginia Opioid Addiction Project ECHO (Extension for Community Healthcare Outcomes) to preferred OBOTs.
Washington	Collect information on the use of health information technology/health information exchange (including telehealth) to support coordination of and transitions in care (e.g., use of e-referrals, closed-loop referrals, creation and exchange of summary of care documents, e-care plans).
West Virginia	Expand infrastructure for telehealth, mobile apps, and other technological solutions. Expand scope of current Project ECHO tele-mentoring in the state. Investigate the feasibility of using phone-based apps to help overcome provider shortages.

Abbreviations: CFR, Code of Federal Regulations; ECHO, Extension for Community Healthcare Outcomes; MAT, medication-assisted treatment; OBOT, office-based opioid treatment; OUD, opioid use disorder; SUD, substance use disorder.

Note: Delaware, Kentucky, and New Mexico did not specifically mention any technology-related capacity-building activities in their applications.

5.1.3 Expanding Use of Best Practices, including MAT, for Medicaid SUD Treatment or Recovery Services

All states proposed activities aimed at increasing capacity for MAT. In addition, some states proposed activities that related to expanding use of other best practices as part of Medicaid SUD service delivery. Each state's proposed activities included provider training and technical assistance.

As noted earlier, the activities proposed to expand best practices were extensive and varied, examples are used to provide an overview of different state approaches to planning grant activities. Exhibit 11 summarizes state planning activities for incorporating best practices into the delivery of Medicaid SUD treatment or recovery services. Examples of approaches include developing cultural competence among providers; training in Screening, Brief Intervention, and Referral to Treatment (SBIRT); providing motivational interviewing and trauma-informed care; providing buprenorphine DATA waiver training to appropriate providers; working with medical schools and other institutions to enhance addiction training; using academic detailing and peer-to-peer learning; training providers

on the American Society of Addiction Medicine criteria; and training providers on working with individuals with polysubstance use or co-occurring mental health conditions.

Exhibit 11. State Planning Grant Activities Related to Use of Best Practices for Delivering Medicaid SUD Treatment or Recovery Services

State	Best Practice-Related Activities in Planning Grant Applications
Alabama	Modify an existing approach to training physicians, physician assistants, registered nurses, and others regarding SUD treatment, specifically including training on use of MAT and on SUD with co-occurring conditions. Develop cultural competence among providers. Address health disparities.
Connecticut	Develop core SUD treatment competencies. Develop content for SBIRT trainings. Continue expanding training and technical assistance to inpatient psychiatric programs to improve screening, MAT induction on the inpatient unit, and warm transfer to continuing care. Expand participation by current and potential SUD providers in Project ECHO (Extension for Community Healthcare Outcomes) and a peer learning collaborative focused on evidence-based practices for OUD treatment. Train providers on evidence-based SUD treatments, such as cognitive behavioral therapy, motivational enhancement therapy, and contingency management.
Delaware	Develop a series of technical assistance and education tools to support primary care providers, including buprenorphine DATA waiver training. Develop a series of technical assistance and education tools to support providers delivering SUD and OUD treatment or recovery services to high-risk populations, including pregnant women, postpartum women, infants, and adolescents and young adults.
District of Columbia	Provide education and support for best practice approaches to diagnose SUD and provide SUD treatment or recovery services among Medicaid beneficiaries with multiple chronic conditions. Provide in-depth, competency-based technical assistance for a cohort of 50–75 providers or provider entities. Convene up to 200 providers to share best practices locally. Extend SUD education to a broader array of Medicaid providers to improve provider education and awareness of SUD and reduce stigma associated with SUD diagnosis and treatment.
Illinois	Increase training for MAT providers. Create OUD/SUD materials to distribute to prescribers at regional training sessions. Create "MAT 101." Implement academic detailing that offers in-person trainings for prescribers to shadow veteran prescribers. Hold quarterly or semiannual site visits for protocol/tool review. Work with partners to offer DATA waiver trainings and open them to other providers, such as FQHCs.
Indiana	Based on needs assessment findings, build on existing initiatives, including (1) education and training to extend MAT services into non-SUD specialty settings—such as primary care, obstetrics/gynecology, and emergency medicine—as well as possibly to extend MAT for non-OUDs such as alcohol use disorder, and (2) adoption of evidence-based practices for assessment and service delivery such as motivational enhancement therapy-cognitive behavioral therapy and other SUD-related evidence-based practices.

State	Best Practice-Related Activities in Planning Grant Applications
Kentucky	Solicit the development of continuing education credits for providers in SUD treatment or recovery services in recognizing OUD in their patient populations. Examine willingness of the licensure board to offer extended continuing education credits for MAT training.
Maine	Develop criteria for training peer support providers. Increase access to SUD training for licensed clinical social workers and clinical professional counselors. Develop and implement training for DATA-waivered providers to incorporate MAT treatment via telehealth. Provide training and technical assistance through a consultation model that supports workflow improvements to support care transitions and care coordination and/or uptake of MAT within primary care settings.
Michigan	Based on assessment, develop a targeted strategic plan for all technical assistance and training activities necessary to increase overall and targeted provider supply. May include training initiatives related to the federal DATA waiver process; evidence-based practices for screening, assessment, and coordination; promotion of training in medical and other schools; Medicaid Graduate Medical Education program policy that encourages recipient institutions to increase SUD treatment or recovery capacity; and creation of learning collaboratives and networks to include a review of current evidence and research.
Nevada	Expand the number of providers trained in SBIRT. Develop a training toolkit for providers on SBIRT protocols, best practices, and recommended screening tools. Develop statewide training on provider care coordination. Disseminate provider toolkit to office-based practices. Provide training to providers on MAT and integrated care.
New Mexico	Provide training on the use of ASAM criteria, SBIRT, MAT, and screening for withdrawal management. Infuse training on culturally competent behavioral health care.
Rhode Island	Increase the number of providers willing to provide MAT by addressing stigma and providing training on OUD. Support providers with training and technical assistance. Address disparities in care and ensure SUD providers work toward compliance with Culturally and Linguistically Appropriate Services Standards. Expand provider capacity to provide trauma-informed/responsive care. Provide training to increase competency in treating tobacco use.

State	Best Practice-Related Activities in Planning Grant Applications
Virginia	Provide six buprenorphine DATA waiver trainings available to all providers, but with a focus on providers in specialty areas (emergency care, obstetrics/gynecology), nurse practitioners, and providers in areas of geographic need or other areas as determined by the needs assessment. Provide technical assistance to up to three free or charitable clinics and FQHCs to become OBOTs; start a pilot program for one to three FQHCs to receive technical assistance and training to become Preferred OBOTs.[a] Provide webinars on the provision of SUD treatment services to pregnant and postpartum members and to justice-involved members, including on providing HIV and hepatitis C treatment to people who currently use substances or have a history of substance use. Develop SBIRT and harm reduction training curriculum geared toward Medicaid providers, including nontraditional SUD providers. Provide technical assistance and training on MAT and peer recovery support services. Develop training to support physicians' treatment of individuals with co-occurring mental health diagnoses.
Washington	Determine training/technical assistance needs for removing/reducing barriers for SUD treatment or recovery service providers, including training requirements for MAT practitioners (prescribers and dispensers). Based on assessment results, identify and arrange for the provision of needed training and technical assistance (including training for DATA-waivered providers, community recovery support services, and use of naloxone). Remove barriers to training for prescribers and dispensers of MAT. Offset/eliminate training and licensing costs to providers, including chemical dependency professionals.
West Virginia	Provide training and technical assistance to identified treatment providers on buprenorphine DATA waivers, patient engagement, polysubstance use, patients aged 12–21 years, and rural patients with co-occurring SUD and mental health diagnoses.

Abbreviations: ASAM, American Society of Addiction Medicine; DATA, Drug Addiction Treatment Act; ECHO, Extension for Community Healthcare Outcomes; FQHC, Federally Qualified Health Center; HIV, human immunodeficiency virus; MAT, medication-assisted treatment; OBOT, office-based opioid treatment; OUD, opioid use disorder; SBIRT, Screening, Brief Intervention, and Referral to Treatment; SUD, substance use disorder.

