Report to Congress:
Agency for Healthcare Research and Quality 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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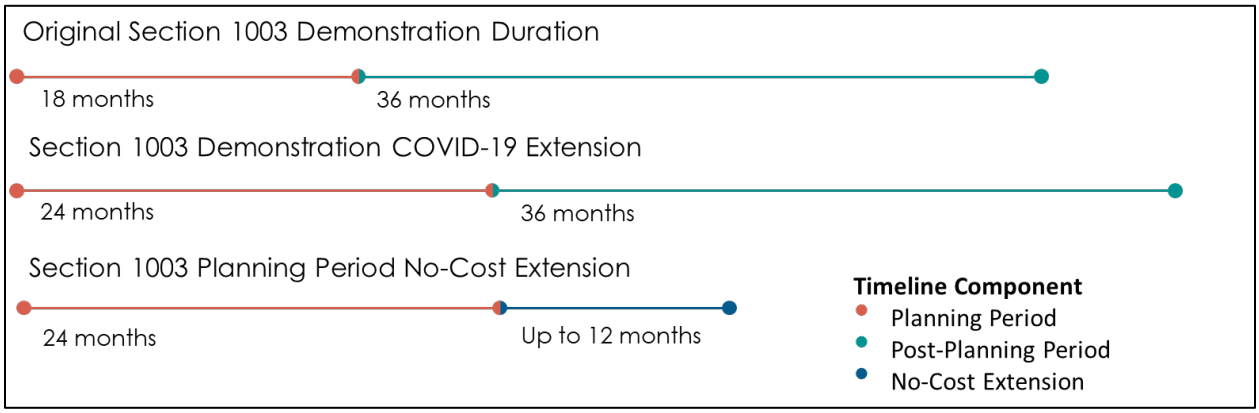
EXHIBITS

SUMMARY OF FINDINGS

In 2018, in response to the rising human and economic costs associated with the opioid crisis, Congress directed 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), to conduct a demonstration project (the Section 1003 Demonstration Project) designed to increase the capacity of Medicaid-enrolled providers to deliver substance use disorder (SUD) treatment or recovery services for Medicaid beneficiaries.[1] The Section 1003 Demonstration Project includes two components. The first component is an 18-month planning period. Up to $50 million was made available for planning grants. The grants were awarded September 30, 2019, to 15 states. The second component of the demonstration is a 36-month post-planning period that began September 30, 2021, during which five states selected from among the 15 planning grant states receive federal reimbursement equal to 80 percent of the qualified sums expended during each of the quarters in the post-planning period.[a] To allow states to focus on the emergent issues created by the COVID-19 pandemic, CMS extended the planning period to 24 months and added a 12-month no-cost extension for states that did not receive a post-planning grant.

Section 1003 Demonstration Project Timeline



The following states were awarded planning grants: Alabama, Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Virginia, Washington, and West Virginia; of these, Connecticut, Delaware,

[a] The qualified sum is the amount by which the sums expended by the state during the quarter that are attributable to SUD treatment or recovery services exceed one-quarter of the sums expended by the state during fiscal year 2018 attributable to SUD treatment or recovery services.

Illinois, Nevada, and West Virginia were subsequently awarded post-planning grants. This document summarizes findings from the experiences of participating states during the planning period and the first 4 months of the post-planning period of the Section 1003 demonstration, based on awardee documents, stakeholder interviews, and technical assistance webinar evaluations.

Findings from the Planning Period

Were the planning grants an effective mechanism to prepare for the demonstration period?

Yes. In stakeholder interviews, states agreed that the planning grants were effective in preparing for the demonstration phase as intended. In addition, most states used the grants not only to prepare for the next phase of the project but also to think more broadly about strengthening their SUD treatment and recovery system, particularly around workforce, capacity building, and relationships with patients and providers.

Did the planning grants increase states' long-term capacity to assess and manage MAT/SUD recovery needs?

Yes. The planning grants allowed states to conduct Medicaid-specific needs assessments, improve data infrastructure, develop provider technical assistance and training, build statewide collaborations, initiate policy changes, and diversify funding and provider reimbursement. Furthermore, the planning grants allowed states to engage in strategic thinking that can continue to sustain the capacity developed through the grant.

Was 18 months the optimal time frame for the planning grants?

No. Most states recommended at least 24 months for a planning grant, even in the absence of a public health emergency.

What lessons would participating states share with future grantees?

- Stakeholder involvement is crucial—engage stakeholders early and establish clear lines of communication and feedback.
- Be flexible and willing to adjust plans based on results from the needs assessment.
- Data integration will take longer than expected, so start early.

Findings from the Initial Implementation of the Post-Planning Period

Is implementation going according to plan and what barriers and facilitators have been encountered?

Implementation of post-planning period activities is going slower than anticipated. Barriers include grant administration issues, the complexity and uncertainty of the federal reimbursement payment process, state procurement processes, and continuing challenges with data integration. Facilitators include the Section 1003 Demonstration Project's encouragement of collaboration with other state initiatives, the ability to carry over funds from the planning grants, and the funds provided by the federal reimbursement.

What benefits do states perceive from participating in the Post-Planning Period?

States felt that the potential combined effect of the federal reimbursement, various state initiatives and legislation, and the 3-year demonstration period presented an opportunity to stay focused on SUD and build long-lasting change.

Findings for Project Management

What changes would have made the application processes for the planning and demonstration projects more useful/easier?

States appreciated the extent to which the applications followed the original legislation and found the application's directions clear. However, participants reported that the delay in providing detailed information about the post-planning period, particularly specifics around the funding formula, hindered their preparation for the post-planning phase.

Was the technical assistance received useful, and how could it have been improved?

Overall, states found the technical assistance useful, although they had suggestions on how assistance could be improved:

- Provide more detailed technical specifications for reporting, and one-on-one technical support focused on individual state characteristics.
- Ask awardees to suggest topics for webinars, send slides ahead of webinars, use more graphics and less text in presentations, and send Q&A documents after webinars.

- Opportunities to learn from peers are especially valuable, so grantees should be grouped according to similar characteristics (focus on priority populations, managed care states, or states with a large rural population) to allow for more peer-to-peer interaction and sharing

How did the COVID-19 public health emergency affect state activities?

COVID-19 delayed implementation timelines and led to shifts in resources since the staff had to be reassigned to focus on the pandemic response. In addition, some aspects of the Section 1003 demonstration had to pivot from in-person to virtual formats. However, some states reported unexpected benefits from this pivot, such as improved attendance of virtual meetings and more successful outreach to hard-to-reach populations.

What recommendations do states have for similar programs in the future?

States recommended that future similar demonstrations:

- Allow adequate time for activities. The original 18-month timeline for the planning period needed to be revised for states to complete their planning grant activities, even if the COVID-19 public health emergency had not been a factor. Awardees recommended increasing the planning period to at least 24 months to allow for time to hire staff, contract with vendors, and implement policy changes. An alternative suggestion was to keep the planning period at 18 months but allow for a delay in the start of the planning grant from award notification so that hiring and vendor contracting can take place prior to the start date. Key information for post-planning applications (such as the funding formula) must be released early enough for states to make decisions.
- Consider an alternative to the federal reimbursement process as a funding mechanism. States that already received a high federal match did not apply for the post-planning period due to concerns that they might need more money to cover their post-planning period implementation plans. Even states that did apply were still determining whether this funding mechanism would cover the increased administrative costs associated with demonstration implementation.
- Include administrative funding during the post-planning period for program management and reporting, since many state Medicaid agency budgets do not have dedicated funding for program administration, and preparing project reports and participating in meetings takes time.

- Keep the Section 1003 Demonstration Project requirement aligned with similar initiatives within the state. This requirement helped states leverage the relationships with other state agencies and/or SUD-related stakeholders they developed or strengthened during the planning period to create sustainable increases in SUD Medicaid provider capacity. States recommended that future opportunities should also align reporting requirements for federal initiatives, consider the timing of related initiatives, and coordinate data access across programs.
- Build in ample opportunities for peer-to-peer sharing and learning.

EXECUTIVE SUMMARY

This report 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 directs the Secretary of the U.S. Department of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services (CMS), 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.[2]

The Section 1003 demonstration comprises two components: (1) a planning period, with planning grants originally awarded for an 18-month period to 15 states with funding of up to $50 million in aggregate,[3] and (2) a 36-month post-planning period with five states selected from among the 15 planning grant states.[4] CMS extended the planning period and delayed the start of the demonstration period by 6 months to allow states to focus on the emergent issues created by the COVID-19 pandemic.

Section 1003 of the SUPPORT Act directs AHRQ to issue this Report to Congress, which describes the experiences of the participating states. 42 U.S.C. 1396b(aa)(6)(C). As directed by Congress, AHRQ worked closely with CMS to design and produce this report, which is focused on the experiences and perceptions of participating states during the planning period and the first 4 months of the post-planning period (September 30, 2019–February 1, 2022) of the Section 1003 demonstration project. Data reviewed for this report included state applications and progress reports; stakeholder interviews conducted with the 15 planning grant states (spring of 2021), six states that did not apply for the post-planning period (fall of 2021), and five post-planning states (January and February 2022); and survey data with participant feedback on technical assistance.

Experiences of States Awarded Section 1003 Planning Grants

The first section of the report describes the experiences of the 15 states (Alabama, Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New

Mexico, Rhode Island, Virginia, Washington, and West Virginia) implementing the Section 1003 planning grants.

The planning grant was designed for states to create a foundation for their demonstrations in the post-planning period. However, rather than using the planning period time and resources solely to prepare for post-planning demonstration projects, we found that states developed long-term, sustainable solutions for increasing provider capacity to deliver SUD treatment or recovery services. States' long-term capacity-building strategies included enhancing data infrastructure, improving workforce development, collaborating with other state agencies, pursuing policy changes, and diversifying funding. Some states identified the planning grant as one of the first opportunities they had to conduct a statewide assessment of needs, treatment and prevalence rates, and gaps in services; to develop plans supported by holistic data; and to share findings with stakeholder groups. States identified the needs assessment as a unique source of population- and service-specific data and analyses that they planned to replicate in the future.

States differed in their recommendations for approaches to future planning grants. Some recommended that future participants take a broad approach to transforming the entire SUD delivery system, whereas others recommended starting with a single population. All states recommended that future planning grant participants engage stakeholders early and establish clear lines of communication and feedback. Most states endorsed a flexible approach in which future planning grant participants adjust their plans in response to new or unexpected results from the needs assessments.

Six of the 15 planning grant states did not apply for the post-planning demonstration. Payment for the post-planning period consists of federal reimbursement equal to 80 percent of the qualified sums expended during each of the quarters in the post-planning period. The qualified sums are the amount attributable to SUD treatment or recovery services furnished by providers participating under the state plan (or a waiver of such plan) that exceeds one-quarter of the sums expended by the state during fiscal year 2018 that was attributable to SUD treatment or recovery services. States that chose not to apply for the post-planning demonstration cited the payment formula as a barrier, either because the calculation was too complicated or because the amount of payment they would receive would not be enough to improve provider capacity. Four of the six states indicated that the administrative burden required to receive the federal reimbursement would outweigh any potential benefits. In addition to concerns about the federal reimbursement,

two of the six states indicated that the demonstration period did not provide an opportunity to pilot new strategies or fund services not traditionally covered by Medicaid.

Experiences of States Selected for the Section 1003 Post-Planning Period

The second section describes the initial post-planning experiences of the five states (Connecticut, Delaware, Illinois, Nevada, and West Virginia) chosen for the post-planning period. Post-planning states reported activities were proceeding but slower than anticipated due to administrative barriers and COVID-19.

The five states are targeting a variety of populations for expanded SUD treatment capacity, including pregnant and postpartum women, Black beneficiaries, and children and families. States are also targeting a variety of provider types in the post-planning period, including buprenorphine providers, primary care providers, residential treatment providers, licensed behavioral health centers, and Federally Qualified Health Centers.

Post-planning states reported several key facilitators of SUD treatment expansion activities: the federal reimbursement, the structure of the demonstration to encourage collaboration with other state initiatives, and the ability to carry over funding from the planning grant to the demonstration. Barriers to implementation included uncertainty that they would receive sufficient payment from the federal reimbursement, delays in the carryover of unspent planning grant funds, and state procurement timelines and processes.

Perceptions of the Section 1003 Demonstration to Date

The third section of the report provides states' perceptions of the SUPPORT Act Section 1003 demonstration to date, including their perceptions of activities during both the planning and post-planning periods.

States appreciated that project requirements tracked closely to the original legislation, which they said was helpful for navigating the application process. They reported that Section 1003 technical assistance was beneficial and particularly appreciated opportunities to connect with other awardees. To make the technical assistance more valuable, states recommended sending webinar slides ahead of time, providing question-and-answer documents after technical assistance events, and grouping grantees with similar characteristics to facilitate peer sharing.

In light of the obstacles created by COVID-19, states appreciated the demonstration flexibilities introduced as a result of the public health emergency, including timeline extensions and the opportunity to carry over planning grant funding into the post-planning period, regardless of whether they were participating in the demonstration.

States identified important considerations for future demonstrations: detailed guidance for project-related reporting, including technical specifications; additional opportunities for peer-to-peer learning; alignment of reporting requirements and timing between related federal initiatives; and a planning period singularly focused on planning activities, as opposed to a planning period with infrastructure development expectations. States also recommended that information about the payment formula be released early, before the planning grant applications are available; that administrative funds be provided for the post-planning period; and that alternatives to an enhanced federal match be considered.

Conclusions

The final section of the report distills key findings of this evaluation related to the statutory provisions and federal design of the planning and post-planning periods, the implementation of demonstration activities, and the impact of the public health emergency on the evolution of state activities. States found the provision of dedicated resources and the focus on Medicaid beneficiaries, providers, and statewide collaboration to be the most effective elements of the planning period, while the time frame of the demonstration and the lack of alignment across related federal initiatives were less so. Administrative funding and an alternative to increased federal reimbursement were recommendations to improve the utility and relevance of the post-planning period to states. COVID-19 negatively affected timelines and planned grant activities for most states, but in some cases, states leveraged their virtual activities to access hard-to-reach populations and create online training resources for future use.

Appendix

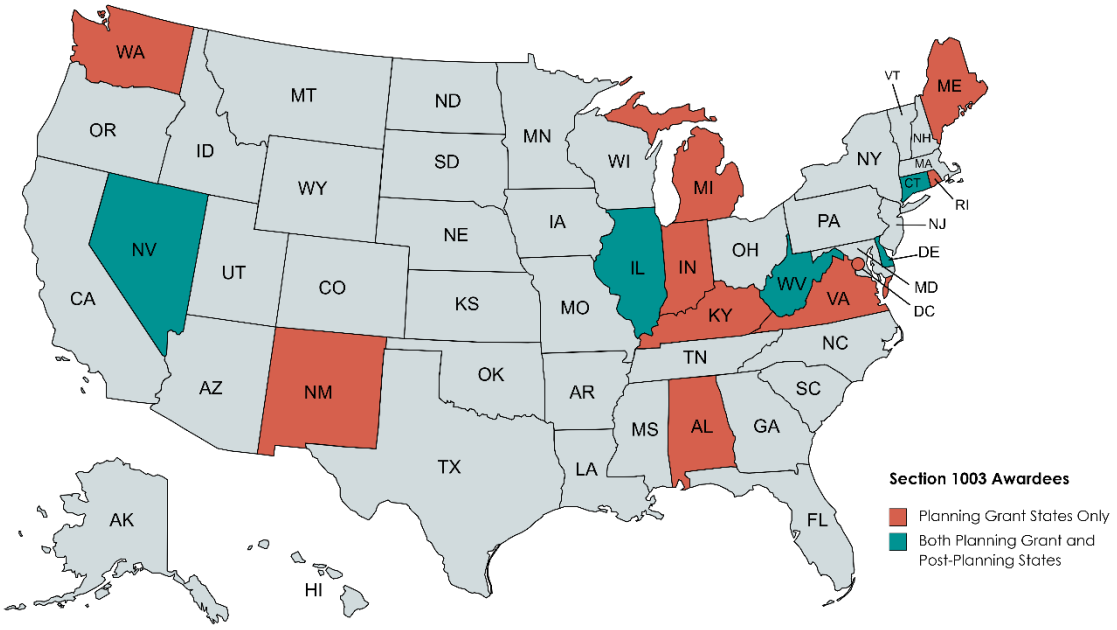
The appendix provides profiles of each state participant's key planning and post-planning period (where relevant) activities around needs assessments, reimbursement, provider training and technical assistance, and collaboration to increase the capacity of Medicaid SUD treatment or recovery providers.

