Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Implementation Challenges Across States

RTI International

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Introduction

Drug overdose is the leading cause of accidental death in America, and opioids were involved in 75 percent of overdose deaths in 2020.[1] Factors contributing to the high number of overdose deaths include low rates of treatment for substance use disorder (SUD),[2] the stigma associated with seeking treatment,[3] and a shortage of health care professionals to treat SUD.[4] Medicaid beneficiaries face additional barriers to finding a treatment setting that meets their needs because of low participation in Medicaid by SUD treatment facilities.[5] Moreover, many SUD services are an optional benefit in Medicaid, and most states historically have not covered the full continuum of SUD services. Through section 1115 demonstrations, the Centers for Medicare & Medicaid Services (CMS) is partnering with states to test means of increasing access to the full continuum of care for SUD, including medication assisted treatment (MAT) and residential treatment, as advocated by leading treatment addiction experts.[6,7,8]

This report is part of a series of rapid cycle reports intended to share findings and insights about section 1115 SUD demonstrations. This report summarizes the major challenges and barriers states are experiencing when implementing their section 1115 SUD demonstrations. Identifying and documenting implementation challenges helps federal and state policymakers address common concerns across demonstration participants and achieve intended results.

Specifically, this report addresses the following four research questions:

1. What are the major implementation challenges states are experiencing when implementing their section 1115 SUD demonstration?
2. What factors are contributing to these challenges?
3. How are states addressing these challenges?
4. What is the potential impact of these challenges on demonstration milestones?

This report provides a high-level look at some implementation challenges relevant to the delivery of MAT. The rapid cycle report titled *State Experiences Expanding Availability of Medication Assisted Treatment for Beneficiaries in Residential Settings* provides an in-depth look at challenges faced by states in expanding access to MAT for Medicaid beneficiaries in residential settings.

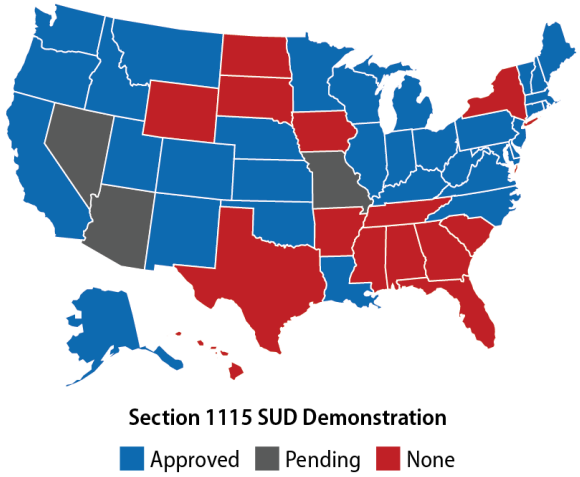
[1] Centers for Disease Control and Prevention (CDC). (2022). *Drug overdose deaths remain high*. https://www.cdc.gov/drugoverdose/deaths/
[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. HHS Publication No. PEP20-07-01-001, NSDUH Series H-55. Rockville, MD: SAMHSA, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf
[3] Cheetham A., Picco L., Barnett A., Lubman D.I., & Nielsen S. (2022). The impact of stigma on people with opioid use disorder, opioid treatment, and policy. *Substance Abuse Rehabilitation*, *13,* 1-12. doi: 10.2147/SAR.S304566.
[4] Jones, C. M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health*, *105*(8), e55–e63.
[5] MACPAC. 2018. *Access to substance use disorder treatment in Medicaid.* Chapter 4 in 2017 Report to Congress (June). MACPAC: Washington, DC.
[6] Centers for Medicare and Medicaid Services (CMS). (2015). *SMD # 15-003: New service delivery opportunities for individuals with a substance use disorder*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf
[7] CMS. (2017). *SMD # 17-003: Strategies to address the opioid epidemic*. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[8] CMS, SAMHSA, National Institutes of Health. (2014). *Medication assisted treatment for substance use disorders*. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

About Section 1115 SUD Demonstrations

The goals of section 1115 SUD demonstrations include increasing access to SUD treatment and raising rates of identification, initiation, and engagement in treatment; increasing treatment adherence and retention; reducing overdose mortality; decreasing preventable or inappropriate emergency department and inpatient hospital utilization; reducing preventable or inappropriate readmissions to the same or higher level of care; and improving access to care for physical health conditions.