[a] The Preferred OBOT model is described here: Virginia Medicaid Addiction and Recovery Treatment Services. *Model Requirements for Providers*. https://www.dmas.virginia.gov/media/3140/how-to-become-a-preferred-obot.pdf

In addition to expanding the use of best practices as described above, states also planned to improve state oversight of providers and provide training on organizational best practices such as including training in practice transformation (District of Columbia and Washington State), use of quality assurance activities (Indiana), workflow improvements (Maine), billing practices (Michigan, New Mexico, and Rhode Island), licensing or certification requirements (New Mexico), determination of medical necessity (Rhode Island), measurement-based care (Rhode Island), and patient engagement (Rhode Island).

5.1.4 Enhancing Integrated and Coordinated Care Capacity as Part of Medicaid SUD Service Delivery

All states proposed activities for enhancing integrated and/or coordinated care as part of SUD treatment or recovery service delivery under their Medicaid programs. Exhibit 12 provides brief descriptions of examples of some of the planned activities. Because activities proposed to enhance integrated and coordinated care capacity were extensive and varied, examples are used to provide an overview of different state approaches to those activities. These activities include assessing capacity to provide coordinated care for different provider types, working with managed care plans to enhance care coordination, developing targeted interventions, supporting quality improvement initiatives, providing technical assistance, and developing reimbursement approaches designed to enhance care coordination.

Exhibit 12. State Planning Grant Activities Related to Provision of Integrated and/or Coordinated Care Approaches for Medicaid SUD Treatment or Recovery Services

State	Care Coordination-Related Activities in Planning Grant Applications
Alabama	Identify a process for seamless care coordination, including addressing the silos of care that exist for pregnant and parenting women.
Connecticut	Assess the degree of primary care and behavioral health integration across three programs (Enhanced Care Clinics, Person-Centered Medical Homes, and Person-Centered Medical Home Plus) to inform the development of a value-based payment model for fully integrated SUD services.
Delaware	As part of workforce assessment, assess the capacity for care coordination across system providers, including primary care, mental health, and SUD treatment or recovery providers. Inventory opportunities to increase care coordination.
District of Columbia	Through the needs assessment, address questions about the level and amount of coordination between primary care, mental health, and SUD providers to care for Medicaid-eligible individuals and what kind of coordination is required between programs and providers in the case of dually eligible beneficiaries with SUD.
Illinois	Using data and a survey, examine the integration of behavioral and physical health service delivery at Illinois FQHCs. Determine whether FQHCs can provide a continuum of care through on-site services and linkages that reflect a recovery-oriented system of care.
Indiana	Undertake a comprehensive assessment of care coordination capacity between primary care, obstetrics/gynecology, mental health, and SUD treatment or recovery providers.

State	Care Coordination-Related Activities in Planning Grant Applications
Kentucky	Survey Medicaid-enrolled providers to ascertain capacity to coordinate care; the number coordinating care between primary care, mental health, and SUD treatment providers; barriers and facilitators to care coordination; and willingness to engage in care coordination and/or colocation of services. Use the results to develop proposals for collaborative targeted interventions for the target populations.
Maine	Measure current status and capacity for care coordination across providers (including for those recently released from incarceration). Query beneficiaries and family members on their experiences with fragmented and/or coordinated care.
Michigan	Assess care coordination activities through data analysis and provider surveys and examine whether an integration program has an impact on care coordination. Analyze currently reimbursable codes for care coordination and compare with provider survey data. In the provider surveys, focus on current perspectives of care coordination (including perceived barriers) in addition to capacity to support coordinated care.
Nevada	Assess the level and amount of coordination by reviewing all assessments completed in the past 5 years. Obtain information on coordination using the complete statewide strategic plan, gap assessment, and needs assessment. Develop a statewide training presentation on provider care coordination.
New Mexico	Conduct provider focus groups and key informant interviews to understand capacity and barriers to providing coordinated care for Medicaid recipients. Analyze the extent of monthly utilization of primary care and SUD treatment or recovery services for each individual with SUD to guide the development of quality improvement initiatives to increase coordination among provider types.
Rhode Island	Promote better integration of care using a more complex organizational structure to be sure that all public units are effectively communicating with the various service providers. Work with providers to ensure effective transition of care exchange among all members of a patient's care team.
Virginia	Survey providers regarding successes and challenges with care coordination, including billing for care coordination under Medicaid. Assess "brightspot" communities for insights into effective interventions around care coordination. Provide technical assistance on reimbursement for underutilized services such as care coordination. Analyze potential reimbursement models that incentivize care coordination at OBOTs.
Washington	Leverage Healthcare Effectiveness Data and Information Set measures to compare the quality of physical health care for people with SUD, mental disorders, and comorbid disorders—conditions that may require significant care coordination by providers--relative to people without those conditions.
West Virginia	Work with the managed care plans to monitor and devise strategies to improve care coordination. Develop plans to expand training and practice facilitation resources to implement better coordinated models and improve care coordination. Provide training in the Collaborative Care Model to strengthen coordination and to support primary care providers to address behavioral health issues.

Abbreviations: FQHC, Federally Qualified Health Center; MAT, medication-assisted treatment; OBOT, office-based opioid treatment; SUD, substance use disorder.

5.1.5 Improving or Reforming Payment/Reimbursement Approaches for Medicaid SUD Service Delivery

All states included some aspect of payment reform or improvement within the Medicaid program. Relevant activities included plans to conduct an inventory of current Medicaid payment methodologies and rates, prior authorization requirements, administrative barriers to provider reimbursement, and limits on the amount, duration, and scope of SUD services, as well as an assessment of the potential impact of these factors on provider capacity. Exhibit 13 summarizes some other state-planned reimbursement-related activities, such as planning for payment reform designed to expand Medicaid provider capacity to deliver SUD treatment or recovery services; working with stakeholders to assess perceptions related to reimbursement and obtain input on planning; training providers on billing, reimbursement, or payment approaches; analyzing billing and reimbursement issues within Medicaid managed care; and revising regulations or policies related to reimbursement. Examples of different state approaches to those activities are listed below.

Exhibit 13. State Planning Grant Activities to Improve or Reform Payment/Reimbursement Approaches for Medicaid SUD Treatment or Recovery Services

State	Reimbursement-Related Activities in Planning Grant Applications
Alabama	Compare Medicaid rates to private/commercial rates, and compare reimbursement process for Medicaid with that of other insurance. Assess denials due to prior authorization and enrollment caps.
Connecticut	Assess feasibility of payment reform. Conduct provider education on payment reform via learning sessions, and integrate stakeholder input. Conduct modeling for developing value-based provider reimbursement.
Delaware	Complete an inventory of credentialing and incentive programs aimed at increasing provider willingness to provide MAT to Medicaid beneficiaries. Present proposed changes to payment methodologies to stakeholders for feedback. Update the Medicaid reimbursement manual for OUD and other SUD treatment or recovery services. Develop a dissemination and education plan aimed at educating and training providers in the updated reimbursement manual.
District of Columbia	Use needs assessment findings to consider payment redesign options to increase and sustain provider capacity to address SUD. Consider the estimated impact of implementing potential value-based payment arrangements to enhance reimbursement and accountability for care.

State	Reimbursement-Related Activities in Planning Grant Applications
Illinois	Conduct an analysis of Medicaid managed care plan billing and reimbursement issues, including an examination of alternative payment systems. Determine financial practices that support the use of appropriate levels of care. Conduct a feasibility study of different approaches to types of payments for both initiation and maintenance of OBOT. Examine mechanisms that allow for the reimbursement of technology-based treatment or recovery support tools.
Indiana	Review and map reimbursement methodologies for SUD providers across programs. Assess potential reimbursement methodologies to expand capacity.
Kentucky	Survey providers to understand attitudes around reimbursement strategies used by the Cabinet for Health and Family Services. Ascertain the potential for changes to reimbursement schemes for providers. Research other state reimbursement models to assess potential reimbursement methodologies that could expand Medicaid provider capacity. Understand where gaps in reimbursement for needed services exist for the targeted population.
Maine	Assess potential reimbursement methodologies to expand Medicaid provider capacity. Conduct a rate study for fee-for-service rate adjustments for SUD residential treatment facilities. Consider alternative payment models to support MAT. Include meaningful stakeholder engagement, such as listening sessions with consumers on cost sharing.
Michigan	Conduct a provider survey to assess perceptions of reimbursement. Assess potential reimbursement methodologies to expand SUD provider capacity. Use the information gained to pursue reimbursement policy initiatives to increase access to and quality of Medicaid SUD treatment or recovery services.
Nevada	Develop an alternative payment methodology for MAT services to overcome barriers in the current payment system. Develop options and cost models for each. Modify prior authorization to streamline treatment. Enhance reimbursement for telemedicine services. Address coding issues and other barriers to reimbursement.
New Mexico	Conduct provider focus groups to determine financial and regulatory barriers to providing Medicaid-funded services. Review reimbursement methodologies and identify benchmark reimbursement rates through comparison with other rates. Conduct fiscal impact analysis of expected costs of rate increases. Draft regulatory changes and guidance needed to implement pilot value-based purchasing model for alternative payment mechanism.
Rhode Island	Assess rates and how to support substance use providers' technological (e.g., to improve data quality from providers) and technical (e.g., use of evidence-based practices) capabilities. Carry out assessments of alternative payment methodologies and sustainability strategies.
Virginia	Analyze potential reimbursement models that incentivize care coordination for subpopulations served in OBOTs. Create a budget proposal if modifications to current rates are necessary. Analyze the feasibility and cost-effectiveness of a value-based payment model. Provide incentive payments to providers to encourage buprenorphine prescribing, with greater payments for providers in practices of greater needs.