INTRODUCTION

In response to the number of individuals in the United States with opioid use disorder (OUD), high rates of fatal and nonfatal overdoses, and the other human and economic costs associated with the opioid crisis, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (hereinafter, the "SUPPORT Act") on October 24, 2018. Section 1003 of the SUPPORT Act directs the Secretary of the U.S. Department of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA), to conduct a demonstration project (the Section 1003 demonstration) designed to increase the capacity of Medicaid-enrolled providers to deliver substance use disorder (SUD) treatment or recovery services for Medicaid beneficiaries.[5]

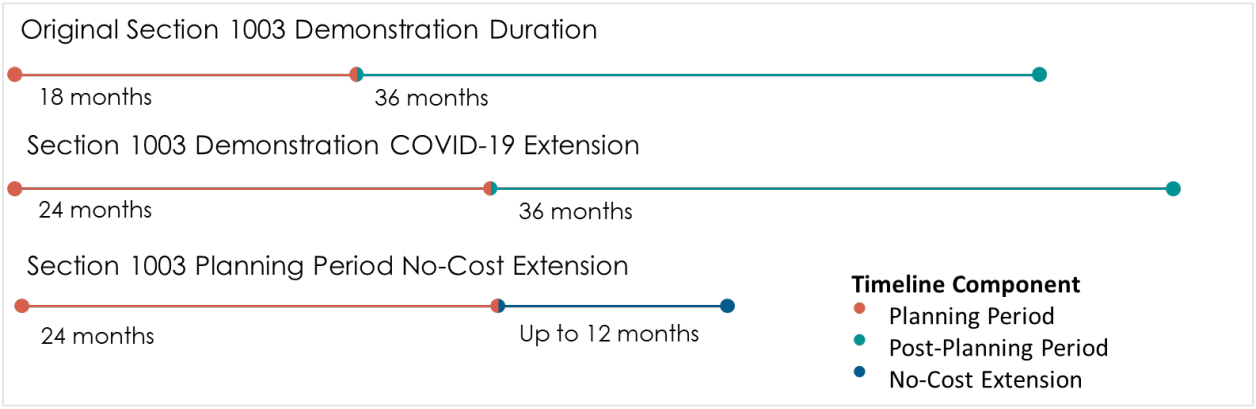
The Section 1003 demonstration includes two components. The first component is a planning period, with planning grants originally awarded for an 18-month period to at least 10 states with funding of up to $50 million in aggregate.[6] The second component is a 36-month post-planning period during which up to five states selected from among the planning grant states receive enhanced federal dollars for specified increases in SUD services.[7] Specifically, states would receive federal reimbursement equal to 80 percent of the qualified sums expended during each of the quarters in the post-planning period. The qualified sum is the amount expended by the state during the quarter that is attributable to SUD treatment or recovery services and exceeds one-quarter of the amount expended by the state during fiscal year 2018 attributable to SUD treatment or recovery services.[8] The states selected for each component of the grant are shown in Exhibit 1.

Exhibit 1. Section 1003 Awardees



As shown in Exhibit 2, CMS extended the end of the planning period and delayed the start of the post-planning period by 6 months to September 30, 2021, to allow states to focus on urgent issues related to COVID-19. Additionally, in September 2021, CMS allowed states that applied for no-cost extensions (states not participating in the post-planning period) or carryover funding (states participating in the post-planning period) to continue planning grant activities beyond the end of the planning grant timeline. States that received approval for no-cost extensions or the carryover of funds are identified later in this report (see Exhibit 17).

Exhibit 2. Section 1003 Timeline



Section 1003 of the SUPPORT Act directs AHRQ to issue this Report to Congress, which describes the experiences of the participating states. 42 U.S.C. 1396b(aa)(6)(C). This report includes information available through February 15, 2022.

As directed by Congress, AHRQ worked closely with CMS to design and produce this report focused on the experiences and perceptions of participating states during the planning period and the first 4 months of the post-planning period of the Section 1003 demonstration project. The report has four sections. The first section outlines the implementation of the planning grants and the states' experiences with the planning grants in relation to their needs. This section also includes information about six states that did not apply for the post-planning period and their reasons for not applying. The second section describes the initial implementation of the post-planning period for the five states selected to participate. The third section addresses the states' perceptions of their SUPPORT Act Section 1003 experience to date, including technical assistance received, impacts of the COVID-19 public health emergency, and recommendations for future demonstrations. The final section describes key findings related to the statutory provisions and federal design of the planning and post-planning periods, the implementation of demonstration activities, and the impact of the public health emergency on the evolution of state activities.

METHODS

Evaluation Questions

The Section 1003 demonstration evaluation addresses the evaluation questions in Exhibits 3, 4, and 5. Findings related to specific evaluation questions are provided throughout the report.

Exhibit 3. Demonstration Evaluation Questions, Data Sources, and Analytic Approaches to Assessing Experiences of States Awarded Section 1003 Planning Grants

Evaluation Question	Data Source(s)	Analytic Approach
Were the planning grants an effective mechanism to prepare for the demonstration period? Why or why not?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Did the planning grants increase states' long-term capacity (including infrastructure) to assess and manage MAT/SUD recovery needs?	Applications, progress reports, other awardee documents, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Were the states able to put arrangements (including infrastructure) in place during the planning period that will help them maintain activities after the end of the grant period that are necessary for sustained expansions and improvements in SUD treatment?	Applications, progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Was 18 months the optimal time frame for the planning grants?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Was 24 months optimal considering the COVID-19 pandemic?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What benefits do states perceive from participating in the planning period?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What lessons learned about planning grants would they share with other states?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What would they do differently if they could do it again?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis

Abbreviations: MAT, medication-assisted treatment; SUD, substance use disorder.

Exhibit 4. Demonstration Evaluation Questions, Data Sources, and Analytic Approaches to Assessing Experiences of States Selected for Section 1003 Post-Planning Period

Evaluation Question	Data Source(s)	Analytic Approach
Describe the populations and providers targeted by states for the post-planning period.	Post-planning period applications	Qualitative analysis: narrative and thematic analysis
Is implementation going according to plan?	Applications, progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What barriers and facilitators have the states encountered [do the states anticipate] while implementing their plans?	Applications, progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What benefits do states perceive [expect] from participating in the demonstration?	Applications, progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis

Exhibit 5. Demonstration Evaluation Questions, Data Sources, and Analytic Approaches to Assessing Perceptions of SUPPORT Act Section 1003 Experience to Date

Evaluation Question	Data Source(s)	Analytic Approach
What changes would have made the application processes for the planning and demonstration projects more useful/easier? Are there other criteria that should be included?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Did states feel they received clear direction on what was expected of them?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What technical assistance did the states receive?	Technical assistance materials and technical assistance evaluation materials	Qualitative analysis: narrative and thematic analysis
Was the technical assistance received useful, and what other technical assistance might have been useful?	Stakeholder interviews, technical assistance evaluation materials	Qualitative analysis: narrative and thematic analysis Quantitative analysis: average ratings across a series of ratings
Do the states have recommendations for how to make the technical assistance provided during the planning and demonstration projects more valuable?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What did the states learn from the interactions among themselves (i.e., learning community/Groupsite interaction)?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis

Evaluation Question	Data Source(s)	Analytic Approach
What was the impact of the public health emergency on state activities?	Progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What recommendations do states have for similar programs in the future?	Stakeholder interviews	Qualitative analysis: narrative and thematic analysis

Abbreviations: SUPPORT Act, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment.

Data Sources

This report drew from three primary data sources: (1) awardee documents, (2) stakeholder interviews, and (3) CMS Section 1003 technical assistance webinar evaluations. The awardee documents included applications for the planning grants and post-planning period, quarterly progress reports, and semi-annual progress reports. Three rounds of stakeholder interviews were conducted with state Section 1003 program leadership. The first round of interviews took place in the spring of 2021 with the 15 planning grant states. The second round of interviews was conducted in the fall of 2021 with six planning grant states that did not apply for the post-planning period. The third round of interviews occurred at the beginning of 2022 with the five post-planning states. Finally, this report draws from data from surveys administered directly after each CMS Section 1003 technical assistance webinar. In the post-webinar surveys, awardees rated the substance and quality of the webinars, whether the level of detail was adequate, and whether the content was useful to them.

Methods of Analysis

Qualitative and quantitative methods were used to analyze Section 1003 demonstration data (see Exhibits 3, 4, and 5 for details on which analytic methods were used for each evaluation question). Qualitative methods included using Dedoose, a qualitative research and analysis platform, to code stakeholder interview notes and awardee documents. Exhibit 6 indicates the types of interview notes and awardee documents available for each state.

Trained qualitative coders developed an initial coding structure based on the evaluation questions. The coding team conducted training to ensure all members had a shared understanding of the coding structure. The team then coded the qualitative data as available on an iterative cycle to ensure that the awardee data available for analysis were up to date. Throughout the coding process, the qualitative analysis lead conducted reliability testing

activities, including comparing code applications across the coding team, to ensure intercoder reliability and a coherent qualitative analysis.

Exhibit 6. Data Included in Report Analysis

State	Planning Grant Application	Semi-Annual Progress Reports	Year 1 Stakeholder Interviews—Planning Grant States	Post-Planning Period Application	Interviews with States That Did Not Apply for the Post-Planning Period	Year 2 Stakeholder Interviews-Post-Planning Period States
Alabama	x	x	x		x	
Connecticut	x	x	x	x		x
Delaware	x	x	x	x		x
District of Columbia	x	x	x		x	
Illinois	x	x	x	x		x
Indiana	x	x	x		x	
Kentucky	x	x	x		x	
Maine	x	x	x	x		
Michigan	x	x	x		x	
Nevada	x	x	x	x		x
New Mexico	x	x	x		x	
Rhode Island	x	x	x	x		
Virginia	x	x	x	x		
Washington	x	x	x	x		
West Virginia	x	x	x	x		x

A content analysis, including the triangulation of awardee reports, application materials, and stakeholder interviews, was conducted on the coding to identify common themes across the evaluation questions. In this report, results presented from the qualitative analyses summarize key themes and are not intended to account for every state's response to each evaluation question. Additionally, when describing content originating from stakeholder interviews, we do not identify state names in accordance with confidentiality assurances given to states during interviews. Quantitative methods were used to analyze the data from the evaluations of the technical assistance webinars to provide average ratings across a series of ratings.

EXPERIENCES OF STATES AWARDED SECTION 1003 PLANNING GRANTS

Background

Fifteen state Medicaid agencies were awarded planning grants in 2019. As part of the planning grant, participating states conducted an initial needs assessment to determine their SUD treatment and recovery needs. Based on the results of the needs assessment, states developed infrastructure in the form of provider recruitment, provider training and technical assistance, and reimbursement improvement activities.

Appendix A provides state profiles that include a summary of key planning grant and post-planning period (where relevant) activities around needs assessments, reimbursement, provider training and technical assistance, and collaboration.

Utility of Planning Grants as the Foundation for Post-Planning Demonstrations

Exhibit 7. Evaluation Question: Effectiveness of Planning Grants

Evaluation Question	Findings
Were the planning grants an effective mechanism to prepare for the demonstration period? Why or why not?	Yes. In stakeholder interviews, states agreed that the planning grants were effective in preparing for the demonstration phase as intended. However, we found that most states used the grants not only to prepare for the next phase of the project but also to think more broadly about how to strengthen their SUD treatment and recovery system.

Abbreviation: SUD, substance use disorder.

Interviews conducted during the planning period, in May and June 2021, revealed mixed sentiments about whether states found the planning grant specifically helpful to prepare for the post-planning period. Six states said they did find the planning grant helpful for preparing for the post-planning period, specifically in providing a framework for the next phase of the project and for facilitating dedicated planning time.

Seven states reported that they did not have enough information about the expectations for the post-planning period to say whether the planning period prepared them for the post-planning period. For example, one state mentioned that it still lacked information about how the federal reimbursement formula would work for managed care. This was a significant barrier to knowing whether the post-planning period would be helpful for the state given that its primary goal was to bring SUD treatment into its managed care contracts and enable providers to fully participate in managed care.

Because states knew there was a one-in-three chance of being accepted into the post-planning period, they broadened the scope of their plans and made them actionable even if they were not selected to participate in the post-planning period. This approach may have been informed by prior experience. One state had a previous experience with a similar two-phased program where it was awarded a planning grant but not the second phase of funding. The state noted it was "unable to take all the lessons learned into the next phase … [and was] left with questions about how to meet stakeholders' expectations"; therefore, the state wanted to avoid potentially falling into the same situation again. Seven states specifically indicated that they thought of the planning grant primarily as a stepping-stone to future SUD workforce development more generally, rather than as a mechanism to prepare for the post-planning period. All seven of those states reported the planning grants were helpful by allowing them to focus on the challenge of building SUD workforce capacity, to take a comprehensive approach to capacity building, and to develop relationships with providers and patients. Examples of the types of activities that states implemented or planned to increase their future SUD treatment and recovery provider capacity are provided in the following section, which covers long-term capacity building and sustainability.

Utility of Planning Grants for Long-Term Capacity Building and Sustainability Planning

Exhibit 8. Evaluation Questions: Long-Term Capacity Building and Sustainability Planning

Evaluation Questions	Findings
Did the planning grants increase states' long-term capacity (including infrastructure) to assess and manage MAT/SUD recovery needs?	Yes. The planning grant allowed states to build their long-term capacity to assess the needs of their SUD treatment system and build the capabilities of Medicaid providers of SUD treatment or recovery services by conducting Medicaid-specific needs assessments and improving statewide information sharing and access to current data.
Were the states able to put arrangements (including infrastructure) in place during the planning period that will help them maintain activities after the end of the grant period that are necessary for sustained expansions and improvements in SUD treatment?	Yes. The planning grant allowed states to develop data and provider technical assistance/training infrastructure and to engage in strategic thinking that will continue to sustain the capacity developed throughout the grant.

Abbreviations: MAT, medication-assisted treatment; SUD, substance use disorder.

The SUPPORT Act required that states develop a plan resulting in long-term and sustainable Medicaid provider networks that will provide a continuum of care for SUD. That plan should include details about how the state is working in close collaboration with key partners, including other state agencies and SUD-related initiatives.[9] *Long-term capacity building* includes the

capacity to meet needs now and increased needs in the future. *Sustainability*, as referenced in the Section 1003 demonstration, refers to capacity building that can be maintained at that increased level, even after the demonstration funding is completed. In their reporting on demonstration activities, states discussed long-term capacity building and sustainability as intertwined. A core component of sustained long-term capacity building is well-informed and evidence-based planning and decision-making. To that end, multiple states identified the planning grant as one of the first opportunities they had to conduct a statewide, population-wide assessment of needs, prevalence, treatment rates, and gaps; to develop plans supported by holistic data; and to share findings with relevant stakeholder groups. One state noted that the planning grant allowed it to develop a cross-department perspective, resulting in the implementation of a system for reviewing and tracking barriers to increasing and improving provider capacity. Another state said that, prior to the planning grant, "the idea of centralizing our responses and strategies was not a focus." To illustrate the sustainability element of the planning grant structure, one state went so far as to say it was "not going back" on the infrastructure and intra-state coordination advancements developed over the course of the planning grant.

Overall, states were successful during the planning period in developing plans for long-term, sustainable capacity building for Medicaid providers to deliver SUD treatment or recovery services. Examples of infrastructure developed by states during the planning period include the creation of data infrastructure, such as data dashboards and other information-sharing technology; workforce development, such as technical assistance/training infrastructure; statewide collaboration across SUD-related efforts; policy changes; and efforts to diversify funding, including aligning with other grants and programs, pursuing external funding, and considering alternative payment models. States designed the infrastructure to be sustainable regardless of their participation in the post-planning period, thereby creating the potential to increase capacity for SUD care in the long term.

Data infrastructure. As described in stakeholder interviews and awardee documents, states used Section 1003 demonstration funding to build data infrastructure, including information-sharing technology between state agencies, and between patients and providers, while ensuring the requisite funding would be in place to continue operations. Examples of specific state actions are described in Exhibit 9. Where states offered specifics regarding the types of data and data

elements included in their data infrastructure efforts, that information is provided in the descriptions below.

Exhibit 9. Examples of Actions Taken to Develop Data Infrastructure

State	Action
Alabama	Developed a data repository that includes all currently accessible data collected by their statewide OUD response initiatives and grants (i.e., the Bureau of Justice Assistance Harold Rogers Prescription Drug Monitoring Program grant), which will be tied to other implementation projects and proposals by the state. Data collected from other groups can be rolled into this data repository on an ongoing basis to promote accurate analysis and assessment.
District of Columbia	Developed a consent management tool to support providers who offer a range of SUD services across varied practice settings to ensure that the system is responsive to provider needs and enhances collaboration.
District of Columbia	Described a sustainability plan created by its vendor that includes collaborating with other Health Information Exchanges, developing an open-source solution, and sharing maintenance and enhancement costs across the region.
District of Columbia	Reported a success in data sharing between its FQHC and Health Information Exchange, where the state used SUPPORT Act funds to initiate an e-consent model pilot. This work resulted in a much more fluid handling of consent for the FQHCs through the Health Information Exchange, which allows for more efficient data sharing with other providers and improves treatment coordination.
Delaware	Asked its data analytic vendors to develop an approach that could be handed off to its internal staff so that the analyses could be replicated. Also asked the vendors to develop guidebooks or manuals so that internal analysts could be trained on these approaches.
Indiana	Developed SUD Prevalence and Treatment Dashboards using state-specific claims data that will be shared widely and serve as a "one-stop shop for relevant and timely data to inform future practice, program, and policy decisions." Also developed and implemented Indiana Community Connect, a virtual resource directory and referral network, which both providers and patients can access to locate SUD services by ZIP Code and providers can use to complete an online referral.
Maine	Developed a Service Locator Tool to allow users—both patients and providers—to identify and access SUD and mental health treatment or recovery services offered in the state. Developed the tool based on feedback surrounding barriers to treatment that it gathered throughout its qualitative assessment process. Also created the MaineCare SUD Policy Inventory—a database that centralizes information relating to SUD services and programs in the state; that identifies exclusions, limitations, and potential barriers to accessing SUD services; and that the state will use to track opportunities for improvement and any progress made.
Maine	Joined the statewide Department of Health and Human Services Opioid Data Sharing Committee to allow the state to sustain meaningful and ongoing reporting on SUD prevalence and needs assessment beyond the grant that includes collaboration with other state agencies and sharing of resources.
Nevada	Focused some of its planning grant vendor activities on documenting the vendor's research methods to equip state staff with the knowledge needed to further build provider capacity and Medicaid infrastructure. Contracted with a vendor to support the development of a long-term strategic plan to address SUD within the state.