As of October 2022, 33 states and the District of Columbia had received approval for section 1115 SUD demonstrations; 3 other states had pending applications (**Figure 1**).

Figure 1. Section 1115 SUD demonstration status as of October 2022



Generally, to receive approval for a section 1115 SUD demonstration, states must outline their plans for expanding access to multiple levels of evidence-based care and explain how inpatient and residential SUD services will coordinate with community-based recovery services. States with approved section 1115 SUD demonstrations can receive federal financial participation (FFP) for SUD treatment services provided in residential and inpatient facilities that qualify as institutions for mental diseases (IMDs). These demonstrations generally require the state to submit and carry out implementation plans that set forth how the state will reach the following six milestones:

1. Access to critical levels of care for OUD and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications, including implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.
4. Sufficient provider capacity at each level of care.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Overview of Findings

States identified several common operational or administrative challenges that impacted implementation of section 1115 SUD demonstrations:

- Lack of provider knowledge about Medicaid structure, billing, and operational requirements.
- Development of reimbursement rates for new residential levels of care.
- Lack of provider familiarity with patient placement criteria.
- Operational challenges associated with utilization review.

External or systematic factors created challenges or slowed state progress toward demonstration milestones:

- A shortage of SUD and behavioral health providers limited states' ability to expand access to SUD services.
- The COVID-19 pandemic limited state and provider staff time available to implement the demonstration.
- Provider stigma toward MAT slowed progress among residential providers to comply with MAT requirements.

States responded to challenges using several common strategies:

- Educating providers about Medicaid certification, billing practices, new patient placement criteria, and MAT.
- Communicating early and often with providers to inform reimbursement rates.
- Expanding telehealth to address limited access to behavioral health professionals, especially in rural areas.

Approach

Findings in this report are based on interviews conducted between December 2020 and July 2021. All states with approved section 1115 SUD demonstrations as of that time were invited to participate with the exception of Maine, due to the recent timing of their demonstration approval. Because California counties develop their own implementation plans within state parameters for the demonstration, we interviewed government officials from three counties to reflect variation in implementation experience.[9] In total, this report reflects 34 interviews in 30 states, 3 California counties, and the District of Columbia.[10] Key informants included state Medicaid officials, behavioral health administrators, and other state staff involved in the oversight of SUD and behavioral health services. **Appendix A** provides more information about the data collection methods used.

Results

States described a variety of challenges that impacted implementation of their section 1115 SUD demonstrations. We discuss the six most frequently reported in this section. Each of the six challenges was reported by at least 10 states and most were identified by more than half of the states with a demonstration. Challenges could broadly be classified into two main categories: 1) operational or administrative challenges associated with meeting demonstration requirements, and 2) external or systemic challenges that impacted implementation. **Appendix B** identifies the challenges reported by each state.

Operational or Administrative Challenges to Meeting Demonstration Requirements

Lack of Provider Knowledge about Medicaid Structure, Billing, and Operational Requirements (19 States). Many states relayed that SUD providers' lack of familiarity and experience with the Medicaid program was a major challenge to implementation. Historically, states' coverage of SUD services has varied, but only a small number of states covered a broad array of services across the SUD continuum.[11] As a result, SUD providers' knowledge of Medicaid's benefit structure, billing requirements, and reimbursement policies was limited. Furthermore, many state officials reported that SUD providers lacked the necessary administrative infrastructure, computer systems, or staffing in place to meet Medicaid's participation and billing requirements. This lack of experience slowed implementation and made it difficult for states to effectively recruit and enroll providers in Medicaid.

To address this challenge, state officials devoted considerable time and energy to educate and train providers on Medicaid program design, benefits, and billing practices during the early months of the section 1115 SUD demonstration. To encourage SUD providers to enroll in Medicaid, states organized Medicaid "101" sessions and held regular meetings and workgroups with providers and managed care organizations (MCOs) to discuss concerns related to certification and billing requirements. In response to provider feedback, one state developed a more streamlined enrollment application to make it easier for providers to become Medicaid certified. Another state representative described creating an SUD-specific mailbox for providers to email questions about enrollment policies, billing, and documentation requirements. State officials would then discuss questions submitted to the mailbox and brainstorm solutions at future provider workgroup meetings. Many states indicated that early and consistent engagement with providers helped implementation run more smoothly.