State	Reimbursement-Related Activities in Planning Grant Applications
Washington	Review best practices and existing alternative payment models to assess existing SUD payment models—including review of alternative payment models nationally, definition of bundle scope, and identification of performance metrics and evidence-based approaches to be implemented under the bundle—and recommend benefit design. Use provider survey and focus groups to determine the anticipated impact of implementing bundled payments and actions needed to support statewide implementation of SUD bundled payments.
West Virginia	Incentivize an increase in the quantity of providers and quality of evidence-based practices, with a focus on the target populations. Review practices in other states that might serve as models for implementation. Review and prepare for more widespread use of bundled rates or proven models of care, in coordination with West Virginia's managed care organizations. Consider the possibility of differential payment for high-quality programs.

Abbreviations: MAT, medication-assisted treatment; OBOT, office-based opioid treatment; OUD, opioid use disorder; SUD, substance use disorder.

5.2 Collaboration in Planning Grant Development

The planning grant states prepared for grant application and implementation in a variety of ways. All states, to some extent, leveraged existing state data and institutional knowledge to shape their planned grant activities. Some states identified opportunities for shared goal accomplishment with other state programs, such as existing Medicaid waivers/demonstrations, university partnerships, or interagency partnerships that could be pursued to further their section 1003 activities. The types of planning activities included (1) research (e.g., review of existing research in the state, research on other states' approaches to capacity expansion or reimbursement, research on workforce recruitment/retention strategies, new analysis to inform the application); (2) collaboration to identify needs (e.g., creation of working groups, solicitation of provider feedback); (3) plans for data sharing across agencies; (4) consideration of reimbursement approaches (e.g., alternative payment approaches, possible Medicaid plan amendments); (5) market research on technological approaches; and (6) creation of a team to conduct the planning grant activities (Exhibit 14). States also identified other expected partners and opportunities. All states identified a contact in the state Medicaid agency for tribal consultation as required by the section 1003 demonstration NOFO.

Exhibit 14. Examples of Collaboration in Development of Section 1003 Planning Grants

State	Collaboration Examples in Planning Grant Applications
Alabama	The Alabama Medicaid Agency and the Department of Mental Health worked to conduct research and develop insights into the state's health climate to identify needs and the ability of the state to meet them. The state also identified opportunities for creating a central data repository for collaboration with the Alabama Department of Economic and Community Affairs, other state agencies, and community organizations.
Connecticut	In Connecticut, the Department of Social Services collaborated with the Department of Mental Health and Addiction Services and the Department of Children and Families to form the core state team. The Department of Social Services also relied on the multiagency Connecticut Behavioral Health Partnership to begin prevalence estimates of SUD within the Medicaid population, ahead of the required needs assessment.
Delaware	In Delaware, the Division of Medicaid and Medical Assistance and the Division of Substance Abuse and Mental Health collaborated to develop the proposed grant activities based on known infrastructure gaps and challenges. They reviewed value-based payment options to gauge how they might be extended to subcontractors through managed care plans and researched successful state examples on increasing the number of DATA-waivered buprenorphine providers and performance incentives.
District of Columbia	The District of Columbia collaborated with existing programs tasked with combating the opioid crisis, such as the District's Opioid Response Program and section 1115(a) demonstration, to identify gaps the planning grant could address.
Illinois	The Illinois Department of Healthcare and Family Services and the Department of Human Services Division of Substance Use Prevention and Recovery jointly conducted a survey of all DATA-waivered providers in Illinois during January through March 2018 to develop an accurate list of DATA-waivered buprenorphine providers through a survey. This information allowed the state to better direct capacity-building projects to increase access to MAT.
Indiana	The Indiana Office of Medicaid Policy and Planning and the Indiana Department of Mental Health and Addiction form the core team for the planning grant. Both are part of the same umbrella agency: the Indiana Family and Social Services Administration. The two departments work together to leverage initiatives to inform Medicaid policy.
Kentucky	Kentucky has been actively working across state agencies to expand the data-sharing capacity of the Department for Medicaid Services, within the department and across cabinets.
Maine	Maine planned grant implementation activities to complement other programs with similar goals. The Office of MaineCare Services and the Maine Health Data Organization previously partnered to develop analytic capacity in the state, which is used to underpin grant activities and further refine the state's needs assessment parameters.

State	Collaboration Examples in Planning Grant Applications
Michigan	Michigan used recent reports and assessments produced by the Michigan Department of Health and Human Services, the University of Michigan, public sector consultants, the Center for Health & Research Transformation, the Michigan Health Endowment Fund, and Altarum to develop a baseline understanding of provider capacity and willingness, thereby shaping planned grant activities.
Nevada	Nevada collaborated with the Nevada Primary Care Association and Nevada's Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative to engage in preplanning activities with representative stakeholder groups. This collaboration was foundational in identifying the most pressing challenges and relevant planning grant activities.
New Mexico	New Mexico collaborated with the New Mexico Behavioral Health Providers Association to research alternative payment methods for Medicaid services, which it planned to explore further over the course of the grant period.
Rhode Island	Rhode Island developed plans to solicit feedback from partner state agencies, such as the Rhode Island Department of Health; the Department of Children, Youth, and Families; and the Department of Corrections. The state also developed plans to ensure alignment and parity in interactions between Medicaid and commercial insurers with providers. Rhode Island gathered results from existing needs assessments performed by other state agencies to inform the initial needs assessment to be conducted under the grant, as well as workforce recruitment/retention strategies.
Virginia	The Department of Medical Assistance Services and the Department of Criminal Justice Services developed a plan to use a data-sharing agreement to link newly released Medicaid-eligible individuals to SUD treatment services.
Washington	The state, in partnership with Department of Health and the Department of Social and Health Services, has designed and implemented the Healthier Washington plan. One goal of this plan is to incentivize whole person care through the integration of physical and behavioral health under Medicaid managed care.
West Virginia	West Virginia worked with local managed care plans to develop plans to improve training and resourcing for the effort. The state created a Telehealth Working Group intended to identify and eliminate barriers to accessing telehealth services in the state. The group's findings were used to develop planned grant activities.

Abbreviations: DATA, Drug Addiction Treatment Act; MAT, medication-assisted treatment; OUD, opioid use disorder; SUD, substance use disorder.

5.3 Status of Planned Activities Initiated by Planning Grant States

Previous sections of this report described information about proposed activities provided in states' planning grant applications; this section addresses the status of activities that states initiated. Because this report is focused on information available during the first 13 months of the planning period, many activities are ongoing. States completed some of their proposed activities by the end of October 2020, but some activities were delayed, often because of the COVID-19 pandemic, or

could not be initiated. States' abilities to begin some activities depended on the findings of the needs assessments, which were still ongoing as of October 2020. Specific challenges and facilitators of activities are addressed separately, as are unplanned activities initiated during the planning period.

5.3.1 Status of Proposed Activities That Were Initiated

Stakeholder engagement progress. Planning grant states reported initiation of activities involving stakeholders as they had originally planned in their grant applications. The examples listed below include completed activities and activities that are currently in progress.