State	Action
Rhode Island	Implemented Mirah, a measurement-based care software that collects and allows for the review of patient data to enhance clinical decision-making, at seven community mental health centers in the state. (The state did not identify the nature of the patient data reviewed by the software.)
Rhode Island	Negotiated with its clinical decision support platform vendor to continue providing services beyond the grant period at a discounted rate for its SUD providers and required that the providers commit to continuing the services with these lower rates. Used this approach to ensure that the providers will have access to, and be incented to use, this software beyond the completion of the grant.
Virginia	Required that its data analysis contractor use its institutional Medicaid knowledge to support the state's efforts to identify efficiencies and additional funding opportunities that could support the continuation of grant activities.
West Virginia	Rolled out the CHESS mobile application, which is intended to increase the capacity of SUD providers by allowing them to connect and engage with their patients to prevent relapse and feelings of isolation. Also developing a pilot data contingency management mobile application called DynamiCare.

Abbreviations: FQHC, Federally Qualified Health Center; OUD, opioid use disorder; SUD, substance use disorder; SUPPORT Act, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment.

States specifically highlighted data sharing with other state agencies, such as their Department of Public Health, Department of Justice, and opioid data sharing committees, as a key requirement for long-term capacity sustainment and a critical component of their collaboration strategies. The types of data shared by states includes electronic health records, SUD prevalence, and provider capacity data. The collaboration strategies included outreach to other agencies to facilitate regular data sharing and using those data to improve Medicaid agencies' understanding of state SUD treatment and recovery needs and capacity. State project teams reported coordinating with their department of public health for access to their overdose data or their department of corrections for their information on medication for OUD treatment in the prison population.

States often identified the SUPPORT Act needs assessment as an important, and sometimes unique, source of population- and service-specific data and analyses that they planned to repeat in the future. States mentioned using the needs assessments to begin developing a more robust SUD surveillance system or to examine subpopulations of interest. One state said, "Even from day one, [we were] excited about this RFP and for making the time and resources to support the needs assessment piece and build relationships/infrastructure within the state … [as well as] beyond the state government, to continue to move this work forward. It has been really impactful and collaborative, and the focus has been on building an informed system of care,

rather than one-off projects." Another state reported using the needs assessment to develop its first Medicaid data codebook, which allows the state to analyze its Medicaid data in ways it never could before the demonstration.

Although the planning grant was a time-limited opportunity, states fostered the long-term utility of their data infrastructure by engaging vendors and contractors in the development of sustainable work. As described in Exhibit 9 above, three states required their vendors to provide knowledge and training materials to state staff to allow them to continue conducting certain analyses or collect relevant data to improve their decision-making in the future, and two states found other ways to use their vendors to ensure sustainability of the strides made in data infrastructure and analysis.

Workforce development. Eleven states developed provider outreach and technical assistance infrastructure, such as websites or a webinar series, that will continue to be hosted online and available to providers beyond the life of the Section 1003 demonstration. The topics of these materials range from instructions for becoming a Medicaid provider and billing for services to skill-building and competency-based content intended to improve health outcomes. Examples of specific state actions are described in Exhibit 10.

Exhibit 10. Example Actions Taken to Develop Provider Workforce

State	Action
Illinois	Targeting providers early in their careers by requiring a rotation in addiction medicine for all internal medicine residents and updating the addiction medicine curriculum for the family medicine resident rotation.
Maine	Hosted two webinars for 20 practice sites consisting of 59 care team staff in primary care settings to increase their capacity for SUD treatment, including MAT. Updated two care team practice guides: *WORDS MATTER: A Substance Use Conversation Guide* and *Maine Pain and Addiction Playbook 2022: A Quality Improvement Guide*.
Virginia	Led or sponsored 53 technical assistance webinar events attended by more than 2,000 people that covered topics such as contingency management, co-occurring mental health and SUD treatment, urine drug screens, behavioral addictions, and the American Society of Addiction Medicine treatment criteria levels. Also offered specific trainings to support the implementation of peer recovery services.

Abbreviations: MAT, medication-assisted treatment; SUD, substance use disorder.

Many states are developing provider technical assistance programs as part of their long-term capacity building, with goals that include decreasing stigma for caring for individuals with SUD; implementing practice transformation specific to treatment retention; developing pathways for

hiring peers, community health workers, and community support workers; and creating opportunities for internships or job shadowing in behavioral health organizations.

Statewide collaboration. States were required to coordinate and collaborate with other agencies and efforts around SUD in their state. Some state agency awardees collaborated with their Department of Public Health and Single State Agency for Substance Abuse or aligned their efforts with state initiatives such as CMS Section 1115(a) demonstrations, SAMHSA State Opioid Response grants, and the CMS Maternal Opioid Misuse Model. Specific examples of statewide collaboration efforts are described in Exhibit 11.

Exhibit 11. Example Actions Taken to Promote Statewide Collaboration

State	Action
Kentucky	Identified treatment barriers specific to women of childbearing age as a result of its needs assessment and joined the Center for Medicaid and CHIP Services' Improving Postpartum Care Affinity Group to further support that population.
District of Columbia	Used the results of its needs assessment to inform planning efforts for a larger carve-in than the state previously had for behavioral health services. Stated that this work "created a system more responsive to SUD provider needs and created opportunities for providers across other practice settings to become more informed and competent and less stigmatizing in their care environments."
Delaware	Developed provisions in its managed care organization contracting specifications intended to increase the quality of and access to SUD treatment.
West Virginia	Plans to develop a capitated payment model for SUD services in the state.

Abbreviations: CHIP, Children's Health Insurance Program; SUD, substance use disorder.

All planning grant states found that these intra-state strategic partnerships were helpful for broadening their perspective regarding the importance of coordinating with related initiatives happening in the state. As one state put it, the grant "has supported a concerted effort to coordinate and align these multiple departmental projects, initiatives, and strategies and identify gaps and opportunities to increase provider treatment and recovery capacity." This state also said the grant "supported exploration of potential funding sources to increase or maintain increases in capacity." Eight states either developed behavioral health action plans or engaged with statewide leadership or steering committees charged with developing and implementing such plans. States also share reports generated from their needs assessment analyses with other state agencies or with members of the governors' opioid/SUD task forces to increase awareness around SUD treatment and recovery capacity and gaps within the state Medicaid system. States collaborated with other initiative teams to identify opportunities for information sharing and

aligning their work toward common goals, and they used the outcomes of their planning grant activities to inform their next steps. Three states also engaged their managed care entities in their long-term capacity plans.

Policy changes. The information received from the planning grant needs assessment provided states with the impetus to implement policy changes and new legislation that would sustain the goals of their Section 1003 demonstration participation. Examples are described in Exhibit 12.

Exhibit 12. Example Actions Taken to Change State Policies

State	Action
Indiana	Expanding the provider types eligible for reimbursement in its Medicaid system.
Michigan	Engaged with leaders in the state's 10 prepaid inpatient health plan regions to discuss the regulatory requirements for delivering peer recovery services. Currently implementing revisions to remove burdensome requirements, a change that is expected to increase the number of people who can become state-certified peer recovery coaches.
New Mexico	Automizing and digitizing three applications and two roster systems to make information submission less time-consuming.
Washington	Leveraged the work done during the planning period to influence the enactment of a state policy to provide funds for tracking provider capacity to prescribe medication for OUD.

Abbreviation: OUD, opioid use disorder.

Four states used the results of their rate studies to propose changes to reimbursement or a rate increase. One state said that communicating "the successes and the positive outcomes" of the planning grant created buy-in with executive leadership and will allow them to influence upcoming budget decision packages. In response to stakeholder feedback about burdensome administrative processes or gaps in services, four states are changing Medicaid policies for provider enrollment processes. Finally, three states will be pursuing State Plan Amendments to transition grant activities into Medicaid-reimbursable services.

Funding diversification and provider reimbursement. All planning grant states identified complementary funding opportunities, such as statewide initiatives, grants, or waivers, to sustain their SUPPORT Act activities. Nine states used the results and recommendations of their needs assessments or rate studies to inform planning sessions for existing statewide transformation efforts. Eight states either expanded or applied for a new Section 1115(a) demonstration to support the continuation of grant activities. Many states are also considering implementing alternative payment models into their SUD treatment systems as a result of the work done under the planning grant. Specific examples are described in Exhibit 13.

Exhibit 13. Example Actions Taken to Implement Alternative Payment Models for SUD Treatment

State	Action
Connecticut	Convened a series of key stakeholder workgroup meetings to discuss the range of value-based payment models used in the behavioral health sphere and determine their feasibility in the state. Based on workgroup recommendations, considering a combination of pay-for-reporting, pay-for-performance, or alternative payment model with shared savings approaches for SUD providers.
Kentucky	Researching alternative payment models, such as bundling services and value-based payment models, to redefine how services are covered and sustain expanded provider coverage. Will work directly with providers on these efforts to ensure their perspectives are reflected in the results.

Abbreviation: SUD, substance use disorder.

Ten states described plans to pursue a Patient-Centered Opioid Addiction Treatment (P-COAT) or a value-based payment model soon, based on the results of their rate studies and provider feedback.

Adequacy of Planning Grant Duration

Exhibit 14. Evaluation Questions: Planning Grant Duration

Evaluation Questions	Findings
Was 18 months the optimal time frame for the planning grants?	No. Most states recommended at least 24 months for a planning grant.
Was 24 months optimal considering the COVID-19 pandemic?	Mixed. Four states agreed that 24 months was enough time for them to complete their planning grant goals. All states said that even without a pandemic, 18 months was too short.

As previously shown in Exhibit 2, the Section 1003 demonstration originally included an 18-month planning period, which was extended to 24 months due to the COVID-19 public health emergency. Interviews in May and June 2021 with state project staff inquired about whether either of those time frames was adequate for the work they intended under the planning grants. Project teams uniformly reported a belief that, even if the pandemic had not occurred, 18 months would have been insufficient to accomplish their planned objectives. Ten states noted that the processes for getting contracts executed and hiring staff resulted in significant delays of between 3 to 6 months before work could get underway. States reported additional barriers other than the pandemic, such as difficulty balancing priorities between the planning activities and activities to increase infrastructure during the planning period, challenges in rapidly obtaining buy-in from stakeholders, and, for two states, the need to include enough time for at least two legislative sessions so that appropriate statutory and regulatory changes could be achieved during the

planning period. One state did suggest that 18 months might have been reasonable if there was a grace period for contracting with vendors and onboarding staff.

Twenty months into the planning grants, state staff were more divided on whether 24 months was sufficient. Four states reported that 24 months seemed appropriate to complete their planning grant activities despite the pandemic. However, when given the opportunity to extend their planning grant activities beyond the 24 months, 11 states sought extensions to do so regardless of whether they were applying for the post-planning period. One state requested and received a 6-month extension, and the other eight states requested and received a 12-month extension. Three of the five states that were chosen for the post-planning period requested and received approval for the carryover of funds for planning grant activities during the post-planning period.

Benefits from the Planning Grant

Exhibit 15. Evaluation Question: Benefits from the Planning Grant

Evaluation Question	Findings
What benefits do states perceive from participating in the planning period?	Benefits states perceived from participating in the planning grant include: • Opportunity to design an informed system of care • Opportunity to examine new populations • New partnerships with other state agencies, providers, and other stakeholders • Time to be strategic rather than reactive • Flexibility to be reactive and responsive to their needs and develop the infrastructure that is right for them

All awardees interviewed said that participating in the Section 1003 demonstration planning grant helped their state increase Medicaid provider capacity for SUD treatment or recovery services. States felt the grants were the first time they had the opportunity to design an informed system of care, rather than focusing on individual components. Additionally, awardees said the planning grant gave them opportunities to examine new populations and to develop a new understanding about the needs of, and the availability of services for, Medicaid beneficiaries with SUD in their state. As mentioned previously, a planning grant requirement was to coordinate and collaborate with other state agencies and SUD-related initiatives. In line with this grant requirement, states emphasized the benefits of discussions with beneficiaries and providers

and the usefulness of new partnerships with sister state agencies, SUD treatment providers, and other stakeholders. States said the grant provided them with the opportunity to be strategic in their efforts, with dedicated time to plan, rather than just being reactive to the opioid crisis. One state mentioned that the Section 1003 demonstration had contributed to increasing the number of collaborations and the collaborative spirit: "There is a state atmosphere of working to try to address the epidemic and get to the continuum of care so we can reduce overall mortality and get people's quality of life back." Another state mentioned that the planning grant was a unique opportunity for the state Medicaid agency to collaborate with other state agencies so that it was not siloed. In these examples, the state Medicaid agency was seen as the leader; therefore, the specific focus was on the Medicaid population and providers.

One state said that the planning grant gave it time to reflect on what it would take to reach the end goal, so although the state was trying to think big, it was making small investments locally. For example, it was focused on increasing medication-assisted treatment (MAT) capacity. When the state realized it did not have the trained workforce to expand those services, it focused on local health systems. One of its health care systems hired a physician whose contract included 25 hours a week dedicated to expanding MAT through three hospitals and 27 clinics. The state said that although this was a small step, it showed that the state was doing more than just saying it wanted to increase MAT capacity because it had dedicated resources to prioritize this capacity increase. The state emphasized that without the planning grant funding, it would not have been able to make increasing MAT capacity such a high priority.

One state described the flexibility allowed by the planning grant as "really helpful in terms of understanding the community and state and meeting needs." The flexibility afforded by this grant structure allows states to be reactive and responsive to their needs and develop the infrastructure that is right for them. For example, one state pivoted from conducting outreach and supporting local tribal entities on an individual basis to creating a tribal behavioral health-focused association, which will continue collaborating after the end of the grant and continue to meet the needs of the community. Another benefit that states appreciated was the opportunity to confer and share information with other state agencies. As one state put it, "The level of collaboration, you can't even put a price on it. There are things like the T-MSIS [Transformed Medicaid Statistical Information System] data sharing that have brought things to light we have thought about digging deeper into. The bigger project has opened a lot of communication and a

lot of doors, and we are thankful for that. If another opportunity came up that met our allowances and that we could participate in, we certainly would."

Lessons Learned from the Planning Grant

Exhibit 16. Evaluation Questions: Lessons Learned from the Planning Grant

Evaluation Questions	Findings
What lessons learned about planning grants would they share with other states?	States said the importance of stakeholder engagement as well as early and flexible strategy development were notable lessons learned they would share with other states.
What would they do differently if they could do it again?	States would have focused on their data knowledge and integration earlier in the planning period, been more strategic about using stakeholder groups, or started training and technical assistance efforts sooner in the planning period if they could do it again.

Planning grants provided states an important opportunity to engage in comprehensive planning toward long-term increases in provider capacity, even without the post-planning demonstration funding. The impact of the planning grants can be enhanced by early stakeholder engagement and flexible strategy development. During stakeholder interviews, nine states mentioned the engagement of stakeholders (e.g., other state agencies, providers, and tribal experts) as one of the key components of their planning grant. They recommended that states participating in future planning grants engage stakeholders early and establish clear lines of communication and feedback. Some states had regular meetings with stakeholder representatives, while others regularly shared documents (e.g., qualitative and quantitative findings from the needs assessment) to keep stakeholders and leadership informed of ongoing planning grant activities. One state mentioned that it was beneficial to capitalize on existing relationships initially and then build new relationships as it moved through the planning period.

States differed in their recommendations for the focus of future planning grants. Two states recommended a broad approach that considers the entire SUD service delivery system, whereas one state recommended starting with a single population and focusing on that group's needs. Additional recommendations to future state participants were to be flexible and willing to adjust the plan if they learn something unexpected during the needs assessment, to conduct both the qualitative and quantitative parts of the needs assessment at the same time so that the qualitative data can provide context to the quantitative analysis, and to take a strengths-based approach to

the needs assessment and infrastructure development. The strengths-based approach allowed states to focus on what was going right and think about how they could expand those portions of their treatment or recovery capacity. Planning grant awardees also recommended states participating in future planning grant initiatives take advantage of the opportunity to be strategic and intentional in their efforts rather than reactive to a crisis.