> *We started working with them [providers] five or six months before the go-live date. We had calls with the Office of Behavioral Health and Medicaid; sometimes our public health joined us. Every other week [we held] group calls to talk about issues and walk through the [payment] rate, make sure they were really comfortable with it and how to bill.*
>
> -State official

Developing New Reimbursement Rates and Policies for SUD Services (17 States). Medicaid officials had to create new payment rates and policies for certain SUD services not previously covered by Medicaid. This is a time-consuming process and state officials looked to surrounding states, Medicare, MCOs, and actuaries to help establish benchmark payment rates for SUD services. States had to develop processes for working with providers and MCOs to not only negotiate rates but also communicate new payment amounts and billing policies. A few state officials also noted having to carefully maneuver between setting rates that would be accepted by providers but also abide by section 1115 demonstration budget-neutrality requirements. One state created a team dedicated to maintaining budget neutrality for every new payment rate or payment adjustment.

State officials noted particular challenges in developing per diem rates for new residential levels of care. Typically, residential services have been covered through state funds and paid using a bundled rate that generally covered room and board as well as treatment costs. Because Medicaid only pays for SUD treatment services and does not reimburse for room and board in residential treatment

[9] California's section 1115 SUD demonstration is approved by CMS at the state level. Counties administer the Medicaid program and participate in the demonstration on a voluntary basis by operating Prepaid Inpatient Health Plans (PIHPs). California has facilitated SUD demonstration adoption by counties in waves beginning in April 2017. Counties that have submitted implementation plans and undergone the approval process by both the state and CMS can be found at https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

[10] For brevity, we refer to states, the District of Columbia, and counties as "states" and all interviewees as "state officials."

[11] Around the time of Medicaid expansion, 13 states covered the "full array" of SUD services and 26 states covered a service under each level. See https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0623 for additional information.

> *Because we can't pay for room and board, we are trying to figure out what the appropriate rate is. We don't have a Medicare comparable really to look at. So we tried to look at surrounding states that implemented this, what their rates are, and what our previous rates were through the division of behavioral health.*
>
> -State official

facilities, states are grappling with how to set payment rates that adequately account for these expenses. Determining fair and adequate residential rates is a sticking point for many states and has implications for provider participation in Medicaid. A few state officials noted that despite increasing their payments, some residential providers still considered the per diem rates inadequate and were hesitant to enroll.

Several officials solicited feedback from providers on various reimbursement models prior to effectuating new policies to facilitate provider acceptance and buy-in. As noted by one state official, educating providers early about payment options helped mitigate confusion and allowed for more informed commentary on rate development rather than reactionary feedback. Additionally, ongoing and consistent communication on new and updated reimbursement policies helped enhance trust and build relationships.

Lack of Familiarity with Patient Placement Criteria and Operational Challenges Associated with Utilization Review (21 States). Participation in the section 1115 SUD demonstration requires that all providers evaluate and document each beneficiary's medical need for SUD treatment using an SUD-specific, multidimensional patient assessment tool. States could decide which tool to adopt as long as it reflects evidence-based clinical treatment guidelines and nearly all elected to use the American Society of Addiction Medicine (ASAM) criteria. To promote consistency in patient placement, ASAM assigns a level of care and treatment recommendation based on the severity of the person's condition. MCOs then use SUD-specific utilization management processes, which incorporate ASAM criteria to ensure that recommendations are appropriate.

Some state officials described ASAM's patient placement criteria as being vague and open to interpretation, making it challenging for providers and MCOs to apply the guidelines consistently. Prior to the section 1115 SUD demonstration, providers in some states had considerable flexibility and autonomy in making treatment recommendations for beneficiaries and were not always fully transparent in recommending certain levels of care. State and Medicaid regulations did not routinely require that providers apply patient placement criteria and MCOs did not necessarily have SUD-specific utilization review processes in place. As one state official noted, providers had become accustomed to delivering a more subjective, curriculum-based model of SUD treatment, which typically encouraged long stays in residential settings. Once the requirement to use ASAM criteria went into effect, providers had to abide by stricter medical necessity and prior authorization guidelines, which often resulted in shorter lengths of stay for patients and different treatment recommendations than providers preferred. This created ongoing friction between providers, MCOs, and state officials. Even states that had patient placement criteria requirements in place prior to the demonstration reported that providers had not been applying the criteria correctly and that significant knowledge gaps existed.