- The District of Columbia awarded a grant to the Chesapeake Regional Information System to develop a consent management solution to support health information exchange.
- Illinois collaborated with the Cook County Health Department and Southern Illinois Healthcare in preparing for and conducting its needs assessment.
- Maine developed an advisory committee that provides feedback on grant activities, ensures there is no duplication of effort, and oversees the needs assessment. As a result of committee activities, the state met with five recognized tribes and planned to explore developing a data sharing agreement.
- Michigan interviewed all 10 of its regional prepaid inpatient health plans, developed a plan to prioritize possible reimbursement changes, and brought top priorities to its actuarial team. Michigan also engaged a clinical consultant to convene a workgroup with the Department of Corrections to address the need for care coordination for people exiting incarceration.
- New Mexico convened all grant subrecipients to ensure everyone was operating from the same information and was aware of the scope of grant activities.
- The Rhode Island Medicaid Agency is working with the state commission on insurance rates to facilitate public conversations with the legislature and relevant community organizations.
- The Virginia Department of Medical Assistance is working with the Department of Behavioral Health and Developmental Services, the Department of Health, the Department of Social Services, and the Department of Corrections to identify areas of overlap and to determine whether grant activities could support the work of other agencies to advance SUD treatment.

- Washington partnered with Oregon Health & Science University to work on a medical effectiveness review of nonpharmacological innovations for SUD.
- West Virginia collaborated with a variety of stakeholder partners, including a telehealth workgroup, Chess Health Connections, both Pennsylvania's and Rhode Island's Centers of Excellence, Maternal Opioid Misuse project directors, and university partners, to solicit subject matter expert feedback on grant activities.

Needs assessment progress. The needs assessment is a foundational component of planning grant states' activities, as other activities proposed as part of the demonstration often depend on the assessment findings. Some states, for example, Indiana, focused most of their proposed planning period efforts on extensive needs assessment activities, with the assessment explicitly intended to inform action plan development and guide future work.

In their planning grant applications, states provided an array of information on existing needs assessments, such as prevalence of SUD or OUD specifically, capacity for certain types of services, and, occasionally, known or suspected gaps between need and capacity. The planning grant applications illustrate how states began the planning period with varying levels of knowledge about existing gaps in Medicaid SUD treatment or recovery service provider capacity. States provided information on overdose rates and, sometimes, limited SUD or OUD prevalence data for some parts of their populations in their applications. As states worked on their needs assessments and reported quarterly data, they moved closer to determining the prevalence of SUD and OUD among enrollees, based on diagnoses in Medicaid claims or encounter data.

State planning grant applications also revealed perceived reasons for gaps based on earlier information. For example, states were aware that residents do not receive services for reasons including provider reluctance to accept Medicaid patients; geographic mismatch; lack of transportation; shortages of certain types of facilities, such as withdrawal management and residential treatment; or shortages of eligible providers of MAT. States often came into the process aware that many capacity problems are most pronounced in rural areas.

By the end of October 2020, the planning grant states could preliminarily identify additional gaps or confirm suspected gaps based on the ongoing needs assessments. These included gaps by subpopulation, such as adolescents; pregnant and parenting individuals, as well as their children in need of early intervention; and individuals involved in the criminal justice system. Racial

disparities in receipt of services also were noted, specifically a disproportionate lack of receipt of opioid treatment program services by African American individuals in one state and a lack of services generally for the American Indian/Alaska Native population in several states. Gaps also appeared to be common in the provision of treatment for non-OUD SUD and for individuals with co-occurring mental or physical health conditions.

Other initial planning period activities. States reported other planning grant activities that were underway as of October 2020. Exhibit 15 highlights some of these activities, including data infrastructure efforts, development and provision of training, development of provider locator tools, reimbursement-related activities, and activities focused on use of telehealth.

Exhibit 15. Selected Planning Grant Activities in Addition to Needs Assessment and Stakeholder Engagement

State	Other Planning Grant Activities Underway
Alabama	Established a data repository. Began development of a learning management system and e-learning modules. Approved telehealth codes for provider billing.
Connecticut	Began development of core competency standards that align with guidelines for level-of-care certification and include cultural competency. Began work on obstetrician pay-for-performance initiative revisions. Began work to identify and propose predictive modeling for alternative payment models, value-based payment methodologies, outcome measures, sustainability, and funding sources available for treatment or recovery services.
Delaware	Began or completed inventories of peer-to-peer technical assistance models, SUD care coordination models, Medicaid payment methodologies, and MAT prescriber incentive models.
District of Columbia	Awarded a contract for Medicaid provider SUD education and technical assistance, including tele-consult peer support for providers. Developed integrated care practice transformation assessment tools using a team-based core competencies framework. Began to identify providers to target for outreach. Held meetings with partners to ensure alignment with health information technology and health information exchange connectivity as well as opioid technical assistance efforts.
Illinois	Began updating a database of MAT providers in the Healthy Southern Illinois Delta Network Substance Misuse Resource Guide and website. Began work to update the Illinois Helpline for Opioids and Other Substances. Implemented an addiction medicine training curriculum for all family medicine residents at Cook County Health. Creating OUD and SUD materials to distribute to regional prescribers.
Indiana	Working on infrastructure development and dashboard development to support needs assessment and future impact evaluation. Working with the steering committee to identify promising practices in care delivery for both providers and beneficiaries that may be continued after the public health emergency.
Kentucky	Began identifying alternative payment models for use in the demonstration. Began assessing eligibility criteria for the pregnant population. Exploring efforts other states are undertaking to extend care for women eligible for Medicaid because of pregnancy.

Maine	Developing a shared data agreement with the five tribal health directors. Creating an inventory of current policies and procedures that may limit number, duration, or scope of SUD treatment or recovery services. Posted a request for proposals for a treatment locator tool and developed the database to support the tool. Reviewing reimbursement alternatives for SUD treatment or recovery services.
Michigan	Interviewed prepaid inpatient health plans about payment rates. Began exploring cross-system beneficiary management with state courts.
Nevada	Examined the state's hub-and-spoke model, including gathering data on best practices and identifying opportunities for expansion. Reviewed requirements for provider certification and licensing to enroll in multiple categories as medical providers who can also provide SUD treatment or recovery services. Analyzed and began conducting fiscal assessment of Patient-Centered Opioid Addiction Treatment (P-COAT) model for reimbursement.
New Mexico	Conducting trainings on SBIRT; Comprehensive Community Support Services for SUD; ASAM standards; and licensed alcohol and drug abuse counselors. Conducting cost analysis of peer support workers, contingency management, and a pilot related to services for those aged 0–5 years. Completed automating the certification process. Conducted six live webinars statewide on the following topics: ASAM Assessment for Treatment Planning and Placement In-Service; Community Crisis Services; Screening: The Window into Evidence Based Practice; Interdisciplinary Teaming; Ambulatory Withdrawal Management; and Peer Support for Substance Use Disorders.
Rhode Island	Conducted telemedicine training for providers. Began Career Pathways and Mentorship Program. Working to expand reach of Mirah software, which allows patients to self-report symptoms and tracks treatment progress. Created a learning module about MAT targeted to peer recovery coaches.
Virginia	Identifying existing OBOT providers and hospital systems to develop linkages of care for their communities. Conducting an environmental scan of Department of Corrections and local jails to determine current infrastructure and technical assistance needs to facilitate Reentry Pilot. Providing technical assistance to SUD providers to assist with requirements of the SUPPORT Act and Medicaid to assess and refer members with SUD to MAT.
Washington	Conducted an alternative payment model environmental scan of existing alternative provider models. Held individual conversations with four of the five managed care plans to gain increased buy-in regarding the current landscape of risk-based arrangements. Began exploring the feasibility of implementing a Health Home Model focusing on people with SUD who are likely receiving services in opioid treatment programs.
West Virginia	Made progress toward implementing and adopting mobile technology. Began updating telehealth policies. Preparing to provide MAT DATA waiver training, with an emphasis on adolescents and transition-aged youth, and training related to treatment of pregnant and postpartum women and their infants. Identified sites for Project ECHO (Extension for Community Healthcare Outcomes) expansion. Collaborated with other state offices to develop a county-level database on SUD or mental health programs and services.