In stakeholder interviews, post-planning states were asked what they would have done differently if they could start over, given their current knowledge. Two post-planning awardees would have focused on their data knowledge and integration sooner in the planning period. Both states felt as though they had underestimated how much time it would take to, for example, integrate data from various state systems or understand the idiosyncrasies of their Medicaid Management Information System. These data-related tasks were time-consuming and led to delays in actual capacity building because the states needed the data to fully understand where the gaps were and what would benefit them. Two states experienced difficulties engaging with groups of stakeholders/subject matter experts that they had originally intended to provide brainstorming and strategic planning for their planning grant work. One of these awardees could not meet with its subject matter expert council enough to obtain useful advice. The other awardee wished it had been more focused in its direction to its stakeholders; rather than allowing the brainstorming to focus on every aspect of the treatment system, the state would have chosen a specific end goal. Finally, one state would have begun its technical assistance efforts earlier to allow for additional in-person trainings and more sessions of its other successful technical assistance efforts.

States That Did Not Apply for the Post-Planning Period

Six states did not apply for the post-planning period, as shown in Exhibit 17. Exhibit 17 also indicates which states received approval of a no-cost extension or the carryover of leftover funds from the planning grant into the post-planning period, regardless of whether they applied or were accepted for the post-planning period.

Exhibit 17. Status of Section 1003 Planning Grant States in Relation to the Post-Planning Period

State	Census Region	Applied for Post-Planning Period	Accepted for Post-Planning Period	No-Cost Extension/ Carryover
Alabama	South	No	Did not apply	NCE: 12 months
Connecticut	Northeast	Yes	Yes	No

State	Census Region	Applied for Post-Planning Period	Accepted for Post-Planning Period	No-Cost Extension/ Carryover
Delaware	South	Yes	Yes	Carryover
District of Columbia	South	No	Did not apply	NCE: 12 months
Illinois	Midwest	Yes	Yes	Carryover
Indiana	Midwest	No	Did not apply	NCE: 6 months
Kentucky	South	No	Did not apply	No
Maine	Northeast	Yes	No	NCE: 12 months
Michigan	Midwest	No	Did not apply	NCE: 12 months
Nevada	West	Yes	Yes	Carryover
New Mexico	West	No	Did not apply	Carryover
Rhode Island	Northeast	Yes	No	NCE: 12 months
Virginia	South	Yes	No	NCE: 12 months
Washington	West	Yes	No	NCE: 12 months
West Virginia	South	Yes	Yes	No

Abbreviation: NCE, no-cost extension.

Note: Carryover is approval for post-planning states to carry over leftover funds from their planning grant to continue planning grant activities in the post-planning period.

The six states that did not apply for the post-planning period cited concerns about the post-planning funding. Specifically, they reported concerns that the funding would not be sufficient to implement their demonstration plans or that the funding formula was too complex to assess whether it would be adequate. Four of the six indicated that the administrative burden required to receive the federal reimbursement would outweigh any potential benefits. One state was concerned that it could potentially receive zero dollars for a quarter but would still have to staff the program. Three states identified that the timing of the release of the detailed methodology for calculating the federal reimbursement was too late for them to assess whether they would receive adequate funding for their implementation plans and thus decided not to apply.

In addition to issues relating to the funding, two states did not apply because they did not feel the post-planning period would allow them to implement the innovative approaches necessary to achieve expanded capacity. These two states would have liked the opportunity to test new strategies or cover services not traditionally covered by Medicaid. Specifically, one state had hoped it could pilot promising SUD services during the post-planning period under the authority of a demonstration. Although the state could have sought a Section 1115(a) demonstration amendment, it decided the additional burden was not worth it. Another state said that the

demonstration “didn’t speak to the issues” found during the planning period. Through the planning grant, the state identified a lack of childcare and a lack of access to transportation as larger barriers to the receipt of treatment than any lack of providers or available services; however, childcare is not a covered Medicaid service and therefore could not be funded through the post-planning period federal reimbursement. The state was also uncertain whether the federal reimbursement would sufficiently cover transportation costs. Three states described turning to other funding sources, such as the newly released American Rescue Plan Act of 2021 or the SAMHSA Certified Community Behavioral Health Clinic expansion grants, to continue the work they started under the planning grant rather than applying for the post-planning period. The three remaining states did not mention identifying alternative ways to implement their plan in their explanation for why they decided not to apply for the post-planning period.

EXPERIENCES OF STATES SELECTED FOR SECTION 1003 POST-PLANNING PERIOD

Background

Exhibit 18. Evaluation Question: Targeted Populations and Providers

Evaluation Question	Findings
Describe the populations and providers targeted by states for the post-planning period.	Populations that states are targeting in the post-planning period include individuals at risk for overdose, Black beneficiaries, pregnant and postpartum women with SUD/OUD, infants with neonatal abstinence syndrome, justice-involved individuals, individuals with stimulant use disorder, rural communities, families, and children, youth, and young adults. Providers targeted by the post-planning states include residential treatment centers, withdrawal management centers, outpatient agencies, providers of medication for OUD, emergency departments, primary care providers, women's health providers, peer and recovery support specialists, nurse practitioners and midwives, and health centers (federally qualified, rural, behavioral, community).

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

Nine of the 15 planning grant states applied for the post-planning period, and five states were chosen: Connecticut, Delaware, Illinois, Nevada, and West Virginia. Exhibit 19 provides information about the target populations and providers of the five states participating in the post-planning period, as identified in their post-planning period applications and stakeholder interviews. States identified priority populations using a variety of mechanisms: the needs assessment, recommendations in the SUPPORT Act legislation, and predetermined state priorities.

Exhibit 19. Targeted Populations and Provider Types for Section 1003 Post-Planning States

State	Populations Targeted	Providers Targeted
Connecticut	Individuals at risk for overdose, Black beneficiaries, Black beneficiaries with co-occurring OUD and HIV.	Residential treatment centers, withdrawal management centers, outpatient agencies, medication for OUD providers, emergency departments, medical/primary care providers, peer and recovery support providers.

State	Populations Targeted	Providers Targeted
Delaware	Pregnant and postpartum women/mothers with SUD, infants with neonatal abstinence syndrome.	Office-based opioid treatment programs, buprenorphine prescribers, women's health providers, opioid treatment programs, residential treatment providers.
Illinois	Justice-involved individuals, children, and families, pregnant and postpartum women with OUD.	Medication for OUD providers in primary health care settings, community-based outpatient providers, opioid treatment programs, FQHCs, nurse practitioners.
Nevada	Pregnant and postpartum women, individuals with stimulant use disorder, adolescents, young adults, rural and frontier communities, justice-involved individuals.	Nurse-midwives, buprenorphine prescribers, FQHCs, Certified Community Behavioral Health Clinics, community health workers, rural health clinics, tribal health centers, peer recovery and support specialists.
West Virginia	Individuals with stimulant use disorder, pregnant and postpartum women and their infants, at-risk and transition-aged youth, rural populations, infants with neonatal abstinence syndrome.	Licensed behavioral health centers, FQHCs.

Abbreviations: FQHC, Federally Qualified Health Center; HIV, human immunodeficiency virus; OUD, opioid use disorder; SUD, substance use disorder.

Exhibit 20 provides examples of post-planning states' planned demonstration activities as proposed in their post-planning period applications. Additional details on states' planned activities and goals for the post-planning period are outlined in the state profiles in Appendix A.

Exhibit 20. Examples of Planned Activities for Section 1003 Post-Planning States for Needs Assessment, Reimbursement, Provider Training and Technical Assistance, and Collaboration

State	Needs Assessment	Reimbursement	Training and Technical Assistance	Collaboration
Connecticut	Examine availability of Medicaid providers accepting new patients, patients' access to care, hospitalizations, and spending.	Provide higher rates to enable providers to meet ASAM standards and implement value-based payment model for outpatient services.	Provide trainings in screening and assessment of SUD in medical or primary care settings and recovery coach trainings.	Collaborate with Connecticut Housing Engagement Support Services and InCK.
Delaware	Identify key monitoring metrics related to prevalence, treatment system capacity, and patterns in SUD service utilization.	Design and implement the preferred OBOT model with a two-tiered payment model.	Design training and technical assistance specialized to Medicaid providers and support the aims of advancing OBOT services.	Lead a cross-agency effort to compile and compare SUD/OUD initiatives and policies across state agencies.

State	Needs Assessment	Reimbursement	Training and Technical Assistance	Collaboration
Illinois	Review service utilization and participation of MAT providers and establish focus groups of individuals and families with lived experience, OTPs, prescribers.	Identify opportunities to introduce an alternative payment model that would help expand the base of prescribers willing to provide MAT services.	Offer a rural opioid training program, peer-to-peer support, and stipends for clinicians to complete Drug Addiction Treatment Act waiver training.	Continue participation at the Illinois Opioid Crisis Response Advisory Council and the SUD Advisory Council.
Nevada	Collect data to assess behavioral health treatment, provider capacity, and level of care coordination needed.	Develop an alternative payment for MAT services and implement a pay-for-performance incentive program through Nevada's Medicaid managed care programs.	Offer MAT providers training and, potentially, incentives for participation in the Patient-Centered Opioid Addiction Treatment model.	Partner with the Division of Health Care Financing and Policy to collect primary data and host a provider design session.
West Virginia	Assess SUD and other behavioral health treatment and recovery service needs by leveraging existing programming, including surveys, surveillance tools, and workforce data.	Explore the incorporation of the Collaborative Care Model billing codes into the state's Medicaid program.	Provide training and technical assistance to programs and providers of SUD treatment and recovery services.	Work with Mountain State Assessment of Trends in Community Health and the Department of Health and Human Resources to understand community health challenges with SUD, mental illness, and access to care.

Abbreviations: ASAM, American Society for Addiction Medicine; InCK, Integrated Care for Kids; MAT, medication assisted treatment; OBOT, office-based opioid treatment; OTP, opioid treatment program; OUD opioid use disorder; SUD substance use disorder.

Initial Implementation of the Post-Planning Period

Exhibit 21. Evaluation Questions: Initial Implementation of the Post-Planning Period

Evaluation Questions	Findings
Is implementation going according to plan?	Implementation of post-planning period activities is going slower than anticipated.
What barriers and facilitators have the states encountered [do the states anticipate] while implementing their plans?	Barriers to implementation are Section 1003 demonstration funding administration and state procurement timelines and processes. Facilitators for implementation are the federal reimbursement funding, coordination and collaboration with other state initiatives, and the ability to carry over funding from the planning grant.
What benefits do states perceive [expect] from participating in the demonstration?	States' perceived benefits were the funding from the federal reimbursement and opportunities to stay focused on SUD provider capacity over the 3-year demonstration period.

Abbreviations: SUD, substance use disorder.

During interviews with project teams, awardees reported that the initial implementation of the post-planning period is proceeding but slower than they would have liked due to grant administration issues, uncertainty around the timing of the first federal reimbursement payment, and data access challenges.

States identified two issues with the SUPPORT Act funding administration that led to delays in activities: (1) a complex federal reimbursement calculation and (2) a lag in their updated notice of award for their planning grant carryover funds. The federal reimbursement payments were described as a key benefit of the post-planning period, with a couple of states indicating their intention is to reinvest the funding from the enhanced rate back into high-priority initiatives. However, the complexity of the funding formula—specifically, the differences in calculations for fee-for-service versus managed care—have made states slightly concerned about how much money they will receive and whether it will be enough for the plans described in their application. Two states reported having not yet received their updated notice of award for their planning grant carryover funds, which their state legislature requires to release operational funds to administer the grant activities. As a result, some activities are delayed as they wait for an updated document.

Other barriers identified by the states include state procurement processes and timelines. For example, one state was renegotiating its contract with the vendor assisting with all SUPPORT

Act-related activities, and another state had recently released a procurement for managed care organizations. Additional barriers included continuing challenges with data integration and an inability to gain access to a complete list of buprenorphine-waivered providers in the state.

When asked about the facilitators of implementation, awardees identified collaboration with other ongoing initiatives in their state, which is encouraged under the structure of the Section 1003 demonstration; the federal reimbursement; and the approval to carry over planning grant funds into the post-planning period. All the states identified intra-state collaboration as an important facilitator of demonstration activities—whether it be their Section 1115(a) demonstration teams conducting helpful analyses and sharing results, State Opioid Response grant teams having existing technical assistance resources available for SUPPORT Act dissemination, or housing initiatives in the state highlighting the community aspect of its grant programming. One state mentioned that it was collaborating with the project team for the state's CMS Section 9813 State Planning Grant for Qualifying Community-Based Mobile Crisis Intervention Services,[10] and with that initiative and the implementation of the SAMHSA funded 988 Suicide and Crisis Lifeline, the state was expecting a "shift in the provider landscape and some potentially new opportunities to think about new access points" for SUD treatment or recovery services.

In terms of grant administration, states described both the approval to carry over funds from the planning grant and the federal reimbursement as facilitators. The three states with carryover funds from the planning grant were able to work through programming disruptions caused by the pandemic, as well as more common issues such as long procurement cycles. For example, one state focused on completing and submitting a Section 1115(a) demonstration as a result of the carryover funds. Another state said it was happy with the extended time allotted to complete its work because it is currently using the carryover funds to develop data dashboards, which will then be further refined and updated using post-planning period funding. As states proceed into the remainder of the post-planning period, they indicated that the combination of the federal reimbursement, various state initiatives and legislation, and the 3-year demonstration period presents an opportunity to stay focused on SUD and build long-lasting change. For example, one state said that it would finally have the dedicated time and resources during the demonstration period to complete work that was often identified as a need in other initiatives but always postponed. Another state referred to the importance of being able to focus on the labor-intensive

work “down on the ground level.” In two separate instances, the project team invested locally to create enduring culture changes to health systems. The first way the project team invested locally was to hire one physician whose contract includes 25 hours a week dedicated to expanding the number of MAT providers in a three-hospital and 27-clinic system. The second way the team invested locally was by providing seed money to a champion who built an MAT training curriculum in one family medicine residency program. This champion was then relocated to a different site with a similar residency program due to its capacity to bring an MAT training perspective. The state described this work as “tiny steps, but when you look back, it really adds up. It makes real changes that don’t require more funding to keep on.”

STATE PERCEPTIONS OF THE SECTION 1003 DEMONSTRATION TO DATE

State Perceptions of the Application Process

Exhibit 22. Evaluation Questions: Application Process

Evaluation Questions	Findings
What changes would have made the application processes for the planning and demonstration projects more useful/easier? Are there other criteria that should be included?	None. States did not have any recommendations for changes to the application process or suggestions for additional criteria.
Did states feel they received clear direction on what was expected of them?	Yes. States appreciated the extent to which the applications followed the original legislation and found the directions clear.

During interviews with state project leads about states' experiences with applying for the planning and post-planning periods, all states reported finding the directions and application expectations clear. Specifically, the post-planning states mentioned that the alignment of the application components with SUPPORT Act legislation enhanced the clarity of expectations. One state mentioned an appreciation for the post-planning period application scoring guide, finding it helpful for organizing and dividing the work to focus on higher point total items. Overall, states had positive experiences with their project officers from CMS during both the planning and post-planning periods. States found their project officers to be very responsive, which allowed states to receive answers to questions quickly and continue to move their projects forward. Two post-planning states mentioned that although their project officers did not always have the answers to their questions about the post-planning period application when they were posed, the project officers got back to them quickly and sent the response to all planning grant states so they all had the same information. There were some gaps in communication associated with administrator transitions for a subset of states midway through the planning period; however, states said they worked with their project officers to have these issues resolved.

All five post-planning states voiced concerns about the delay in the release of the post-planning period application. States were anticipating the application to be available much earlier and had to scramble when it was released with what they perceived to be a tight turnaround time (posted on July 9, 2021, and due on August 20, 2021). Post-planning states mentioned some difficulties around the application's release conflicting with other SUD-related applications, noting their staff were spread thin applying for multiple initiatives.

State Perceptions of Technical Assistance

Exhibit 23. Evaluation Questions: Technical Assistance

Evaluation Questions	Findings
What technical assistance did the states receive?	States received technical assistance intended to improve clarity around reporting requirements and expectations and to foster a collaborative learning environment. This technical assistance included 17 webinars, a cross-grantee meeting, ad hoc individual technical assistance calls, written resources (e.g., frequently asked question documents on the quarterly progress reports, quarterly feedback on the quarterly progress report submissions), Groupsite (a web-based repository and grantee interaction platform), and project officer calls.
Was the technical assistance received useful, and what other technical assistance might have been useful?	Overall, states found the technical assistance useful. States noted that it would have been helpful to have detailed technical specifications for reporting and one-on-one technical support focused on their state characteristics.
Do the states have recommendations for how to make the technical assistance provided during the planning and demonstration projects more valuable?	Recommendations for how to make the technical assistance more valuable included sending slides ahead of webinars, using more graphics and less text in presentations, sending question-and-answer documents after webinars, and grouping grantees on similar characteristics to facilitate peer sharing.
What did the states learn from the interactions among themselves (i.e., learning community/Groupsite interaction)?	States indicated that technical assistance opportunities to connect with their peer states were the most beneficial. States enjoyed hearing about what other states were doing as well as sharing strategies and ideas for how to overcome barriers. Many states did not find Groupsite beneficial for peer-to-peer sharing.