> *"I think on the managed care side, one thing that we learned …. was that using ASAM as our coverage framework was challenging. I think we all know ASAM wasn't designed to be a utilization management or a prior authorization tool. So we've spent a lot of time with our MCOs as part of our stakeholder work as well, trying to educate and discuss and find some alignment on the use of ASAM."*
>
> -State official

To address this challenge, states applied the same strategies as those adopted to address providers' lack of familiarity with Medicaid: education, training, and the formation of stakeholder workgroups where providers could raise concerns about ASAM criteria and MCO utilization review processes. One state official highlighted the importance of having clinicians from the MCOs attend its workgroup meetings to help explain the service authorization process. Although many states indicated that enhancing education and training around ASAM was helpful, interpreting the patient placement criteria in a way that satisfied both providers and MCOs remained a challenge.

External or Systematic Challenges to Implementation

Shortages of SUD and Behavioral Health Providers (17 States). About half of the states participating in the section 1115 SUD demonstration attributed challenges to expanding access to SUD services to ongoing shortages of SUD providers. Shortages were particularly prevalent in states with large rural or frontier populations.[12] According to one state official, an individual residing in a frontier part of the state might have to drive 300 miles to get to a treatment center. State officials identified shortages for multiple types of behavioral health and SUD professionals—psychiatrists, psychologists, alcohol drug counselors, peer support specialists, social workers, and behavioral health counselors. States also noted low numbers of SUD providers trained and willing to provide MAT services, in addition to the lack of available mental health and psychosocial supports in some areas. Low reimbursement rates for behavioral health professionals were cited as a key impediment to expanding the number of SUD providers in the state and increasing access to SUD treatment more generally.

[12] Ten states or approximately one-third reported challenges specific to serving rural or frontier populations.

> *"To state [a major challenge] again, the shortage of behavioral health professionals. I think that's always going to be an issue for every state, and I don't know how that can be addressed at the federal level, but that is really a challenge."*
>
> -State official

Medicaid can play a key role in implementing strategies for extending the behavioral health workforce but collaboration with other state agencies and partners may be necessary to effectively expand provider supply and capacity. Strategies for addressing workforce shortages reported by states included expanding access to telehealth services, creating workgroups to discuss increasing reimbursement rates for SUD services, and offering more training to behavioral health clinicians to help them more effectively meet the complex needs of beneficiaries with SUD. Telehealth helped expand access to behavioral health care in many states, particularly in rural areas, and many state officials considered telehealth a long-term solution for addressing the mental health and SUD workforce shortage. A few state officials also noted that telehealth had become an effective approach for engaging beneficiaries who historically felt stigmatized when seeking or receiving SUD treatment. Other strategies relayed by state officials to address shortages included recruiting and training more peer support specialists to expand access to SUD counseling services and coordinating with other state agencies to develop legislative options to increase the size of the SUD and behavioral health workforce.

COVID-19 (13 States). Many states reported delays in implementation due to the COVID-19 pandemic. Most of the states reporting COVID-related challenges were the early implementing states that began their section 1115 SUD demonstrations in 2018 and 2019. State officials reported that Medicaid officials and other state staff could not devote as much time to implementing the demonstration as they would have liked because they often had to redirect their attention to the public health emergency. Providers also could not adequately participate in the state's implementation activities such as meetings, workshops, or trainings because they were overwhelmed with COVID-related demands. States could not do much to address the delays posed by COVID-19 other than listen to provider concerns and adjust their training and implementation schedule to accommodate provider availability.

> *"Given the level of social distancing requirements, many of the providers have reduced their room capacity from, if it was two down to one, if it was three, maybe two or one. So you're looking at anywhere from 50% of the residential capacity being shrunken or being reduced."*
>
> -State official

COVID-19 also had a negative impact on the behavioral health and SUD workforce. According to one state official, COVID forced the closure of behavioral health treatment centers in certain parts of the state, thereby further limiting access to treatment. This happened at the same time that demand for behavioral health and SUD services was rising, creating more pressure on an already stressed workforce. The strategies discussed to address these COVID-related challenges were the same as those described above to address workforce shortage—expanding access to telehealth, recruiting and training more SUD and behavioral health providers, and increasing reimbursement rates to attract more professionals to the field.