Abbreviations: ASAM, American Society of Addiction Medicine; DATA, Drug Addiction Treatment Act; ECHO, Extension for Community Healthcare Outcomes; MAT, medication-assisted treatment; OBOT, office-based opioid treatment; OUD, opioid use disorder; P-COAT, Patient-Centered Opioid Addiction Treatment; SUD, substance use disorder; SUPPORT, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment.

5.4 Additional Activities Initiated Beyond Those in the Applications

In addition to conducting activities identified in the planning grant applications, states also shifted their approaches to planned activities. Some of this adjustment of activities was a natural progression based on discoveries made during the provider needs assessment. Many changes, however, were made in response to the COVID-19 pandemic, which often interfered with initial plans.

5.4.1 Adjustments Reflecting Discoveries During the State Needs Assessment

Discoveries by states as part of their initial needs assessments began to inform later activities during the planning period. Examples include the following:

- Alabama established a partnership with the League of Municipalities to better facilitate town hall meetings and focus groups with city councils throughout the state.
- Connecticut considered how it might address racial disparities, homelessness, and high rates of co-occurring human immunodeficiency virus (HIV) among the population in need of substance use services found in an assessment by the Connecticut Behavioral Health Partnership. Connecticut also reported that it wished to add the criminal justice-involved population as a targeted subpopulation.
- Based on preliminary needs assessment findings, Indiana began activities to support enrollment of mid-level providers (e.g., nurse practitioners, physician assistants) as Medicaid providers.
- Michigan and Washington added needs analysis activities focused on the criminal justice-involved population.
- Nevada sought to address staffing issues and to work on implementation of the state's planned value-based payment model.
- Rhode Island added a technical assistance opportunity for providers to help address patients' social determinants of health.
- Washington developed a COVID-19 Behavioral Health Group consisting of the Department of Health and the Washington Health Care Authority Analytics division. The group produces weekly behavioral health impact situational reports.

5.4.2 Adjustments in Response to the COVID-19 Pandemic

The most frequently reported disrupter of states' initial proposed activities was the COVID-19 pandemic, which affected much of the United States by spring 2020. States almost universally depicted COVID-19 as a challenge, but some also noted specific hurdles encountered and the resulting adjustments made. For example, Virginia reported that 2,000 individuals were eligible for early release from incarceration due to the pandemic, which diverted some attention to ensuring that programs were ready to connect these individuals to behavioral health services.

More commonly, states reported that planned data collection or training activities were delayed or otherwise altered because of the pandemic. Among the data collection changes were moving from in-person to online focus groups for beneficiaries in Alabama and the addition of a supplemental member and provider telehealth survey that was not originally planned in Connecticut. Michigan developed new data collection protocols, adding questions for beneficiary interviews that focused on how their health care needs, providers, medications, or encountered barriers had changed as a result of COVID-19. One training-related change involved the purchase of new equipment in New Mexico to provide planned provider trainings remotely.

Relatedly, many states reported in their planning grant applications that they expected to focus on telehealth, but as reflected in states' quarterly reports, the COVID-19 pandemic accelerated plans to expand telehealth services. Maine, for example, included enhanced telehealth capabilities as an objective in its planning grant application, with activities planned to assess provider willingness and capacity to use telehealth and then, based on assessments, provide software licenses and technical assistance to support telehealth implementation. By spring 2020, however, the state reported that COVID-19 had forced an early shift in that direction. Maine pivoted, based on the readiness assessment and provider input, and developed a revised training plan and technical assistance curriculum on offering telehealth services for SUD, because providers had already secured software licenses. Maine also promulgated emergency rules permitting the implementation of telehealth changes to align with updated federal laws and policies. The pandemic also resulted in more assessment activities focused on understanding telehealth needs and barriers. For instance, Connecticut Medicaid fielded a supplemental survey to gauge provider and member satisfaction with, barriers to, and utilization of telehealth SUD services. Other states noted that the pandemic disrupted SUD-related services that could not be performed through telehealth. For example,

Virginia reported disruptions in access to alternative pain management services, such as physical therapy.

Four states (Delaware, Indiana, Kentucky, and New Mexico) initially had not included telehealth development as part of their planning grant applications, yet by summer 2020, all had reported some related activity in response to the pandemic. For example:

- Delaware had plans to purchase Zoom licenses for providers and to create a financial sustainability program for use of telehealth.
- Indiana was implementing temporary policy changes and expanding telehealth services significantly.
- Kentucky was planning to analyze data to determine the impact of telehealth on subpopulations and providers.
- New Mexico had implemented billing codes for telehealth and telephone service delivery, and provider focus groups were indicating favorable responses.

5.5 State Subpopulations of Focus and Related Planning Grant Activities

This section discusses subpopulations that states identified as points of focus for their planning grants and their initial activities under the planning grants related to those subpopulations.

5.5.1 Statutory and Notice of Funding Opportunity Provisions Regarding Subpopulations

Section 1003 of the SUPPORT Act did not require the planning grant states to undertake activities focused on specific subpopulations of Medicaid enrollees. It did, however, encourage states to address in their planning grant applications the extent to which any proposed activities were focused on subpopulations identified in the statute as well as others. The section 1003 demonstration NOFO stated that applicants were encouraged to consider the SUD treatment and recovery needs of the following Medicaid subpopulations in their assessments: pregnant women, postpartum women, infants (including those with neonatal abstinence syndrome), adolescents and young adults between the ages of 12 and 21 years, American Indian/Alaska Native individuals, people living in rural areas, individuals with dual eligibility for Medicare and Medicaid, and other populations of specific interest to their states.[44]

The NOFO also encouraged applicants to provide information on the prevalence of SUD among the Medicaid subpopulations listed above and the prevalence of neonatal abstinence syndrome.[45] Further, it stated that applicants should provide information on the extent to which any proposed

activities are focused on the Medicaid subpopulations described in section 1003 and on providers qualified to address their needs.[46]

5.5.2 State Identification of Subpopulations of Focus for Planning Grants

Exhibit 16 indicates the initial populations of focus in the planning grant states' applications. Some states were more explicit than others in identifying populations of focus in their applications. Every state planned to focus on pregnant and/or postpartum women and infants with neonatal opioid exposure. One state (Kentucky) aimed to focus its entire demonstration on this population. Many states also explicitly focused on youth and young adults and on rural populations, whereas fewer planned to target American Indian/Alaska Native individuals or those dually eligible for Medicare and Medicaid. Among the diverse other populations that states identified, the most frequently noted in initial applications were incarcerated or justice-involved individuals and individuals with co-occurring mental disorders. Notes included in Exhibit 16 indicate additional state-specific populations targeted in the applications.

Exhibit 16. Section 1003 Planning Grant Application Subpopulations of Focus

State	Pregnant/ Postpartum/ NAS/NOWS	Youth and Young Adults	American Indian/ Alaska Native[a]	Rural Populations	Dually Eligible	Other[b]
Alabama	✓	✓	—	✓	—	—
Connecticut	✓	✓	✓	✓	✓	✓
Delaware	✓	✓	—	—	—	—
DC	—	—	—	—	✓	—
Illinois	✓	—	—	✓	—	—
Indiana	✓	✓	—	—	✓	—
Kentucky	✓	—	—	—	—	—
Maine	✓	✓	✓	✓	—	✓
Michigan	✓	✓	✓	✓	✓	—
Nevada	✓	✓	—	—	—	—
New Mexico	✓	✓	✓	—	—	✓
Rhode Island	✓	✓	—	—	✓	✓
Virginia	✓	—	—	—	—	✓
Washington	✓	✓	—	—	—	✓

State	Pregnant/ Postpartum/ NAS/NOWS	Youth and Young Adults	American Indian/ Alaska Native[a]	Rural Populations	Dually Eligible	Other[b]
West Virginia	✓	✓	—	✓	—	—
Total	14	11	4	6	5	6

Abbreviations: NAS, neonatal abstinence syndrome; NOWS, neonatal opioid withdrawal syndrome.

[a] Applicants were required to include a description of their plans for conducting tribal consultation in their application. Simply having an individual designated for tribal consultation was not considered sufficient to indicate the state identified the American Indian/Alaska Native population as one of focus.

[b] Other populations identified in planning grant applications: CT: older adults, individuals diagnosed with human immunodeficiency virus (HIV), and high-need, high-cost individuals; DC: individuals with co-occurring mental disorders and individuals with comorbid physical health conditions participating in Health Homes; ME: incarcerated/criminal justice involved; NM: incarcerated/criminal justice involved; RI: Medicaid members with co-occurring mental and substance use disorders and criminal justice involved; VA: incarcerated/criminal justice involved; WA: people who use syringe service programs.