Abbreviation: CMS, Centers for Medicare & Medicaid Services.

During the planning period, states were provided with technical assistance through webinars, a cross-grantee meeting, ad hoc individual technical assistance calls, written resources (e.g., frequently asked question documents on the quarterly progress reports, quarterly feedback on the quarterly progress report submissions), Groupsite (a web-based repository and grantee interaction platform), and project officer calls. During the post-planning period, technical assistance includes quarterly webinars and individualized technical assistance during project officer calls for the post-planning period awardees and planning grant awardees that received a no-cost extension (for the length of their no-cost extension).

Webinars. During interviews with state project teams, planning grant states reported that the webinars were interesting and that they shared relevant information learned from the webinars with other team members. There were 17 technical assistance webinars presented during the planning period, and there has been one webinar thus far during the post-planning period. Exhibit 24 shows participants' ratings of the content and level of detail from the post-webinar surveys. Due to technical difficulties, two webinars did not have post-webinar survey results.

Overall, participants found the content of the webinars to be excellent and the level of detail to be adequate and useful. The lowest rated webinar was related to the use of T-MSIS Analytic Files (TAF) data; participants indicated they did not understand why this was an important topic for the Section 1003 demonstration planning grants. From their perspective, the data lag meant that there were not current data they could use from T-MSIS for their quarterly reporting. In subsequent webinars, explanations of how T-MSIS data would be used for the evaluation and for the post-planning period funding formula led to higher ratings of webinars about T-MSIS.

Exhibit 24. Percentage of Respondents Reporting Agreement or Strong Agreement with "Content of Webinars Was Excellent" and "Level of Detail Was Adequate and Useful" for Cross-Grantee Learning Cohort Webinars

Webinar Topic	Date	Total No. of State Attendees	Substance of Webinar Was Excellent		Level of Detail Was Adequate and Useful	
			Total No. of Respondents	% Agree or Strongly Agree	Total No. of Respondents	% Agree or Strongly Agree
Value-Based Payment	01/22/20	33	20	95	20	70
Special Populations: Rural	02/20/20	22	9	100	9	89
Using Data to Increase SUD Provider Capacity	02/27/20	27	14	86	13	85
Medication-Assisted Treatment for SUD	03/18/20	48	18	95	18	95
Special Populations: Perinatal	03/26/20	44	14	100	14	100
Value-Based Payment #2	04/29/20	63	20	100	20	100
Special Populations: Perinatal #2	06/23/20	50	14	86	14	100
Reimbursement Approaches for Increasing SUD Provider Capacity	08/12/20	56	22	81	21	86
T-MSIS SUD Databook 101	05/27/20	80	32	100	32	97
Telehealth	06/03/20	54	20	95	20	95

Webinar Topic	Date	Total No. of State Attendees	Substance of Webinar Was Excellent		Level of Detail Was Adequate and Useful	
			Total No. of Respondents	% Agree or Strongly Agree	Total No. of Respondents	% Agree or Strongly Agree
Quarterly Progress Report Instructions Overview	06/09/20	64	27	100	27	100
Using TAFs	06/24/20	73	24	79	24	67
Evaluation Overview	04/13/21	36	16	82	16	94
Use of T-MSIS in Evaluation	06/29/21	58	19	95	19	79
Peer to Peer Discussion of Common T-MSIS Data Reporting Challenges	09/22/21	53	12	100	12	92
Grantee Approaches to Sustainability Planning	12/07/21	23	10	90	10	90

Abbreviations: SUD, substance use disorder; TAF, T-MSIS Analytic File; T-MSIS, Transformed Medicaid Statistical Information System.

Note: Due to technical difficulties, two webinars did not have post-webinar survey results: Quarterly Progress Reports: Reporting Approaches and Common Challenges (01/21/21) and Coordinating Benefits with Medicare-Enrolled opioid treatment programs (01/31/20).

Cross-grantee meeting (September 9 and 10, 2020). During the planning period, states attended a 2-day virtual cross-grantee meeting. The cross-grantee meeting included session topics such as an overview of the application and selection process for the post-planning period, federal efforts in fighting the opioid epidemic, data sharing to enhance Medicaid SUD provider capacity and building infrastructure, and sustained Medicaid SUD treatment capacity (see Appendix B for meeting agenda). In addition to formal presentations, there was a round-robin session focused on states' needs assessments and facilitated discussions about special populations and telehealth implementation during the public health emergency. In stakeholder interviews in which awardees were asked about the effectiveness of the technical assistance they had received thus far, awardees reported technical assistance opportunities incorporating peer-to-peer learning and sharing, such as grantee report-outs during the cross-grantee meeting, as the most beneficial type of technical assistance provided during the planning period. Overall, 86 percent of the respondents (N = 14) in the post-cross-grantee meeting survey reported agreement that the objectives were clearly laid out and the sessions were useful for informing sustainability approaches after the planning grant ends. Participants also liked the opportunities for peer-to-peer sharing in the breakout rooms and wished there could have been more opportunities for similar small group discussions.

Groupsite. To engage states in peer-to-peer learning and sharing, at the beginning of the planning period, CMS's technical assistance contractor posted questions on the project's Groupsite web-based forum, encouraging participants to share their planning period experiences and ask questions of their fellow awardees. Some states found this to be a useful strategy to facilitate peer learning, but many states said that there was not as much collaboration on the site as they would have liked and that questions went unanswered or responses unacknowledged by other states. Overall, eight states reported that they would have liked to have different avenues for peer-to-peer learning, such as virtual affinity group meetings or in-person meetings, if COVID-19 had not been a factor. Two states indicated that Groupsite was helpful for states as a repository of previous information related to the grant for new employees to catch up on the overall project. States also mentioned logistical issues with accessing Groupsite in the form of forgotten passwords, sometimes not being able to log in despite having their password, and having to reach out to add new team members to the access list. States noted that as they got busier with planning grant activities, checking Groupsite fell off their radar.

Project officer calls. The technical assistance provided during quarterly project officer calls focuses on the required quarterly progress reports and TAF data. Many states reported the technical assistance they received for the quarterly progress reports (in project officer calls and written documents) was very helpful; however, they wished it had occurred sooner and that they had received more individualized support based on their grant focus (for those focusing on one priority population) or the delivery system in their state.

State Recommendations for Technical Assistance

States offered suggestions from both stakeholder interviews and post-event evaluations for how to make technical assistance during the planning period more valuable. For example, they recommended:

- Sending the slides for webinars ahead of time so grantees could review and develop questions before joining the presentation
- Providing question-and-answer documents in writing so that they were easily accessible for those not wanting to watch a webinar recording
- Including more graphics and less text in presentations to keep the audience engaged
- Seeking input from awardees on what topics would be useful

- Grouping awardees on similar characteristics (focus on priority populations, managed care states, or states with a large rural population) to allow for more peer-to-peer interaction and sharing

Several states reached out directly to other states to share strategies and get ideas for how to overcome barriers that were emerging in their programs; however, they would have preferred to have these discussions facilitated through CMS.

Additionally, six states reported a need for more focused or one-on-one technical assistance given that they all differed in their goals and progress across the planning period. States enjoyed the information-sharing opportunities afforded by the topical webinars and learning cohorts, in part because "cross-state discussion breeds brainstorming," but states with certain system characteristics, such as a heavily managed care or fee-for-service delivery system, would have appreciated targeted technical assistance that reflected the nuances of their systems. Other states indicated that they would have appreciated one-on-one technical assistance for the more "in the weeds" data and reporting requirements, which they were often unfamiliar with or found to be different from the reporting requirements for other grants.

Post-planning states said they would appreciate future technical assistance opportunities to connect with their peer states. They were unaware of what other states had in mind for their post-planning period activities and would welcome opportunities to share and learn from one another.

State Perceptions of the Impacts of COVID-19

Exhibit 25. Evaluation Question: Impacts of COVID-19

Evaluation Question	Findings
What was the impact of the public health emergency on state activities?	COVID-19 delayed implementation timelines and led to shifts in resources in that staff had to be reassigned to focus on pandemic response. Some aspects of the Section 1003 demonstration had to pivot from in-person to virtual formats. However, some states reported unexpected benefits resulting from these impacts, such as improved attendance of virtual meetings and more successful outreach to hard-to-reach populations.

The COVID-19 public health emergency delayed implementation (as noted previously), resulted in shifts to virtual formats, and created a need to pivot some planned activities and resources. However, some states noted unexpected benefits because of these COVID-19 impacts, such as increased attendance of virtual events compared with in-person events and improved access to hard-to-reach populations.

Two states indicated that they wished they could have conducted in-person site visits. One state had originally intended to conduct trainings on site and felt that it would have been more impactful than the virtual format to allow for spontaneous questions or more specific tailoring of the training. Another state had planned in-person site visits with SUD Centers of Excellence providers in other states to explore potential new programs and services. Given the public health emergency, the awardee pivoted those discussions to other state Medicaid agencies rather than providers, which, while still helpful, did not provide the "boots on the ground" perspective the state was hoping to gain from site visits. Awardees also mentioned difficulties in the collaboration and brainstorming process due to an inability to meet face to face. They noted that coming to a consensus about the focus for their capacity-building activities took longer than it would have had they been in one room together.

States noted several benefits associated with the transition to virtual formats. Post-event survey data from the cross-grantee meeting indicated that the virtual format allowed more team members to attend than if it were an in-person meeting. In stakeholder interviews, states reported that the virtual format of their stakeholder outreach allowed them to connect with traditionally hard-to-reach populations. For example, Maine held virtual listening sessions and

received a tremendous amount of feedback from people with lived experiences who may not have been able to participate in in-person sessions. Although the project team feared target populations would not have access to the needed technology, many of the sessions brought input from areas with the least access to technology by using innovative approaches, such as community partners setting up rooms with computers that people could access. Michigan felt that the virtual stakeholder outreach was so successful, especially given the lack of needed travel, that the state may be able to pursue similar grants in the future by using virtual stakeholder engagement.

In some cases, states had to change the scope of their sustainability planning due to the public health emergency. Six states expanded their focus to include telehealth services. One state broadened its efforts to include more telehealth services after certain flexibilities were allowed during the public health emergency, including providing funding and developing telehealth infrastructure for providers newly interested in offering those services. Three states developed telehealth toolkits and other provider training activities. These training resources will continue to be available after the public health emergency ends.

Although states developed strategies to adapt their grant activities, COVID-19 presented resource and administrative issues that hindered implementation of activities and related sustainability planning. One state described a challenge resulting from staff being reassigned to work on the state pandemic response. The state's operations have since become more normal, but its original plan to tie grant activities to a broader state response is no longer an option. Further, some of the pillars from the original plan were reprioritized to accommodate the pandemic response. The state reported feeling as if it is unable to "effectively hitch their wagon to other horses." However, none of the states that did not apply for the post-planning period mentioned COVID-19 as a reason for not applying.

During stakeholder interviews conducted in January and February 2022, post-planning states indicated that COVID-19 is continuing to negatively affect resources, particularly in relation to provider availability and capacity. One state was concerned that it will not be able to staff its new Center of Excellence programs due to COVID-19-related provider shortages, especially nursing shortages. Many nurses and other health care support staff who had traditionally provided SUD-related care had been reassigned to hospitals to care for COVID-19 patients, and state project teams were unsure whether these staff members would be returning to their previous

roles. Another state was hesitant to conduct outreach to providers after a spike in COVID-19 cases, knowing that providers were already overloaded. One state was concerned that it is asking providers to do something new and different, and with the challenges providers have faced with the pandemic over the past 2 years, they do not have the mental or physical capacity to take on something new. Another state mentioned that it "would be hard-pressed to try to do outreach about system improvement right now when everyone is just trying to hang on." This state also mentioned a benefit of the slower uptake of post-planning period activities: "The transition [from the planning period to the post-planning period] has probably benefited us because we didn't have to try to push people when they don't have the capacity to be pushed." Another state noted that it delayed a planned promotional campaign because the state felt it only had one shot at this opportunity and would be better off waiting until people had more bandwidth.

State Recommendations for Future Similar Demonstrations

Exhibit 26. Evaluation Question: State Recommendations for Future Similar Demonstrations

Evaluation Question	Findings
What recommendations do states have for similar programs in the future?	States recommended that future similar demonstrations include: • Detailed guidance for project-related reporting • Early release of information on the funding formula • The provision of administrative funds for the post-planning period • Consideration of an alternative to federal reimbursement as a funding mechanism • Alignment of agencies and initiatives at the federal level • A planning period singularly focused on planning activities as opposed to a planning period with expectations for infrastructure building in addition to planning • Opportunities for peer-to-peer sharing and learning

States' recommendations for future demonstration projects included detailed guidance for project-related reporting, earlier release of information on the funding mechanism for the post-planning period, alignment of agencies and initiatives at the federal level, balance between planning and implementation during the planning period, and regular opportunities for peer-to-peer learning.

Nine states recommended detailed guidance for project-related reporting for future demonstrations. Specifically, states recommended that CMS provide guidance in the form of assumptions, definitions, and technical specifications for quarterly progress reports in future demonstration projects. States understood that CMS was trying to be flexible given different existing state approaches but voiced a need for more structured specifications.

Nine states recommended information on the funding formula be released well in advance of the application deadline for the post-planning period. In addition to the six states that did not apply for the post-planning period, three other states reported concerns about the funding formula for the post-planning period. Many awardees expressed concerns about a lack of timely transparency for how the federal reimbursement would be calculated, especially given the complexity around managed care and capitated payments, and identified this uncertainty as a barrier to deciding whether to participate in the post-planning period. Two of the post-planning states did not feel like they had adequate information about the funding formula at the time of the stakeholder interviews in early 2022 and were concerned about whether they would have enough funding to be redirected into the SUD priorities they had planned to implement in the post-planning period. For future opportunities, states recommended that the details be decided, and specifics be released, as part of the initial notice of funding opportunity.

Seven states recommended providing administrative funding for the post-planning period in future opportunities. They noted that many state Medicaid agency budgets did not have dedicated funding for program administration, and preparing reports and participating in meetings took up quite a bit of time.

Six states recommended that the government consider an alternative to federal reimbursement as a funding mechanism. States that did not apply for the post-planning period recommended considering funding for future opportunities that did not rely on federal reimbursement so that even states that already have a high Federal Medical Assistance Percentage could participate.

States recommended aligning agencies and initiatives at the federal level to foster demonstration success. They noted that the timing of both the planning grant and post-planning period applications coincided with other SUD-related federal initiatives and that application teams were spread thin or had to prioritize one opportunity over another given the overlap. Five states indicated it would have been helpful if the reporting methodologies, definitions, and

specifications were consistent across related initiatives (such as the Section 1115(a) SUD demonstration). In addition to the Section 1115(a) demonstration process at CMS, additional initiatives that awardees mentioned as related to but sometimes conflicting with the SUPPORT Act demonstration timing or requirements included the CMS Maternal Opioid Misuse Model and Mobile Crisis Grants, as well as the Certified Community Behavioral Health Clinic expansion and State Opioid Response funding through SAMHSA. States also mentioned the difficulties they faced in accessing a complete list of buprenorphine-waivered providers. Buprenorphine-waivered providers are one of the key provider groups targeted by the Section 1003 demonstration, and states reported the lack of access to this complete list as a barrier to their needs assessment and measurement of increased capacity of MAT providers in their state. Awardees recommended increased coordination and alignment between the federal agencies to provide access to all needed data for similar SUD-related initiatives.

States proposed regular opportunities for peer-to-peer sharing and learning. Four states recommended that for future opportunities CMS implement specific, regular opportunities for awardees to check in with and learn from one another. One state noted that a regular meeting time for all states across the life of the opportunity set up by CMS at the beginning of the planning period would have been helpful. Another state mentioned that it learned about strategies other awardees were using during SUPPORT Act technical assistance opportunities (such as the cross-grantee meeting), but because those opportunities went away, it never had the chance to ask other states how those strategies played out or what changes they had to make. One state mentioned it would have liked to know how other awardees were affected by and dealing with COVID-19 in relation to their SUPPORT Act activities.

States recommended clarifying the balance between planning and capacity building in future demonstrations that include a planning period. As previously mentioned, states were required to develop infrastructure in the form of provider recruitment, provider training and technical assistance, and reimbursement improvement activities based on the results of their needs assessment. During interviews with the planning grant awardees, three states indicated that they found it difficult to balance the required implementation activities with the planning activities in the planning period. One state said it would have preferred to focus on understanding policy and practice changes that needed to occur without the burden of also implementing capacity-building activities and reporting on outcomes. Two states mentioned confusion around the true purpose

of the planning period—they thought the goal was planning, but the capacity-building requirements made it so that they had to focus on both. One state said its staff was overextended trying to do a thorough needs assessment and simultaneously implement capacity-building activities. States recommended a complete focus on planning activities during the planning period for future opportunities.