Provider Stigma Toward MAT (21 States). About two-thirds of state officials reported experiencing resistance to MAT among the SUD provider community, which impacted their ability to expand access to therapeutic medications to treat SUD. State officials cited several reasons for provider resistance toward MAT including a belief that a medication-free, abstinence approach to SUD treatment is more appropriate, a fear that providing medication will attract large numbers of outsiders to the community to receive treatment, and a lack of understanding about how MAT therapy works. At least one state official described contracting with residential providers who indicated on paper that they offered MAT services, but then learning through member complaints and website descriptions that MAT was not supported by clinician leadership.

The most common approach for addressing stigma toward MAT reported by states was ongoing outreach and education to providers and the public at large. One state official created a MAT "101" guide for providers and used social media platforms to educate the community about the section 1115 SUD demonstration and the benefits of MAT therapy. Other strategies discussed by interviewees included identifying a public health or physician champion to help with outreach and education, offering regular trainings on MAT for providers, using continuing education requirements to encourage provider participation in MAT training, and organizing media campaigns to address stigma in the community. One state official also noted the importance of conducting regular site visits and on-site audits to ensure that SUD providers are meeting MAT access requirements. Another described including language specifically prohibiting discrimination against beneficiaries requesting MAT therapy in its contracts with SUD treatment providers.

Conclusions

This report highlights the key barriers and challenges states are experiencing while implementing their section 1115 SUD demonstrations. More than half of states had significant challenges related to providers' lack of experience with Medicaid. Given that many states offered limited Medicaid coverage of SUD treatment prior to the demonstration, state officials had to invest considerable time and energy into training and educating providers about Medicaid's benefits, structure, and billing requirements. States also had to establish new payment rates and policies for SUD services not previously covered by Medicaid—a complicated process that involved engaging in time-intensive negotiations with providers and MCOs.

States also reported obstacles related to implementing patient placement and utilization review criteria. Although providers were familiar with ASAM criteria, the organization's guidelines had not been consistently applied or enforced by payers. SUD providers also indicated

frustration with having to comply with stricter patient placement criteria. Subsequently, states had to work with providers and MCOs to resolve differences in interpretation and application.

Aside from administrative hurdles, state officials identified three external or systemic factors that negatively impacted implementation: COVID distracted Medicaid staff and providers from focusing on demonstration-related activities; workforce shortages across the SUD continuum made it difficult to expand access to treatment; and long-standing stigma related to MAT impeded states' ability to extend provider capacity to treat SUD. These factors are harder for states to address without additional coordination and engagement from other state and federal partners.

The operational and administrative obstacles related to providers' lack of familiarity about Medicaid and states' strategies for developing reimbursement policies are likely to affect the states' progress toward meeting Milestone #1 (access to critical levels of care), Milestone #4 (sufficient provider capacity), and Milestone #6 (improved care coordination and transitions between levels of care). For example, given the level of effort required to recruit and enroll providers in Medicaid, we may not see immediate increases in provider capacity after the demonstration begins. We would expect this number to slowly rise over time as more providers adapt to Medicaid's program requirements and reimbursement policies. Additionally, because later implementing states had 2 years to implement policy changes, we may not see large increases in the number of beneficiaries receiving SUD treatment early in the demonstration. Providers' reluctance to adopt standard patient placement criteria will also likely impact states' progress toward meeting Milestone #2 (use of evidence-based, SUD-specific patient placement criteria) as some residential providers may be hesitant to enroll because they do not support the assessment criteria enforced by states.

The remaining three external challenges—COVID-19, ongoing workforce shortages, and stigma toward MAT—are harder for states to address without additional support from other state and federal partners. COVID-19 has reduced provider capacity and impeded access to care (Milestones #1 and #4), but the timing and extent of impacts likely differ among states. Shortages in the behavioral health workforce is a long-standing challenge for both federal and state policymakers. We anticipate these shortages to have a greater impact on provider capacity and access to care in some states participating in the demonstration, particularly those with large rural and frontier populations. Similar to workforce shortages, stigma toward MAT is a persistent, nationwide problem that continues to impede access to appropriate, evidence-based care. We expect stigma to impede states' progress toward meeting Milestones #1 and #4, as well as Milestone #3 (use of nationally recognized, evidence-based SUD program standards) and Milestone #6 as state officials grapple with increasing the number of residential facilities willing to offer MAT.