Some states, such as Delaware, clearly defined one or more limited subpopulations and adhered to those original groups throughout the formal quarterly reporting process as they conducted their needs assessment. However, other states' targeted subpopulations evolved over the course of the planning period. Maine removed pregnant and postpartum women as a target population after the state received a Maternal Opioid Misuse award from CMS. Other states, such as Nevada, defined limited subpopulations but, once presented with a template for their quarterly progress reports, chose to provide data on all groups identified in the template as potential targets for their needs assessment. Several states also realized over time that many subpopulations not included as targets may have relevant SUD service capacity gaps that need to be addressed. For example, Washington noted subpopulations of non-English speakers, and Connecticut added the population involved in the criminal justice system as a targeted subgroup and recognized the needs associated with those who are homeless and have SUD. Some states identified optional subpopulations to target, based on earlier information about treatment challenges. For instance, the District of Columbia recognized that those with multiple health and social needs have difficulty navigating care between disconnected clinical and social services, so it opted to focus planning grant activities on those populations and their need for enhanced care coordination.

Through October 2020, planning grant states reported plans and activities related to all three areas identified in the NOFO as potentially pertinent to selected subpopulations: (1) determinations of SUD prevalence, (2) the needs assessment, and (3) proposed section 1003 activities generally.

5.5.3 SUD Prevalence and Subpopulations

The section 1003 demonstration NOFO encouraged, but did not require, applicant states to provide information on SUD prevalence for Medicaid subpopulations.[47] Some planning grant states included existing SUD prevalence information for target subpopulations in their applications. As planning grant work progressed, however, states not only refined their target populations but also gathered current prevalence information on target populations of Medicaid enrollees with SUD and/or OUD.

As states learned more about the prevalence of SUD and OUD in target subpopulations, this information sometimes informed decisions on capacity building. For example, Kentucky's needs assessment identified a concentration of infants born with neonatal abstinence syndrome along certain transportation routes, laying the groundwork for the state to assess OUD service capacity for the pregnant and postpartum population and their infants in locations where need is highest. In addition, Washington discovered that OUD diagnoses are not reliably reported for adolescents, making determining prevalence for that subpopulation difficult.

5.5.4 Needs Assessment and Subpopulations

The NOFO encouraged planning grant applicants to address identified subpopulations in planning and conducting their needs assessments.[48] State plans for their needs assessments often allowed for flexibility in implementation around target subpopulations. For example:

- Connecticut included a number of subpopulations of interest in its application. As the assessment progressed, the state began to see subtleties in and connections between groups. For example, Connecticut's analysis identified greater need in the subpopulation of individuals with HIV and SUD as they age. Connecticut also found that the prevalence of SUD among certain groups of Medicaid enrollees, such as those who are homeless or at risk of homelessness, may be underreported. Based on this information, the state decided to look more closely at areas of potential underestimated need.
- Kentucky discovered early in its needs assessment that it should expand its approach from focusing only on members of the pregnant and postpartum population and their children. Specifically, as Kentucky's data collection evolved, the state realized that it needed to include current information on the percentage of women generally (rather than specifically those who were pregnant or postpartum) receiving MAT, thereby addressing the issue of

capacity for preconception OUD treatment, with the objective of preventing neonatal abstinence syndrome.

- Following exploratory discussions with cross-agency workgroups to determine whether there are capacity issues for beneficiaries dually eligible for Medicare and Medicaid, Maine identified a need to better understand and review available data pertaining to those beneficiaries.
- Rhode Island began the planning period explicitly reserving the possibility of adding new subpopulations, depending on the results of its needs assessment.

During the first 13 months of the planning grants, states encountered two primary types of challenges to needs assessments specific to target subpopulations: (1) technological barriers and (2) difficulty obtaining or using data on target subpopulations.

Because states turned to technology to address impediments caused by the COVID-19 pandemic, technological challenges often surfaced. One example is limited broadband in rural areas, which impeded the virtual listening sessions that replaced in-person events in Maine. In Connecticut, subpopulation-specific challenges were identified, such as the inability to hold virtual meetings with homeless individuals or with adolescents who were not engaged in treatment and, therefore, could not be contacted through a provider. A lack of resources, such as laptops, also was identified specific to American Indian/Alaska Native subpopulations, which required Washington to distribute "loaner" equipment to tribal health care providers and tribal members. In Nevada, a lack of access to internet and broadband services in certain areas to implement use of telehealth led the state to identify a private grant opportunity for tribes.

States also encountered data-related challenges for specific subpopulations. Washington initially identified individuals in syringe service programs as a target subpopulation but soon recognized that the state does not capture administrative data on syringe service programs. This lack of individual-level data from these programs, coupled with no diagnostic code specific to intravenous drug use, meant that Washington could not use encounter data to determine whether that population was receiving treatment or other services or to assess provider capacity needs. Connecticut identified several data-related issues it encountered specific to subpopulations, including difficulty (1) assessing HIV prevalence and use of community-based services due to the protected nature of HIV information, (2) obtaining SUD prevalence data for the American Indian/Alaska Native population, and (3) linking Medicaid eligibility records with Department of Corrections data.

5.5.5 Other Section 1003 Activities and Target Subpopulations

In addition to determining SUD prevalence and other aspects of the capacity needs assessment, states began trying to address needs related to their target subpopulations. This work often included technical assistance and training that the states planned to deliver to providers to address the needs of different populations. Some activities that states undertook to support target subpopulations included technical assistance (1) to encourage the use of MAT and other evidence-based practices for youth and young adults among Medicaid providers (Connecticut, Rhode Island, and West Virginia), (2) to expand provider capacity and ability to serve pregnant and postpartum individuals and their children (Delaware, Virginia, and West Virginia), and (3) to expand provider capacity and reduce stigma for criminal justice-involved individuals (Virginia). Related activities also included determining where to focus provider technical assistance to serve the HIV/SUD population (Connecticut).

Other common subpopulation issues relate specifically to SUD treatment or recovery services for pregnant or parenting individuals. These issues often pertain to stigma, fear, and perceived legal risk regarding the use of medication to treat pregnant women diagnosed with OUD and requirements to report on a woman's SUD use during pregnancy. For example, as its needs assessment progressed, Virginia identified trends indicating that women were avoiding prenatal care or SUD treatment while pregnant because they feared negative consequences. Often, these women are involved in the criminal justice system, and there is significant fear and stigma associated with accessing care for people involved with the criminal justice system. Virginia identified a need to share general information about these issues with providers, as well as a need to reduce stigma. The state planned to assess provider and member experiences with Child Protective Services/Department of Social Services involvement and the effect of those experiences on treatment and care.

5.6 State Providers of Focus and Related Planning Grant Activities

The statutory focus of increased provider treatment capacity is threefold:

- Increase the capacity of providers participating under the state plan (or a waiver of such plan) to provide SUD treatment or recovery services[49];

- Expand the number or treatment capacity of providers participating under the state plan (or waiver) that are qualified to provide treatment or recovery services to the targeted populations[50]; and
- Expand the number or treatment capacity of providers participating under the state plan (or waiver) that are authorized to dispense FDA-approved medications for SUD withdrawal management or maintenance treatment.[51]

The 15 planning grant states targeted certain provider populations during their needs assessments and other activities under the planning grants. These include providers who can enroll in Medicaid as *individual providers*. States also focused on *facility types*, as care settings in which individual providers may be located, to ensure that the appropriate levels of care are available where needed for Medicaid SUD treatment or recovery services. Because the provision of MAT is a key part of the section 1003 demonstration, states paid particular attention to both individual and facility *providers of MAT* for SUD. States also focused on SUD *recovery* services provided by individual or facility providers. In addition, states explored or implemented increased use of *technological* approaches designed to expand provider capacity, particularly in light of the COVID-19 pandemic. States' strategies for targeting each of these provider types and their technological approaches to expand provider capacity are described below.

5.6.1 Individual Providers of Services to Address SUD, including OUD, within the Medicaid Program

The first category of providers targeted by planning grant states consists of those who can enroll in Medicaid as individuals. These individuals may provide services in any appropriate setting, ranging from outpatient solo practices or clinics to large inpatient settings. The types of providers targeted differ by state, including peer providers, master's-level providers, primary care providers, addiction specialists, psychiatrists, and obstetricians.