CONCLUSIONS

Statutory Design of the Planning Period

The statutory design of the planning grant was effective at facilitating states' development of a strategy to build the long-term capacity of Medicaid providers of SUD treatment or recovery services. Future similar demonstrations should consider these key features of the planning grant identified by states as integral for its effectiveness: the provision of dedicated resources, a focus on the needs of Medicaid beneficiaries and providers, and the requirement that state Medicaid agencies be central to the collaborative statewide effort to combat the opioid epidemic.

Another useful design feature that states indicated should be adopted in future demonstrations was the requirement to align similar initiatives within the state. This requirement was beneficial because it helped states strategically use funding to maximize benefits, avoid duplicative efforts, and foster data integration to understand treatment needs and gaps. The states leveraged the relationships with other state agencies and/or SUD-related stakeholders they developed or strengthened during the planning period to create sustainable increases in SUD Medicaid provider capacity. States perceived that the lack of similar integration or alignment at the federal level was sometimes a barrier to efficiency and progress on their goals for the Section 1003 demonstration. In future opportunities, states recommended aligning reporting requirements for federal initiatives, considering the timing of related initiatives, and coordinating data access across programs.

One aspect of the design that states did not find adequate and should be considered in the design of future demonstrations was the time frame. The original 18-month timeline for the planning period was not sufficient for states to adequately complete their planning grant activities, even if the COVID-19 public health emergency had not been a factor. Awardees recommended increasing the planning period to at least 24 months to allow for time to hire staff, contract with vendors, and implement policy changes. An alternative suggestion was to keep the planning period at 18 months but allow for a delay in the start of the planning grant from award notification so that hiring and vendor contracting can take place prior to the start date.

Statutory and Federal Design of the Post-Planning Period

States recommended that future demonstrations consider an alternative to an enhanced federal match as a funding mechanism. States that already received a high federal match did not apply

for the post-planning period due to concerns that they might not receive enough money to cover their post-planning period implementation plans. Even states that did apply, and some that were accepted into the post-planning period, were uncertain that this funding mechanism would cover the increased administrative costs associated with demonstration implementation. States recommended that future demonstration projects include administrative funding during the post-planning period for program management and reporting.

Grant Design and Administration

Section 1003 demonstration states appreciated that project requirements tracked closely to the original legislation. This consistency helped them navigate the application processes for the planning and post-planning periods. However, participants reported that the delay in providing detailed information about the post-planning period, particularly specifics around the funding formula, hindered their preparation of strategies and planning implementation. Therefore, the timely release of demonstration details in the future should be considered a priority.

Although the planning grant was intended to facilitate implementation in the post-planning period, states took a broader focus when designing their activities. Specifically, states developed steps for building long-term capacity of Medicaid providers of SUD treatment or recovery services that could be implemented regardless of their participation in the post-planning period. According to states, future demonstrations that include both planning and demonstration periods should be designed so that participants in the planning period will benefit from participation regardless of their interest and acceptance into the post-planning period.

States found the technical assistance provided to them as part of the Section 1003 demonstration beneficial. Planning grant states particularly appreciated the assistance they received about data reporting for their quarterly progress reports and any opportunities they had to connect with other awardees. Post-planning states would also like peer-to-peer learning opportunities. Thus, states may benefit from more peer-to-peer learning opportunities in future demonstrations.

Impact of COVID-19

COVID-19 affected many aspects of the Section 1003 demonstration, causing shifts in the timing of the demonstration, forcing states to pivot from in-person to virtual activities, and creating workforce-related issues. Awardees appreciated the initial planning grant extension and then the

opportunity to apply for a no-cost extension, reporting that they would not have met their goals without the timeline flexibilities.

However, the impact of the COVID-19 public health emergency was not all negative. On the one hand, the pivot from in-person to virtual activities because of the public health emergency disrupted outreach to stakeholders, collaboration within state teams, and plans for on-site activities such as trainings or provider site visits. On the other hand, the switch to virtual activities allowed states to access otherwise hard-to-reach populations, and many states recorded their online training and technical assistance for self-paced provider learning in the future.

Several COVID-19-related workforce issues affected the Section 1003 demonstration planning grant that will likely shape the work done during the post-planning period. Just after the start of the post-planning period, a new wave of COVID-19 infections delayed many of the activities that post-planning states had intended to initiate during that time. States had delayed outreach to providers about new training opportunities or big marketing pushes around their project activities. Post-planning states also voiced concerns about how provider burn-out would continue to influence their capacity-building efforts.

Future Section 1003 Reports to Congress

In addition to this AHRQ Report to Congress, CMS is required to submit initial, interim, and final Reports to Congress on the implementation and impact of Section 1003 demonstration activities. 42 U.S.C. 1396b(aa)(6)(B). The Initial Report to Congress details the characteristics of the planning grant states and their plans for the planning period and is currently being prepared for HHS clearance. The interim report will describe activities carried out during the post-planning period and the extent to which post-planning states have achieved the goals they laid out in their application. The last report will provide updates and changes to the matters reported in the interim report and findings from an evaluation of the demonstration project.

The future Reports to Congress will include data from providers in the planning grant states collected via surveys and focus groups. Additional stakeholder interviews will be conducted annually with the project leads for the post-planning states. Section 1003 demonstration that stakeholders that will be interviewed over the next few years include the Single State Agencies for Substance Abuse, Medicaid managed care plans (if relevant), and state provider organizations in each of the post-planning states. The Interim and Final Reports to Congress will also include

robust T-MSIS claims analysis to examine the impact of the Section 1003 demonstration on Medicaid provider SUD treatment or recovery capacity and quantitative analysis of other SUD-related data.

REFERENCES

[1] SUPPORT Act, Section 1003(aa)(1),(2).

[2] SUPPORT Act, Section 1003(aa)(1),(2).

[3] SUPPORT Act, Section 1003(aa)(3).

[4] SUPPORT Act, Section 1003(aa)(4)).

[5] SUPPORT Act, Section 1003(aa)(1),(2).

[6] SUPPORT Act, Section 1003(aa)(3).

[7] SUPPORT Act, Section 1003(aa)(4)).

[8] Centers for Medicare & Medicaid Services. Notice of Funding Opportunity, Section A4. *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity. Notice of Funding Opportunity*. June 25, 2019. https://www.medicaid.gov/sites/default/files/2019-12/supportact1003nofo.pdf

[9] Centers for Medicare & Medicaid Services. Notice of Funding Opportunity, Section E1. *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity. Notice of Funding Opportunity*. June 25, 2019. https://www.medicaid.gov/sites/default/files/2019-12/supportact1003nofo.pdf

[10] American Rescue Plan Act, Section 9813. State option to provide qualifying community-based mobile crisis intervention services.

APPENDIX A: SECTION 1003 STATE PROFILES

Alabama

Section 1003 Participants
Primary: Alabama Medicaid Agency, Alabama Department of Mental Health
Others: Alabama Department of Public Health, Alabama Child Rehab Services, Alabama Department of Economic and Community Affairs, community organizations

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Determine the number of Drug Addiction Treatment Act (DATA)-waivered providers[a] actively providing Medicaid substance use disorder (SUD)/medication-assisted treatment (MAT) services. Survey those not engaged to determine reasons. • Assess the number of telehealth providers, providers in rural areas, and providers in areas with limited public transportation. • Assess the number of telehealth providers and increase use of telehealth. • Identify a process for seamless care coordination, including addressing the silos of care that exist for pregnant and parenting women.
Reimbursement	• Compare Medicaid rates with private/commercial rates and compare reimbursement process for Medicaid with that of other insurance. • Assess denials due to prior authorization and enrollment caps. • Approve telehealth codes for provider billing.
Provider Training and Technical Assistance	• 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. • Provide training for physicians to improve patient care by maintaining or improving knowledge, skills, and attitudes toward SUD. • Leverage telehealth technologies to include tele-psychiatry, opioid use disorder (OUD) services, and community wrap-around services. • Increase use of distance learning. • Develop a learning management system and e-learning modules.
Collaboration	• Coordinate between the Alabama Medicaid Agency and the Department of Mental Health to conduct research and develop insights into the state's health climate to identify needs and the ability of the state to meet them. • Identify opportunities for creating a central data repository for collaboration with the Alabama Department of Economic and Community Affairs, other state agencies, and community organizations.

[a] *DATA-waivered providers* refers to providers granted waivers under the Drug Addiction Treatment Act of 2000 (DATA 2000), which authorized the outpatient use of buprenorphine to treat opioid use disorder.

District of Columbia

Section 1003 Participants
Primary: Department of Health Care Finance, Department of Behavioral Health **Others:** District Office of Contracts and Procurement, DC Primary Care Association, DC Health, Fire and Emergency Medical Services, District of Columbia's Opioid Response Program, local and national experts, community providers (including community behavioral health providers, opioid treatment providers, and Federally Qualified Health Centers [FQHCs])

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. 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. • Pilot the selection and implementation of e-consult and tele-MAT supports to assess ways providers can use these tools to transform practice.
Reimbursement	• 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• 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. • 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. • Make products available on a publicly available project website. • 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. • Award a contract for Medicaid provider SUD education and technical assistance, including tele-consult peer support for providers. • Develop integrated care practice transformation assessment tools using a team-based core competencies framework. • Identify providers to target for outreach. Held meetings with partners to ensure alignment with health information technology and health information exchange connectivity and opioid technical assistance efforts. • Develop and implement consent management tools to facilitate appropriate exchange of 42 Code of Federal Regulations Part 2 information via the District's designated health information exchange.
Collaboration	• Collaborate with existing programs tasked with combating the opioid crisis, such as the District of Columbia's Opioid Response Program and the District's Section 1115 demonstration, to identify gaps the planning grant could address.

Indiana

Section 1003 Participants
Primary: Indiana Family and Social Services Administration's Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration's Department of Mental Health and Addiction **Others:** Indiana State Department of Health, Indiana Professional Licensing Agency, Indiana Division of Child Services, Indiana Department of Corrections, Indiana Commission to Combat Drug Abuse

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports submitted during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • Identify gaps in provider oversight. • Undertake a comprehensive assessment of care coordination capacity between primary care, obstetrics/gynecology, mental health, and SUD treatment or recovery providers. • Inventory all SUD-related licensure and certification. • Review sections of the Indiana Administrative Code specific to SUD service delivery and provider monitoring. • Inventory and review provider manuals and other documentation. • Develop recommendations for edits and enhancements to licensure and certification standards. • Develop infrastructure and dashboard to support needs assessment and future impact evaluation.
Reimbursement	• Review and map reimbursement methodologies for SUD providers across programs. • Assess potential reimbursement methodologies to expand capacity.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Build on existing initiatives, including education and training to extend MAT services into non-SUD specialty settings—such as primary care, obstetrics/gynecology, and emergency medicine—and possibly to extend MAT for non-OUDs, such as alcohol use disorder, and the adoption of evidence-based practices for assessment and service delivery, such as motivational enhancement therapy-cognitive behavioral therapy. • Engage state health information technology staff to consider additional linkages specific to SUD providers. • 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.
Collaboration	• Coordinate between the Indiana Office of Medicaid Policy and Planning and the Indiana Department of Mental Health and Addiction to form the core team for the planning grant. Work together to leverage initiatives to inform Medicaid policy initiatives. • Work 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

Section 1003 Participants
Primary: Kentucky Cabinet for Health and Family Services Department for Medicaid Services
Others: Kentucky Department for Public Health, Kentucky Office of Health Data & Analytics, Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, Kentucky Office of Drug Control Policy, other state agencies, state universities

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • Assess scope-of-practice laws to expand the role of nurse practitioners, including the prescribing of MAT. Identify key stakeholders in expanding the scope of practice for nurse practitioners and consider the potential to expand legislation. • Conduct individual interviews with providers and clients/Medicaid-enrolled individuals related to services, focusing on barriers to treatment services for clients and coordination of care. • Survey Medicaid-enrolled providers to ascertain their 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 interventions for the target populations. Began assessing eligibility criteria for the pregnant population. • Explore efforts other states are undertaking to extend care for women eligible for Medicaid because of pregnancy.
Reimbursement	• 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 to expand Medicaid provider capacity. • Understand where gaps in reimbursement for needed services exist for the targeted population. • Identify alternative payment models for use in the demonstration.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Solicit the development of continuing education credits for providers in SUD treatment or recovery services and for providers in recognizing OUD in their patient populations. • Examine the willingness of the licensure board to offer extended continuing education credits for MAT training.
Collaboration	• Work across state agencies to expand the data-sharing capacity of the Department for Medicaid Services, within the department and across cabinets.

Maine

Section 1003 Participants
Primary: Office of MaineCare Services, Office of Substance Abuse and Mental Health Services (both within the Maine Department of Health and Human Services) **Others:** State Director for Opioid Response, Maine Prevention and Recovery Cabinet (inclusive of the Commissioner for the Department of Education and the Department of Corrections), a state-level Clinical Advisory Committee, a Department of Health and Human Services-wide Opioid Coordinating Council, state opioid treatment authority, Maine Health Data Organization, the Muskie School of Public Service at the University of Southern Maine, HealthInfoNet, Passamaquoddy Health Center, Penobscot Nation Health Department, health care associations and providers

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Conduct gap analyses by 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 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. • 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. • Secure and operationalize a treatment locator. • Create an inventory of current policies and procedures that may limit number, duration, or scope of SUD treatment or recovery services.
Reimbursement	• Assess potential reimbursement methodologies to expand Medicaid provider capacity. • Conduct a rate study to consider 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Conduct provider telehealth readiness assessments. • Amend MaineCare telehealth rules to align with federal guidelines. • Provide licenses and technical assistance to support implementation of telehealth for MAT, behavioral counseling, and integrated care. • Develop a shared agreement on criteria for training peer support providers. • Increase access to SUD training for licensed clinical social workers and licensed 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 strengthen care transitions and care coordination and/or uptake of MAT within primary care settings. • Provide technical assistance through a consultation model that supports workflow improvements within primary care settings. • Use specialized workflow consultation to help primary care providers integrate SUD services. • Review any licensing and MaineCare policy misalignment to address the lack of cross-trained behavioral health providers. • Review reimbursement alternatives for SUD treatment or recovery services.
Collaboration	• Develop analytic capacity in the state through a previous partnership between the Office of MaineCare Services and the Maine Health Data Organization. • Develop a shared data agreement with the five tribal health directors.

Michigan

Section 1003 Participants
Primary: Michigan Department of Health and Human Services Medical Services Administration, Behavioral Health and Developmental Disabilities Administration, the Public Health Administration, the Policy and Planning Administration (which includes the liaison to the Governor's Office, Indian Health Care Providers, and Michigan Department of Education) **Others:** University of Michigan, Community Mental Health Association of Michigan, Michigan Center for Rural Health

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • 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 the findings with provider survey data. • Focus on current perspectives of care coordination (including perceived barriers) in addition to capacity to support coordinated care in the provider survey. • Interview prepaid inpatient health plans about payment rates. • Explore cross-system beneficiary management with state courts.
Reimbursement	• Compare inventory by prepaid inpatient health plan region with data from other states. 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Possibly implement 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. • Provide 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. • Provide training and technical assistance to rural communities on the use of telehealth for SUD treatment or recovery services. • Develop a targeted strategic plan for all technical assistance and training activities necessary to increase overall and targeted provider supply based on the needs assessment. • Possibly include training related to the federal DATA waiver process; evidence-based practices for screening, assessment, and coordination; the promotion of training in medical and other schools; and the Medicaid Graduate Medical Education program policy that encourages recipient institutions to increase SUD treatment or recovery capacity. Consider creation of learning collaboratives and networks that include a review of current evidence and research.
Collaboration	• Use 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.

New Mexico

Section 1003 Participants
Primary: New Mexico Human Services Department Medical Assistance Division
Others: New Mexico Behavioral Health Services Division; New Mexico Behavioral Health Collaborative; New Mexico Children, Youth and Family Department's Behavioral Health Services; New Mexico Department of Health; Behavioral Health Providers Association of New Mexico; Behavioral Health Planning Council; Local Collaboratives (representing each of the state's 13 judicial districts and five Native American communities); Life Link Training Institute; University of New Mexico; consultants

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • 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. • Conduct cost analysis of peer support workers, contingency management, and a pilot related to services for those aged 0–5 years.
Reimbursement	• 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. • Review policies under the state plan to identify areas to increase the number of providers delivering SUD services. • Conduct a 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Train providers on use of the American Society of Addiction Medicine (ASAM) criteria; Screening, Brief Intervention and Referral to Treatment (SBIRT); MAT; and screening for withdrawal management. • Provide individualized technical support to providers on licensing, certification, and billing expectations for Medicaid SUD services. • Develop guidance documents to clarify pathways to licensure and certification for SUD treatment. • Identify a national certification process to be used for peer support workers. • Conduct six live webinars statewide: 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.
Collaboration	• Collaborate with the New Mexico Behavioral Health Providers Association to research alternative payment methods for Medicaid services, which the state planned to explore further over the course of the grant period.