All challenges discussed above delayed implementation slightly but their impacts on progress toward meeting section 1115 SUD demonstration milestones will vary across states, both because of differences in state context (such as rurality or the timing and extent of COVID impacts) and differences in states' success in addressing these challenges. The meta-evaluation of section 1115 SUD demonstrations will examine how and why some approaches for addressing challenges were more successful than others. In addition, demonstration impacts may be less favorable in states that experience more significant challenges. The meta-evaluation will explore whether the extent of challenges experienced and the effectiveness of strategies to overcome them help explain variation in demonstration outcomes across states.

Authors and Acknowledgments

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The Federal Meta-Analysis Support Contract

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

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

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews conducted between December 2020 and July 2021. All states with approved section 1115 SUD demonstrations were invited to participate with the exception of Maine, due to the recent timing of their demonstration approval. Because California counties develop their own implementation plans within state parameters for the demonstration, we interviewed government officials from three counties to reflect variation in implementation experience.[13] Thus, this report reflects 34 interviews in 30 states, 3 California counties, and the District of Columbia.[14] Key informants included state Medicaid officials, behavioral health administrators, and other state staff involved in the oversight of SUD and behavioral health services.

The interviews used a common, semi-structured protocol that covered multiple topics; those relevant for this report included characteristics of states' section 1115 SUD demonstrations, states' rationale and motivations for pursuing the demonstration, states' implementation experiences and challenges, and lessons learned during implementation. Interviews were 90 minutes in length.

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

This analysis has a few limitations. One is our reliance on key informant interviews as the primary source of data. Although we provide a count of states that reported each challenge, these numbers are not meant to be exact. Counts are intended to give readers a sense for the prevalence of certain challenges and to help prioritize areas for future inquiry.[15] Additionally states' perspectives may have varied depending on how far along they were in implementation. At the time our interviews were conducted, some states had only been engaged in implementation for six months or less whereas others had been operating their section 1115 SUD demonstration for one year or longer. Furthermore, COVID-19 could have had different impacts on states' experiences. As interview protocols were designed and approved prior to the pandemic, we did not systematically probe on COVID-related barriers to implementation. Therefore COVID-19 challenges were only reported by states that specifically identified the pandemic as a barrier to implementation.

[13] California's section 1115 SUD demonstration is approved by CMS at the state level. Counties administer the Medicaid program and participate in the demonstration on a voluntary basis by operating Prepaid Inpatient Health Plans (PIHPs). California has facilitated SUD demonstration adoption by counties in waves beginning in April 2017. Counties that have submitted implementation plans and undergone the approval process by both the state and CMS can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx.

[14] For brevity, we refer to states, the District of Columbia, and counties as "states" and all interviewees as "state officials."

[15] California is included as a state in the counts, but the three counties are not counted separately. If one or more California county official identified a topic or challenge, they are included as part of a single count for the state.

Appendix B: Implementation Challenges Reported by States

State	Lack of Provider Knowledge about Medicaid	Developing New Reimbursement Rates and Policies	Confusion about Application of Patient Placement Criteria	Behavioral Health and SUD Provider Shortages	COVID-19	Stigma Related to MAT
Alaska	X		X	X	X	X
California	X	X	X			X
Colorado		X	X			X
Delaware						
District of Columbia	X	X		X	X	
Idaho	X	X	X	X	X	
Illinois	X	X		X	X	
Indiana	X	X		X		X
Kansas	X	X		X		X
Kentucky	X		X		X	X
Louisiana			X			X
Maryland		X	X	X		X
Massachusetts	X	X	X			X
Michigan	X		X	X	X	X
Minnesota			X			X
Nebraska	X					
New Hampshire	X		X	X		X
New Jersey	X	X	X		X	X
New Mexico			X	X	X	X
North Carolina	X		X		X	X
Ohio		X	X	X	X	X
Oklahoma	X		X	X		X
Oregon			X	X	X	X
Pennsylvania			X	X	X	X
Rhode Island		X				
Utah	X	X		X		
Vermont	X	X				
Virginia		X	X	X		X
Washington						
West Virginia	X	X	X	X		X
Wisconsin	X	X	X		X	
Total	**19**	**17**	**21**	**17**	**13**	**21**

Note: Two states (Delaware and Washington) in our analysis did not report any challenges to implementation.