The predominant individual provider types targeted by states are primary care providers, obstetricians, and neonatologists. Primary care providers and obstetricians typically are targeted to expand the reach of office-based opioid treatment (OBOT), which often involves the use of buprenorphine but may also include naltrexone. Addressed separately below are general approaches to expanding MAT capacity, but a few examples here can demonstrate state approaches to increasing the number of providers of non-methadone MAT. For example, New Mexico is

working with the state's primary care association to identify ways to expand the use of MAT in primary care. Delaware is trying to understand barriers to the provision of MAT by primary care providers; they found that barriers to prescribing may include misunderstanding of or lack of knowledge about MAT, as well as provider discomfort in working with patients with SUD and patients who are Medicaid enrollees. In response, Delaware is offering buprenorphine DATA waiver training and technical assistance to primary care and other outpatient providers, to develop the infrastructure needed to support OBOT services. Connecticut is planning to leverage an existing obstetrical pay-for-performance program to promote and incentivize screening and referral to treatment of pregnant/postpartum individuals for SUD/OUD.

The third individual provider type most often identified by planning grant states is neonatologists. This focus seeks to address issues related to neonatal abstinence syndrome and neonatal opioid withdrawal syndrome in substance-exposed infants. For example, Connecticut is evaluating the capability and willingness of Medicaid providers specializing in infant care to treat opioid-affected infants under a bundled rate.

5.6.2 Medication-Assisted Treatment Providers

As required by section 1003, all states are focused on enhancing the number and/or capacity of Medicaid-enrolled providers authorized to prescribe or dispense medications to treat SUD—primarily OUD and, to a much lesser extent, alcohol use disorder. This work has involved assessing capacity, identifying gaps, and taking steps to increase capacity.

Planning grant state capacity assessment has focused predominantly on the number of providers with a DATA waiver to prescribe buprenorphine, the extent to which those providers serve the maximum number of patients allowed by their DATA waiver, and whether they accept Medicaid. In assessing current capacity and determining the number of current DATA-waivered providers in the state, many states found that the SAMHSA provider locator was unreliable because it includes out-of-date entries and lists only providers who consent to be publicly identified. Despite that hurdle, states made progress in assessing DATA waiver provider capacity. For instance, New Mexico identified that only 698 out of 12,460 potential prescribers in the state, or about 6 percent, have obtained a DATA waiver. Rhode Island discovered that only 200 of 451 DATA-waivered physicians in the state are using their capacity to prescribe. West Virginia found that approximately one-fifth of qualified providers do not accept Medicaid. In response to their assessments, Connecticut, Illinois, and Kentucky are updating statewide listings, search engines, or maps of

buprenorphine prescribers—both to assess capacity and gaps and to ensure the information is accurate for individuals who may need to identify and access a provider.

Identified gaps in MAT capacity include shortages of buprenorphine providers in many states, often in rural areas. However, states are identifying shortages of opioid treatment programs as well, which also are more commonly found in urban areas. For instance, West Virginia's planning grant application indicated the presence of legislative mandates that prohibit expansion of opioid treatment programs in the state. Maine has identified a shortfall of methadone providers, with a decreasing number of methadone clinics in operation, despite an 83 percent increase in reimbursement rates for methadone treatment over the past year. Maine also is seeking to increase the use of naltrexone.

In addition to identifying capacity and gaps, some states already are working to expand MAT provider capacity. Among other things, states are focusing on the need for provider technical assistance to address stigma and misunderstanding about the use of medication to treat OUD and to understand unwillingness to provide OUD medication. These challenges may relate either to provider lack of familiarity or comfort in using medication to treat OUD or to the belief that use of an opioid agonist (methadone) or partial opioid agonist (buprenorphine) medication to treat OUD is merely replacing one opioid with another. States are also working to enhance medical training to increase capacity, including for target populations, and to help providers make the best use of their DATA waivers. Some examples include the following:

- Alabama has identified that technical assistance is needed to help providers understand the benefits of MAT.
- Illinois has developed an addiction medicine training curriculum for all family medicine residents at Cook County Health, with a focus on building skills, competency, and capacity for prescribing in a primary care setting. Cook County Health also has created a required addiction medicine rotation for all family medicine residents.
- Michigan is assessing the extent to which different types of prescribers may need further technical assistance on using their DATA waivers to prescribe buprenorphine to treat OUD.
- Virginia is using surveys to determine factors that drive providers to provide buprenorphine—with target respondents including psychiatrists, obstetricians-gynecologists, family practice providers, emergency care providers, and nurse practitioners. Virginia hopes

to recreate success factors across the state by using technical assistance to encourage DATA-waivered providers to prescribe at a higher volume.

- West Virginia is providing DATA waiver training to enhance the supply of providers for youth and young adults.

Other approaches to increasing MAT provider capacity relate to revising reimbursement strategies and determining provider willingness to attain a DATA waiver to encourage buprenorphine prescribing to special populations. For instance, Maine has streamlined its authorization process for prescribing buprenorphine to decrease provider administrative burden. Nevada is working to reimburse for technology-based treatment or recovery support to expand treatment access to areas where there is a lack of qualified providers and to aid existing DATA-waivered providers who lack support services. Nevada also has developed a statewide policy on MAT for Medicaid providers with a special emphasis on reimbursement. Virginia is conducting a mixed-methods qualitative analysis to assess the willingness of non-waivered practitioners to obtain a DATA waiver, with a particular focus on prescribing for the pregnant and postpartum population.

A number of planning grant states also are focused on care coordination between intensive and outpatient settings, to ensure that MAT can begin in an intensive facility and transition to lower levels of care. Examples include Connecticut, which seeks to support MAT induction in inpatient settings and warm transfers to continuing care in Enhanced Care Clinics that provide integrated care in outpatient settings; Maine, which is assessing transitions from the emergency department or incarceration to community-based care; Virginia, which seeks to develop linkages between emergency department initiation and OBOT providers in the community; and Washington, which has concluded from its initial assessments that withdrawal management should be considered a treatment pathway toward access to MAT.

To date, states have identified challenges to improved MAT provider capacity. For example, during the COVID-19 pandemic, some states reported that providers seeking a DATA waiver have found it increasingly difficult to participate in the required training. Additionally, several planning grant states noted that, at all times, opioid treatment programs can be challenging to open because of zoning requirements and public opposition and that the application and wait time for approval can be financially burdensome.

5.6.3 Providers of Recovery Services

States are targeting providers of recovery services to enhance their capacity to provide these services under the Medicaid program. Connecticut, Illinois, Maine, Michigan, New Mexico, Virginia, and Washington all specified peer services as a focus of their planning grants. Connecticut has worked to identify best practices, barriers, implementation, certification, and utilization of peer supports for individuals with SUD, including for pregnant and parenting individuals, youth, and the lesbian, gay, bisexual, transgender, and queer population specifically, as well as in emergency department settings. Aware of the administrative hurdles related to provider enrollment in Medicaid, Virginia is providing technical assistance to peer recovery support specialists to assist with satisfying requirements for Medicaid participation.

Other states, such as Nevada, are looking more generally at data on social determinants of health, and some, such as Connecticut, noted a pronounced lack of housing availability for individuals at risk of homelessness who have SUD. Services such as recovery housing also may fall under the umbrella of recovery services and are supported through SAMHSA's Substance Abuse Prevention and Treatment Block Grant program. Both Alabama and Maine noted a lack of public funding to support such facilities.

5.6.4 Technological Approaches to Expand Provider Capacity

Before the emergence of COVID-19, a handful of states identified in their planning grant applications telehealth and other technology as an avenue for extending provider capacity. Connecticut planned to analyze its Medicaid rate schedules to promote use of telehealth and to begin assisting with telehealth startup costs. Maine wanted to assess provider willingness to use and be reimbursed for telehealth and to develop infrastructure, including distributing telehealth software licenses. Nevada sought to expand treatment to areas with insufficient providers through the use of telehealth. Rhode Island planned to provide agencies with technical assistance, telemedicine tools, and an evidence-based patient engagement application to increase participation in treatment. West Virginia intended to expand its telehealth infrastructure, mobile applications, and other technological solutions, such as video directly observed therapy.