Rhode Island

Section 1003 Participants
Primary: Rhode Island Medicaid, Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, Rhode Island Executive Office of Health and Human Services, Rhode Island Department of Health, Department of Children, Youth, and Families **Others:** Rhode Island Department of Corrections, Rhode Island Office of the Health Insurance Commissioner, stakeholders on the Opioid Taskforce and on the State Innovation Model steering committee (e.g., Medicaid managed care plans, health care providers, Medicaid beneficiary advocates, Indian health care providers and tribal governments, and Medicare providers for dually eligible beneficiaries), Substance Abuse and Mental Health Leadership Council, community providers

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Assess service capacity gaps among Medicaid providers, for example, gaps related to integration of substance use and mental health services and geographic disparities in access to care. • Assess the need for increased capacity across the ASAM levels of residential service. • Assess factors affecting wait times for residential level of care and the willingness of residential providers to provide care for SUD.
Reimbursement	• Establish a billing and claims processing structure that standardizes the billing process. • 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. • Assess alternative payment methodologies and sustainability strategies.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Provide training related to best practices and incorporate practice strategies from the State Innovation Model-funded Triad Project. • Increase provider willingness to deliver MAT, with a particular focus on mid-level providers and use in primary care and emergency departments, with efforts focused on overcoming stigma, lack of confidence and training, and the need for on-site support staff. • Address disparities in care and ensure SUD providers work toward compliance with culturally and linguistically appropriate services (CLAS) standards. • Expand provider capacity to provide trauma-informed/responsive care. • Offer training to increase competency in treating tobacco use. • Work with providers to ensure effective transitions of care among all members of a patient's care team. • Conduct telemedicine training for providers. • Begin career pathways and mentorship program. • Create a learning module about MAT targeted to peer recovery coaches.
Collaboration	• 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. • Ensure alignment and parity in interactions between Medicaid and commercial insurers with providers. • Identify and gather results from existing needs assessments to inform the initial needs assessment to be conducted under the grant, as well as workforce recruitment/retention strategies.

Virginia

Section 1003 Participants
Primary: Virginia Department of Medical Assistance Services **Others:** Governor's Advisory Commission on Opioids and Addiction (Virginia Department of Health & Human Resources, Virginia Department of Public Safety and Homeland Security), Virginia Department of Health, Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Criminal Justice Services, provider associations, providers, tribes

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Solicit input from enrollees, providers, and other stakeholders on assessment development through six regional "World Cafes." • Analyze Medicaid data alone and together with Department of Corrections data to assess needs. • Analyze data from the National Survey of Substance Abuse Treatment Services, the Drug Enforcement Administration's list of DATA-waivered prescribers with Medicaid data, and peer support specialists using Medicaid behavioral health agency data to assess provider capacity. • Determine gaps relative to prevalence and use qualitative data to understand gaps. • Identify at least one office-based opioid treatment (OBOT) and health system per high-need community to develop linkages of care. • Survey providers regarding successes and challenges with care coordination, including billing for care coordination under Medicaid. Assess "bright spot" communities for insight into effective interventions around care coordination. • Identify existing OBOT providers and hospital systems to develop linkages of care for their communities. • Conduct an environmental scan of the Department of Corrections and local jails to determine current infrastructure and technical assistance needs to facilitate a reentry pilot.
Reimbursement	• Analyze potential reimbursement models that incentivize care coordination for subpopulations at 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• Provide technical assistance to health systems to establish an OBOT in areas without one. • 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 warmlines. • 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. • 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. • Provide technical assistance and training to preferred OBOTs. • Provide webinars on the provision of SUD treatment services to pregnant and postpartum members and to justice-involved members, including on providing human immunodeficiency virus (HIV) and hepatitis C treatment to people who currently use substances or have a history of substance use. • Develop an 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. • Provide technical assistance on reimbursement for underutilized services, such as care coordination. • Provide technical assistance to SUD providers to assist with requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) and Medicaid to assess and refer members with SUD to MAT.
Collaboration	• Develop a plan to use a data-sharing agreement between the Department of Medical Assistance Services and the Department of Criminal Justice Services to link Medicaid-eligible individuals who are newly released from incarceration to SUD treatment services. • Rely on work done by the Advisory Commission on Opioids and Addiction as building block for needs assessment.

Washington

Section 1003 Participants
Primary: Washington State Health Care Authority Division of Behavioral Health and Recovery, other Health Care Authority divisions (including Healthier Washington, Policy, Tribal Liaison, Clinical Quality Care Transition, and Analytics, Research, and Measurement), Department of Social and Health Services, Office of Research, Data, and Analytics
Others: Washington State University, Oregon Health Sciences University, Leavitt Partners

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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). • 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). • Assess the level and amount of coordination. • 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, relative to people without those conditions. • Assess demographic and geographic disparities. • Conduct an alternative payment model environmental scan. • Hold individual conversations with four of the five managed care plans to gain increased buy-in regarding the current landscape of risk-based arrangements. • Explore the feasibility of implementing a Health Home model focusing on people with SUD who are likely receiving services in opioid treatment programs.

Activity Type	Planned and Implemented Activities
Reimbursement	• Review best practices and 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 anticipated impact of implementing bundled payments and actions needed to support statewide implementation of SUD bundled payments.
Provider Training and Technical Assistance	• Identify and arrange for needed training and technical assistance, including training focused on 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; and evaluate provider shortages in tribal areas. • 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).
Collaboration	• Design and implement the Healthier Washington plan, in partnership with the Department of Health and the Department of Social and Health Services, one goal of which is to incentivize whole-person care through the integration of physical and behavioral health under Medicaid managed care.

Post-Planning States

Connecticut

Section 1003 Participants
Primary: Connecticut Department of Social Services (the state Medicaid agency), Connecticut Behavioral Health Partnership Administrative Services Organization (Beacon), Connecticut Department of Mental Health and Addiction Services, Connecticut Department of Children and Families **Others:** Connecticut Community Health Resources and other treatment or recovery providers, CT Housing Engagement Support Services (CHESS), Integrated Care for Kids (InCK)

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • 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.
Reimbursement	• Assess feasibility of payment reform, conduct provider education, and integrate stakeholder input via learning sessions. • Conduct modeling for developing value-based provider reimbursement. • Revise obstetrician pay-for-performance initiative. • 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.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• 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 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. • 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. • 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. • Develop core competency standards that align with guidelines for level-of-care certification and include cultural competency.
Collaboration	• Collaborate with the Department of Mental Health and Addiction Services and the Department of Children and Families to form the core state team. • Rely on the multiagency Connecticut Behavioral Health Partnership to begin prevalence estimates of SUD within the Medicaid population, ahead of the required needs assessment. • Pursue the ability to offer behavioral health services via telehealth through state plan authority.

Activities planned for the post-planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment and Data Related	• Assess impact of providing SUD treatment services on hospital emergency department utilization, inpatient hospital utilization, and readmission rates. • Create stakeholder feedback loops (gather member experiences, share findings, and implement best practices) to develop capacity building and quality improvement. • Poll attendees on virtual platforms during trainings for real-time feedback. • Examine the availability of Medicaid providers accepting new patients, patient access to care, and hospitalizations and spending. As part of the SUD waiver work, devise reports looking at the capacity of the SUD system for ASAM levels of care to ensure that the increase in standards (e.g., a shift from the ASAM second to third edition) improves the standard of care for residential and ambulatory settings.
Reimbursement	• Provide higher rates to enable providers to meet the current edition of ASAM standards and other applicable requirements. • Implement a value-based payment model for outpatient services that will supply tools and incentives for providers to make measurable improvements to the care provided to individuals with SUD.
Provider Training and Technical Assistance	• Provide trainings in screening and assessment of SUD in medical or primary care settings, as well as instruction to providers on how to receive reimbursement for SUD screening. • Offer training and technical assistance in conducting CLAS assessments and developing CLAS/health equity plans. • Provide opportunities for recovery coach trainings. • Offer a universal training program for providers to assess treatment needs. • Give technical assistance and consultation to providers to help them meet ASAM third edition practice standards. • Provide technical assistance for performance improvement activities and metrics.
Collaboration	• Collaborate with Connecticut Housing Engagement Support Services and InCK to help consider alternative ways for Medicaid to provide services to high-need populations, for example, treating individuals with SUD in the primary care setting. • Collaborate between the Department of Children and Families, the Department of Mental Health and Addiction Services, and the Department of Social Services.

Goals for Post-Planning Period Identified in Post-Planning Application

1. Increase identification of SUD, allowing members to access SUD services earlier.
2. Increase member access to and engagement with quality treatment.
3. Increase provider capacity.
4. Monitor overdose deaths among Medicaid beneficiaries.

Delaware

Section 1003 Participants
Primary: Delaware Division of Medicaid and Medical Assistance, Delaware Division of Substance Abuse and Mental Health (both part of Delaware Department of Health and Social Services)
Others: Partner agencies such as Bureau of Health and Vital Statistics, Delaware Drug Monitoring Initiative (including Office of Emergency Medical Services of the Division of Public Health, the Department of Safety and Homeland Security, the Division of Forensic Science, the Delaware Information and Analysis Center, and others)

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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 memoranda of understanding 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. • Review current Medicaid provider recruitment practices and current peer-to-peer support models. • 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. • Complete an inventory of credentialing and incentive programs aimed at increasing provider willingness to provide MAT to Medicaid beneficiaries. • Complete inventories of peer-to-peer technical assistance models, SUD care coordination models, Medicaid payment methodologies, and MAT prescriber incentive models.

Activity Type	Planned and Implemented Activities
Reimbursement	• 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. • Present proposed changes to payment methodologies to stakeholders for feedback. • Update the Medicaid reimbursement manual for OUD and other SUD treatment or recovery services.
Provider Training and Technical Assistance	• 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 adolescences and young adults. Provide training to attain DATA waiver. • Add more Medicaid providers to Department of Substance Abuse and Mental Health learning collaboratives. • Add Medicaid-specific components to provider change packets. • Increase provider supports to meet the needs of high-risk populations. • Develop a dissemination and education plan aimed at educating and training providers in the updated reimbursement manual.
Collaboration	• Collaborate between the Division of Medicaid and Medical Assistance and the Division of Substance Abuse and Mental Health to develop the proposed grant activities based on known infrastructure gaps and challenges. • Review 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.

Activities planned for the post-planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment and Data Related	• Identify available data sources to conduct the analyses and establish data sharing agreements as needed. • Identify key monitoring metrics related to SUD/OUD prevalence analyses, treatment system capacity and gaps analyses, and patterns in SUD service utilization. • Develop an internal SUD/OUD monitoring dashboard, containing detailed data—with map views that can be assessed over time and across different indicators, such as by ZIP Code, racial and ethnic group, and age group. • Identify community stakeholders—including dually eligible clients, health care providers, beneficiaries and their families, and advocates—to participate in in-depth interviews to provide qualitative insight into the current operations of Delaware's Medicaid SUD/OUD treatment continuum, their personal experiences with the system, and opportunities for improvement. • Update and replicate an analysis of key monitoring metrics related to SUD and compare the results with national data on an annual basis.
Reimbursement	• Design and implement the preferred OBOT model. • Consider converting the preferred OBOT program into a value-based payment initiative. • Provide substantive payment rate increases for a wide range of specialty SUD services across the continuum of care.
Provider Training and Technical Assistance	• Design training and technical assistance content that is inclusive of and specialized to Medicaid providers and supports the aims of advancing OBOT services, facilitates provider knowledge of and ability to enroll in Medicaid and contracts with managed care organizations, provides pragmatic billing and coding guidance, and educates on Medicaid rules and regulations germane to their practice. • Work with managed care organizations to promote other technical assistance resources, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Response Network, SAMHSA Provider Clinical Support System for Medication-Assisted Treatment, and National Clinician Consultation Center Substance Use Warmline.
Collaboration	• Lead a cross-agency effort to compile and compare SUD/OUD initiatives and policies across agencies (e.g., Division of Substance Abuse and Mental Health, Division of Medicaid and Medical Assistance, Department of Correction, Division of Public Health) to streamline and reduce system confusion. • Partner with the Division of Substance Abuse and Mental Health to ensure that its technical assistance resources and initiatives—primarily funded through the State Opioid Response grant—address the needs of Medicaid SUD/OUD providers.

Goals for Post-Planning Period Identified in Post-Planning Application

1. Design and implement an administrative infrastructure and processes to comply with demonstration project fiscal and programmatic reporting, evaluation requirements, and coordination with extant initiatives.
2. Continue assessment of SUD prevalence, SUD treatment and recovery system capacity and gaps, service utilization patterns, and policy and reimbursement barriers affecting the Medicaid population.
3. Implement strategies to develop a long-term, sustainable provider network under the Medicaid program that offers the full SUD and OUD continuum of care.

Illinois

Section 1003 Participants
Primary: Illinois Department of Healthcare and Family Services (the state Medicaid agency), Illinois Department of Public Health, Illinois Department of Human Services, Illinois Department of Children and Family Services, Illinois Governor's Office
Others: Cook County Health, University of Illinois Office of Medicaid Innovation, Southern Illinois Hospital Services

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Conduct data-driven assessment of current treatment needs among Medicaid members. • Identify trends from hospital, emergency department, and death certificate data. Pinpoint counties/municipalities at higher risk of overprescribing opioid-involved painkillers and benzodiazepine. • 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. • Examine the integration of behavioral and physical health service delivery at Illinois FQHCs, using data and a survey. • Identify whether services delivered by FQHCs include access to MAT and recovery services. • Determine whether FQHCs can provide a continuum of care through on-site services and linkages that reflect a recovery-oriented system of care.
Reimbursement	• Conduct 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 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.

Activity Type	Planned and Implemented Activities
Provider Technical Assistance	• Provide technical assistance by establishing networks connecting MAT providers for services to patients and technical assistance to providers. • Start a fellowship program for non-MAT providers that includes weekend immersion training with MAT providers followed by ongoing coaching and mentoring. • Coordinate other technical assistance opportunities available through support from SAMHSA, ASAM, and the Illinois Department of Public Health. Increase training for MAT providers. • Create OUD/SUD materials to distribute to prescribers at regional training sessions. • Create "MAT 101" training. • 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. • Expand technical assistance for prescribers through in-person and web-based platforms. • Begin work to update the Illinois Helpline for Opioids and Other Substances. • Implement an addiction medicine training curriculum for all family medicine residents at Cook County Health.
Collaboration	• Coordinate between the Illinois Department of Healthcare and Family Services, the Department of Public Health, the Department of Human Services, the Department of Children and Family Services, and the Governor's Office to form the core team for the planning grant. • Conduct a joint survey—by the Illinois Department of Healthcare and Family Services and the Department of Human Services Division of Substance Use Prevention and Recovery—of all DATA-waivered providers in Illinois to develop an accurate list of DATA-waivered buprenorphine providers, allowing the state to better direct capacity-building projects to increase access to MAT.

Activities planned for the post-planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment and Data Related	• Increase rates of identification, initiation, and engagement in treatment. • Review service utilization and participation of prescribers providing MAT services. • Review and publish federal Data Workbook metrics on the Illinois SUD system to inform the SUPPORT Act project and help understand the totality of Illinois SUD reform efforts. • Perform cost analysis, measure cost growth, and watch for service trends to inform SUPPORT Act project. • Establish focus groups with individuals and families with lived experience, opioid treatment program staff, prescribers, and other stakeholders to inform efforts. • Identify key staffing resources to implement and support the SUPPORT Act project. Conduct focus sessions with physicians with waiver status to obtain input and information on their history of usage and any potential barriers on current use, as well as perceived future impacts (negative and positive) of any new alternative payment model being reviewed.
Reimbursement	• Identify opportunities to introduce an alternative payment model that would help expand the base of providers/prescribers willing to provide MAT services. • Develop an SBIRT benefit specifically for hospital emergency departments to address OUD and overdoses. • Develop a bundled payment that would include screening/assessment, initiation of buprenorphine, referral, and coordination of care. • Develop a plan for the creation and implementation of the Certified Community Behavioral Healthcare Clinic model. • Review and determine the feasibility for an alternative payment model as a mechanism to address barriers for implementing MAT.
Provider Technical Assistance	• Provide through DocAssist targeted training to providers on targeted topics such as motivational interviewing, managing MAT services, and other mental health and SUD-related topics. • Provide pediatric phone consultation to Department of Healthcare and Family Services-enrolled primary care providers and mid-level mental health providers caring for Medicaid-enrolled youth (ages 0–21 years). • Offer a rural opioid training program, peer-to-peer support, and stipends to eligible clinicians to complete DATA waiver training and actively prescribe buprenorphine. • Expand Illinois Helpline's functionality to house provider resources for OUD and other SUD regarding providing medications for OUD, one-on-one mentoring, and access to a peer provider group for ongoing support.

Activity Type	Planned and Implemented Activities
Collaboration	• Establish regular partnership, communication, and coordination of services between the Department of Healthcare and Family Services, contracted managed care organizations, and the Department of Human Services Substance Use Prevention and Recovery, through reporting and coordination with the Medicaid Advisory Committee and its subcommittees on the various SUD initiatives affecting the Illinois Medicaid program. • Continue ongoing participation at the Illinois Opioid Crisis Response Advisory Council and the Substance Use Disorder Advisory Council. • Work with the Illinois Department of Public Health to publish a monthly map of active providers on its Opioid Dashboard. • Work with Department of Human Services Substance Use Prevention and Recovery to engage both the Opioid Crisis Response Advisory Council and the Substance Use Disorder Advisory Council to identify interested stakeholders and stakeholder organization

Goals for Post-Planning Period Identified in Post-Planning Application

1. Implement the activities that Illinois spent the planning period assessing and planning and demonstrate, through identified metrics, that the increased infrastructure has increased service capacity, increased the number of SUD providers, and reduced the number of overdoses in Illinois.
2. Ensure an equitable but supportive alternative payment model can be identified to help expand the number of providers/prescribers willing to provide MAT services.
3. Continue activities that support an ongoing assessment of the behavioral health treatment needs of the state.
4. Support the development of the state infrastructure with activities including training and technical assistance to providers.
5. Improve reimbursement through the development of a variety of mechanisms as described in table above (under Reimbursement).

Nevada

Section 1003 Participants
Primary: Nevada Health & Human Services Division of Health Care Financing and Policy, Health & Human Services Director's Office, Nevada Division of Public and Behavioral Health, Nevada Substance Abuse Prevention & Treatment Agency, Nevada Office of Public Health Informatics and Epidemiology **Others:** Intertribal Council of Nevada, Nevada Primary Care Association, Nevada's Opioid Use Disorder, Maternal Outcomes, Neonatal Abstinence Syndrome Initiative

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• Provide baseline assessments and epidemiology data that are available on a county-by-county basis in one comprehensive document. • 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. • Examine the state's hub-and-spoke model, including gathering data on best practices and identifying opportunities for expansion.
Reimbursement	• Develop an alternative payment methodology for MAT services to overcome barriers in the current payment system. • Enhance reimbursement for telemedicine services. • Address coding issues and other barriers to reimbursement. • Consider telehealth for patients requiring psychotherapy as part of behavioral health services. • Reimburse for technology-based treatment or recovery support tools. • Develop an alternative payment methodology for MAT services to overcome barriers in the current payment system. • Modify prior authorization to streamline treatment. • Analyze and conduct a fiscal assessment of the Patient-Centered Opioid Addiction Treatment (P-COAT) model for reimbursement.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• 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 a provider toolkit to office-based practices. • Provide training to providers on MAT and integrated care. • Provide services and staff training through Project ECHO to expand eligible providers, increase current providers' provision of SUD services, develop a comprehensive MAT policy and Medicaid Service Manual chapter, advance an integrated care system, and increase the education and delivery program for pregnant women with OUD and their infants with neonatal abstinence syndrome. • Provide training to providers on reimbursement. • Review requirements for provider certification and licensing to enroll in multiple categories as medical providers who can also provide SUD treatment or recovery services.
Collaboration	• Conduct a collaborative needs assessment at both the county and state level to identify the most pressing challenges and planning grant activities. • Collaborate 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.

Activities planned for the post-planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment and Data Related	• Gather accurate and relevant information to assess the current state of behavioral health treatment needs, provider capacity, and the level of care coordination needed. • Develop and execute a multipronged stakeholder engagement process. • Collect primary data through surveys, interviews, and focus groups with both statewide and community-wide stakeholders on the following topics: behavioral and mental health needs, suicide prevention, substance abuse, provider capacity and willingness to provide care, the need for health information exchange, clinical care delivery, social determinants of health, professional training preferences, MAT policy, and reproductive health. • Execute strategies to collect relevant and accurate data and information from a variety of key sources. • Use data dashboards, needs assessments, and outcomes reports to evaluate SUD provider capacity, including level of care and location, and examine the level of Medicaid beneficiary need for SUD treatment and recovery services.

Activity Type	Planned and Implemented Activities
Reimbursement	• Implement a pay-for-performance incentive program through the Division of Health Care Financing and Policy's Medicaid managed care program in 2023.
Provider Training and Technical Assistance	• Incentivize providers to obtain the necessary training, education, and support to deliver SUD treatment or recovery services in the state. • Provide free training, including continuing education units, to providers through Project ECHO. • Deliver a no-cost learning collaborative provided by the Nevada Promoting Innovation in State & Territorial MCH (Maternal and Child Health) Policymaking, or PRISM, workgroup. • Promote and expand on addiction medicine fellowship programs.
Collaboration	• Partner with the Division of Health Care Financing and Policy to collect primary data through surveys, interviews, focus groups, and a provider design session with both statewide and community-wide stakeholders.

Goals for Post-Planning Period Identified in Post-Planning Application

1. Strengthen and sustain Nevada's health care continuum infrastructure to expand provider capacity for SUD treatment and recovery services.
2. Increase Nevadans' access to and delivery of SUD treatment and recovery services.
3. Improve Nevada's data collection, data integrity, and reporting infrastructure and capabilities to enable data-driven insights and decision-making to increase the number and capacity of SUD providers.

West Virginia

Section 1003 Participants
Primary: West Virginia Bureau for Medical Services, West Virginia Bureau for Behavioral Health (both within West Virginia Department of Health and Human Resources), West Virginia Office of Drug Control Policy, West Virginia University
Others: Shatterproof, managed care organizations, Telehealth Working Group

Activities planned for or implemented during the planning grant period as described by states in their planning grant application or progress reports during the planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment	• 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. • Investigate the feasibility of using phone-based apps to help overcome provider shortages. • Identify sites for Project ECHO expansion.
Reimbursement	• 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 what West Virginia's managed care organizations are implementing. • Consider the possibility of differential payment for high-quality programs.

Activity Type	Planned and Implemented Activities
Provider Training and Technical Assistance	• 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. • Work with the managed care plans to monitor and devise strategies to improve care coordination. • Develop plans to expand training 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. • Design a Center of Excellence for SUD model 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. • Expand the scope of current Project ECHO telementoring in the state. • Prepare 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.
Collaboration	• Work with local managed care plans to develop plans to improve training and resourcing for the effort. • Create a Telehealth Working Group intended to identify and eliminate barriers to accessing telehealth services in the state; use findings to develop planned grant activities. • Collaborate with other state offices to develop a county-level database on SUD or mental health programs and services.

Activities planned for the post-planning period:

Activity Type	Planned and Implemented Activities
Needs Assessment and Data Related	• Assess SUD and other behavioral health treatment and recovery service needs by leveraging existing programming, including surveys, surveillance tools, and workforce data.
Reimbursement	• Explore incorporation of the Collaborative Care Model billing codes into West Virginia's Medicaid program to increase provider capacity and willingness to provide SUD treatment and/or recovery services. • Establish an alternative payment model that will provide a higher level of reimbursement for programs that train staff members and implement evidence-based practices with fidelity.
Provider Training and Technical Assistance	• Provide training and technical assistance to programs and providers of SUD treatment and recovery services.

Activity Type	Planned and Implemented Activities
Collaboration	• Work with Mountain State Assessment of Trends in Community Health (MATCH) and the Office of Drug Control Policy to understand community health challenges with SUD, mental illness, access to care, and social foundations. • Collaborate on project activities with the West Virginia Behavioral Health Planning Council; the Primary Care Association; the Behavioral Health Providers Association; the Statewide Epidemiological Outcomes Workgroup; the System of Care Regional Family Coordinators; Department of Health and Human Resources Bureau Directors from the Bureau for Medical Services, the Bureau for Behavioral Health, the Bureau for Children & Families, and the Bureau for Public Health; Kepro; and West Virginia University.

Goals for Post-Planning Period Identified in Post-Planning Application

1. Increase the number of people with OUD receiving medications for OUD.
2. Increase the number of individuals receiving stimulant use disorder treatment.
3. Increase the use of innovative, nationally recognized evidence-based practices for SUD across providers, substance types, and special populations (pregnant and postpartum women and their infants, those with neonatal abstinence syndrome, at-risk and transition-aged youth).
4. Increase the capacity to serve rural residents, as more than 50 percent of West Virginia's population resides in rural areas.

Specific strategies to achieve these goals:

1. Develop a SUD Center of Excellence-type program to address OUD and stimulant use disorder.
2. Provide training, technical assistance, and management of performance data for demonstration project activities.
3. Establish differential reimbursement rates for high-fidelity implementation of evidence-based practices. Explore use of the Collaborative Care psychiatric consultation model, increase the number of Certified Community Behavioral Health Clinics, and develop an interface with the West Virginia Department of Corrections to reduce the number of overdoses.

APPENDIX B: SECTION 1003 CROSS-GRANTEE MEETING AGENDA

AGENDA
SUPPORT Act Section 1003 Virtual Grantee Meeting

Registration	https://cms.zoomgov.com/meeting/register/vJIsd-mspz4jHWebc8FUB_4CJJBUuULlPRQ
Date and Time	**September 9 – 10, 2020, 12:00 pm – 5:00 pm ET**
Learning Objectives	1. Collaborate virtually with fellow grantee states, expert technical assistance providers, and Centers for Medicare & Medicaid Services (CMS) project officers 2. Provide problem-solving and strategy sessions to assist grantee states with acquiring additional knowledge for increasing Medicaid provider capacity to deliver substance use disorder (SUD) services. 3. Identify successes and solutions to challenges related to planning grant goals, activities, and timelines; discuss applying for the demonstration phase to increase Medicaid SUD provider capacity

Day 1: Wednesday, September 09, 2020		
Effie George, PhD, CMS Moderator **Zoom Logistics: Marvelyn Davis, CMS Technical Moderator**		
Time	**Topic**	**Description**
12:00 pm – 1:00 pm (60 minutes)	**Welcome, Introductions, and Meeting Objectives** *Speakers:* Jennifer Bowdoin, PhD, Director, Division of Community Systems Transformation (DCST), Center for Medicaid and CHIP Services (CMCS), CMS Douglas Olson, MD, Chief Medical Officer, CMCS, CMS	CMS will welcome the group and review the meeting objectives. Grantees are invited to introduce themselves and identify one learning they are looking forward to at the virtual meeting.
1:00 pm –1:45 pm (45 minutes)	**Fighting the Opioid Epidemic** *Speakers:* Kim Brandt, Deputy Administrator, CMS Neeraj Gandotra, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration	This session discusses federal efforts in fighting the opioid epidemic. The last 15 minutes of the session will be a question and answer (Q&A) session.
1:45 pm – 2:00 pm (15 minutes)	**Break**	

Day 1: Wednesday, September 09, 2020		
Effie George, PhD, CMS Moderator **Zoom Logistics: Marvelyn Davis, CMS Technical Moderator**		
Time	**Topic**	**Description**
2:00 pm – 3:15 pm (75 minutes)	**State Round-Robin—Needs Assessments** *Speakers:* Peggy O'Brien, PhD, IBM Watson Health *Breakout session hosts: Group 1:* Bianca Desai, IBM Watson Health, Thomas Schenck, IBM Watson Health *Group 2:* William J. Olesiuk, PhD, IBM Watson Health Gladys Chuy, IBM Watson Health	Grantees are preassigned to one of two breakout groups for a 60-minute interactive discussion. Grantees will present on their needs assessment summaries, utilizing the slide deck template as the basis of their presentation. Each grantee state will speak for at most 7-minutes, highlighting key themes. After the 60-minute interactive break-out session, the attendees will join the main meeting to hear a summary of key takeaways and themes. *Group A: AL, CT, DE, IN, MI, RI, WA, WV Group B: DC, IL, KY, ME, NM, NV, VA*
3:15 pm – 3:30 pm (15 minutes)	**Break**	
3:30 pm – 4:00 pm (30 minutes)	**Overview of Demonstration Phase** *Speakers:* Melanie Brown, PhD, Technical Director, DCST, CMCS, CMS Fred Filberg, Grants Management Officer, Office of Acquisition and Grants Management, CMS	CMS will provide an overview of the application and selection process for the Post-Planning phase of the Demonstration Project and address questions from grantees regarding the application process.
4:00 pm – 4:45 pm (45 minutes)	**Cross-Grantee Learning Session I** *Special Populations speaker/moderator:* Peggy O'Brien, PhD, IBM Watson Health *Telehealth speaker/moderator:* Thomas Schenck, IBM Watson Health	Collaborative learning discussion among grantees, assigned to one of two concurrent break-out sessions on Day 1 and Day 2. ***Special Populations*** The session's facilitated discussion among grantees focuses on successes and common challenges with identifying the special populations for focus through the grant, and cross-grantee sharing of strategies for addressing encountered challenges. *Special Populations Day 1 (Group B): DC, IL, KY, ME, NM, NV, VA* ***Telehealth Session*** The session's facilitated discussion among grantees focuses on the successes and challenges with telehealth implementation and delivery during the public health emergency, and cross-grantee sharing of strategies for addressing encountered challenges. *Telehealth Day 1 (Group A): AL, CT, DE, IN, MI, RI, WA, WV*

Day 1: Wednesday, September 09, 2020		
Effie George, PhD, CMS Moderator **Zoom Logistics: Marvelyn Davis, CMS Technical Moderator**		
Time	**Topic**	**Description**
4:45 pm – 5:00 pm (15 minutes)	**Wrap-up of Day 1** Melanie Brown, PhD, Technical Director, DCST, CMCS, CMS	CMS will provide closing notices to wrap up Day 1 and reminders for Day 2.

Day 2: Thursday, September 10, 2020		
Time	**Topic**	**Description**
12:00 pm – 12:15 pm (15 minutes)	**Welcome, Summary of Day 1, and Objectives for Day 2** Melanie Brown, PhD, Technical Director, DCST, CMCS, CMS	CMS will summarize the key takeaways from Day 1 and highlight the purpose of the two-day meeting.
12:15 pm – 1:10 pm (55 minutes)	**Building Infrastructure and Sustained Medicaid SUD Treatment** *Speaker:* Peggy O'Brien, PhD, IBM Watson Health	This session describes state agency, local, and partnership approaches to developing infrastructure to build Medicaid provider capacity to furnish SUD services, with focus on facilitating provider enrollment and retention, and implementing strategies to increase the number of DATA-waivered providers.
1:10 pm – 1:15 pm (5 minutes)	**Break**	
1:15 pm – 2:00 pm (45 minutes)	**Cross-Grantee Learning Session II** *Special populations speaker/moderator:* Peggy O'Brien, PhD, IBM Watson Health *Telehealth speaker/moderator:* Thomas Schenck, IBM Watson Health	Collaborative learning discussion among grantees, assigned to one of two concurrent break-out sessions on Day 1 and Day 2. ***Special Populations*** The session's facilitated discussion among grantees focuses on successes and common challenges with identifying the special populations identified for focus through the grant and cross-grantee sharing of strategies for addressing encountered challenges. *Special Populations Group Day 2 (Group A): AL, CT, DE, IN, MI, RI, WA, WV* ***Telehealth Session*** The session's facilitated discussion among grantees focuses on the successes and challenges with telehealth implementation and delivery during the public health emergency, and cross-grantee sharing of strategies for addressing encountered challenges. *Telehealth Group Day 2 (Group B): DC, IL, KY, ME, NM, NV, VA*

Day 2: Thursday, September 10, 2020		
Time	**Topic**	**Description**
2:00 pm – 2:45 pm (45 minutes)	**Improving State TMSIS SUD Data Quality** *Speakers:* Ronna Bach, Data Systems Group, CMCS, CMS Su Liu, PhD, Senior Researcher, Mathematica Policy Research Paloma Newcombe, Health Analyst, Mathematica Policy Research	This session provides a demonstration of how grantees could use the newly released DQ Atlas on www.medicaid.gov to review SUD- related data quality in the Transformed Medicaid Statistical Information System (T- MSIS). The implication for improving data quality related to SUD and reporting for grant monitoring purpose will be discussed too, followed by Q&As.
2:45 pm – 3:15 pm (30 minutes)	**SUPPORT ACT Section 1003 Evaluation Design** *Speakers*: David Meyers, MD, Deputy Director and Chief Physician, Agency for Healthcare Evaluation and Quality IBM Watson Health	This session will provide an overview of the purpose and objectives of the SUPPORT Act Section 1003 evaluation.
3:15 pm – 3:30 pm (15 minutes)	**Break**	
3:30 pm – 4:30 pm (60 minutes)	**Data Sharing to Enhance Medicaid SUD Provider Capacity** *Speakers:* Lekisha Daniel-Robinson, IBM Watson Health Heidi Bryan, IBM Watson Health Erin Holve, PhD, Director of the Department of Health Care Finance's Health Care Reform and Innovation Administration, Washington, DC	This session discussion focuses on state agency and provider successful strategies and challenges in data sharing, care coordination, and cross-system data use, highlighting grantee experience. The last 15-minutes of the presentation will be a Q&A session.
4:30 pm – 5:00 pm (30 minutes)	**Meeting Wrap-up** Jennifer Bowdoin, PhD, DCST, CMCS, CMS	CMS will recap the purpose of the two-day virtual meeting and remind grantees to complete meeting evaluation.