The spread of the pandemic, however, prompted all states to make telehealth a focus of their planning grant Medicaid provider capacity-building activities, and the states that originally included telehealth typically expanded their plans to address unforeseen needs. For example, recognizing

how rapidly providers had to adopt telehealth, Maine assessed the readiness of rural primary care and behavioral health providers to increase capacity through telehealth so the state could develop technical assistance accordingly. Virginia developed a series of online courses on how to provide services via telehealth and how to conduct screenings. Washington developed a strategy that includes surveys of providers and beneficiaries, technical assistance on billing and delivery, reimbursement for visits outside of office hours, expanded interpretation services, addressing gaps in broadband, provision of licenses for videoconferencing software for providers, provision of computers and smart phones for beneficiaries, reduced or no monthly fees for telephone and internet service, establishment of a telemedicine data dashboard, and analysis of telehealth use in the state. Certain aspects of the Washington response (e.g., reduced service fees, smart phone distribution) were funded by donations from outside sources.

West Virginia included in its original application an intention to participate in Project ECHO (Extension for Community Healthcare Outcomes) to provide telementoring to providers of SUD treatment or recovery services, including using a "train the trainer" approach. Project ECHO is a guided-practice model intended to reduce health disparities in remote and other underserved areas. It uses telementoring, whereby expert teams lead virtual clinics, increasing the capacity for providers to give best-in-practice care to the underserved individuals in their own communities.[52] Other jurisdictions, such as Delaware, the District of Columbia, Indiana, and Nevada, also moved in that direction either before or with the advent of COVID-19, relying on Project ECHO or another approach to e-consulting.

Despite the urgency to incorporate telehealth into their planning grant activities, states encountered barriers. These included broadband capacity and connectivity issues, particularly in rural areas (Connecticut, New Mexico, and West Virginia); initial provider discomfort with telehealth or the need to modify standard practices for screening, consent, and safety (Connecticut and West Virginia); contracting delays due to high demand for telehealth services (Maine); difficulty engaging beneficiaries without housing (Connecticut); and the need to amend regulations, reimbursement policies, and billing codes to permit expanded use of telehealth (Alabama, Connecticut, Delaware, District of Columbia, and Maine).

States are reporting positive indicators from this rapid expansion of telehealth use for the delivery of SUD treatment or recovery services. For instance, preliminary analysis of claims data from March to May 2020 in the District of Columbia showed a high rate of adoption and use of telehealth for

behavioral health care and a decrease in no-show rates. In addition, Rhode Island reported that, after 8 weeks, it could see advances in telehealth's impact on communities of color and low-income communities.

Alabama, Delaware, the District of Columbia, Indiana, Kentucky, and Washington are considering how best to sustain ongoing telehealth use, including after the COVID-19 pandemic wanes.

6 CONCLUSIONS

This Initial Report to Congress under section 1003 of the SUPPORT Act preliminarily addresses the planning period of the section 1003 demonstration, encompassing information available 13 months into the 24-month period. Pursuant to the statute, this report describes (1) the criteria used for selecting the planning grant states, (2) the states that were selected, and (3) initial state activities under the planning grants. In this concluding section, the key challenges and facilitators to implementation of the planning grant are discussed.

6.1 Challenges and Facilitators to Implementation of Planning Grant Activities

6.1.1 Challenges That Interfered with or Prevented Initiation of Planned Activities

States encountered two broad categories of challenges in initiating and implementing activities during the first 13 months of the section 1003 demonstration planning period: (1) challenges related to the COVID-19 pandemic beginning in early 2020 and (2) challenges concerning quantitative and qualitative data unrelated to the pandemic.

Challenges posed by the pandemic. The pandemic affected many aspects of states' activities, including their ability to hire necessary personnel and to access resources. Several states experienced hiring freezes. Reduced state resources also delayed contracting in some instances, and state contractors were sometimes impeded in their work. For example, in Maine, a telehealth contractor experienced competing demands related to the rapidly expanded use of telehealth, with providers having little to no preparation or training, and a Virginia contractor had delays in claims system access due to teleworking constraints. Virginia also was forced to terminate a contract with the Virginia Hospital and Healthcare Association, which was supposed to include work on integration of MAT and peer services into emergency departments.

One of the clearest impacts of the pandemic on state implementation was the inability to hold in-person listening sessions, town halls, or focus groups. This change affected both general

stakeholder engagement and fact-finding, as well as qualitative data collection for the needs assessment. Many states shifted from in-person to virtual meetings, sometimes on a delayed schedule. As these changes occurred, at least some states voiced concern about problems with broadband in rural areas that could reduce many residents' ability to participate virtually. In addition, states reported a desire not to burden providers who were prioritizing patient care. The pandemic also disrupted at least one state's plan to provide in-person career training and shadowing of providers. These factors led to delays as states adapted their approaches or waited until providers and others were more available.

Non-pandemic-related data challenges. States also experienced data-related challenges unrelated to the pandemic. As they worked on their needs assessments, states encountered difficulties with quantitative data completeness or accuracy and the use of multiple datasets. Three common data completeness issues were missing Medicaid data, lack of data on specific subpopulations (e.g., American Indian/Alaska Native populations, syringe service program participants), and insufficient information on care coordination capacity across behavioral and physical health providers. Data accuracy issues included imprecise diagnostic coding of SUD (e.g., in adolescents), poor coding practices by providers, and outdated or incomplete information in the SAMHSA buprenorphine provider locator[d]. Problems using multiple datasets surfaced (1) because encounter data (for services covered by managed care) often differ from claims data (for services covered by fee-for-service payments), (2) when attempting to link to data from third-party payers, (3) as a result of cross-agency data differences, and (4) because of the labor intensiveness of identifying unique enrollees across datasets and deduplication.

States also struggled with how best to identify Medicaid enrollees with SUD, how to comprehensively identify Medicaid providers of SUD treatment or recovery services, and how to define Medicaid SUD services. States often were still refining their methodology by the thirteenth month of the planning period because they had different levels of experience working with SUD data or changed approaches over time. Although less frequently reported, states also experienced common difficulties in qualitative data collection, such as provider non-response.

[d] SAMHSA strives to ensure that the data on the buprenorphine treatment locator is accurate. However, as noted on the locator site, practitioners are responsible for updating their contact information.

6.1.2 Facilitators of Initiation or Implementation

A common facilitator of implementation was collaboration with other relevant state agencies. Every state Medicaid agency partnered formally or informally with the counterpart single state agency for substance abuse services as part of the application process and for ongoing collaboration. Often, these entities had a history of working together on, for instance, section 1115(a) demonstrations or their governor's opioid task force or workgroup. Collaboration with the single state agency for substance abuse services provided the state Medicaid agency with added expertise or resources for implementation. For example, Washington collaborated with the Washington State Department of Health and Washington Medical Commission to obtain data needed for surveying all licensed providers. Indiana, Kentucky, and Washington developed steering committees to provide ongoing review and guidance to their state SUPPORT Act team. Collaboration with provider or community organizations can also provide the state Medicaid agency with critical clinical or lived experience. Kentucky, for example, has connected with SUD service programs in different parts of the state to inform its needs assessment. Virginia also planned to work with the Virginia Hospital and Healthcare Association Foundation to pilot MAT and peer recovery support services in emergency departments.

Although COVID-19 created challenges for states, certain factors associated with the pandemic also facilitated state work under the planning grants. For example, the extended planning period provided by CMS gave all states an additional 6 months to complete work on their needs assessments and other planning activities that were delayed or interrupted by the pandemic during much of 2020. Additionally, the pandemic resulted in a rapid adoption of technology that may have accelerated and spurred capacity building in ways that might not have occurred otherwise. The pandemic expedited some states' plans to expand telehealth services and caused other states to shift attention to the use of telehealth when that was not originally intended to be a focus of the planning period. These adaptations resulted in more needs assessment activities focused on understanding telehealth needs and barriers and on-the-ground activities to expand access to Medicaid SUD treatment or recovery services.

REFERENCES

[1] Section 1903(aa)(1), (2) of the Act.

[2] Section 1903(aa)(3) of the Act.

[3] Section 1903(aa)(4) of the Act.

[4] Section 1903(aa)(6)(B)(iii) of the Act.

[5] Section 1903(aa)(1),(2) of the Act.

[6] 1903(aa)(3) of the Act.

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