Report to Congress:

Interim Report

As Required by Section 1003 of the

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115-271)

from the

Department of Health and Human Services

Office of the Secretary

Xavier Becerra

Secretary of the Department of Health and Human Services

May 2024

CONTENTS

EXHIBITS

TABLES

1 EXECUTIVE SUMMARY

1.1 Background

This *Interim Report to Congress* is provided in accordance with section 1003 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act) (Pub. L. No. 115-271), enacted on October 24, 2018. Section 1003 of the SUPPORT Act amends section 1903 of the Social Security Act (the Act) and directs the Secretary of the U.S. Department of Health and Human Services (HHS), in consultation with the 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 qualified Medicaid providers to deliver substance use disorder (SUD) treatment or recovery services.[1]

The section 1003 demonstration comprises two components: (1) a planning period, with planning grants of up to $50 million in aggregate, originally awarded for an 18-month period to 15 states (Alabama, Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Virginia, Washington and West Virginia),[2] and (2) a 36-month post-planning period with five states (Connecticut, Delaware, Illinois, Nevada, and West Virginia) selected from among the 15 planning grant states.[3] CMS extended the planning period and delayed the start of the demonstration period by six months to allow states to focus on the emergent issues created by the COVID-19 public health emergency.

Section 1003 of the SUPPORT Act also directs the Secretary to issue four Reports to Congress. This *Interim Report to Congress* is the third such report. Pursuant to the statute, this report describes: (1) the activities carried out by the five post-planning period states, (2) the extent to which states selected for participation in the post-planning period have achieved the stated goals in their applications, (3) the strengths and limitations of each state's demonstration project, and (4) plans for the sustainability of the SUPPORT Act project based upon the information available through the first 15 months of the post-planning period (September 30, 2021–December 31, 2022). Critical context for the demonstration, including the COVID-19 public health emergency

that led to competing financial and resource pressures on all states and coincided with increased rates of opioid-related overdoses, is also discussed.

1.2 Methods

Qualitative and quantitative analysis were used to address the statutory requirements for this report. Two primary data sources were used for analysis in this report: post-planning period state documents (applications for the post-planning period, quarterly progress reports, and semiannual progress reports), and stakeholder interviews.

The following evaluation questions, derived from the statutory requirements, are addressed in this *Interim Report to Congress*:

1. What were the activities carried out under the demonstration?
2. How is the demonstration coordinated with other state activities, including other federally funded activities and initiatives, to address SUD?
3. Have states made progress in achieving the aims of their demonstration applications, and how/why not?
4. Has the number of Medicaid SUD providers and SUD services provided increased?
5. How did legislation and policies of the individual states influence the decisions of the states on how they would expand treatment?
6. What are the strengths and limitations of the demonstration?
7. What is the plan for the sustainability of the demonstration?

1.3 Key Findings

While the five post-planning period states have different goals and strategies for the post-planning period, common elements of their efforts include the continuation of activities related to the assessment of SUD treatment needs, the provision of technical assistance, training and provider education, and collaboration with stakeholders, including other state agencies.

All post-planning period state Medicaid agencies described collaborating with other state agencies to advance their goals addressing SUD, including working with other teams funded by federal grants to leverage the results of their SUPPORT Act planning grant work to provide

decision-making support. For example, three states are working with other state agencies to develop and submit for approval Medicaid section 1115(a) SUD demonstration applications.

All states have made progress on the aims described in their demonstration applications, and overall, the demonstration has led to greater collaboration between state agencies and improved the capacity of state Medicaid agencies to collect and share data. In addition, all five post-planning period states have reported increases in the number of Medicaid providers qualified to prescribe medication for opioid use disorder (MOUD) – an overarching goal of the SUPPORT Act.

All states indicated that state legislation and policies influenced their decision-making. For example, three states implemented changes to reimbursement policies for SUD treatment that they hope will impact the treatment landscape in their states. One state, West Virginia, described a pre-existing policy restriction on methadone, which influenced their focus on other medications during the demonstration.

The strengths and limitations of each state's demonstration project differ according to their specific circumstances. However, most states identified increased state agency collaboration or meaningful stakeholder engagement as strengths of their respective efforts, and ongoing funding issues or competing priorities due to COVID-19 as challenges.

Finally, while the details of their sustainability plans differ, all states plan to ensure that the initiatives that they have undertaken continue beyond the life of the SUPPORT Act demonstration by pursuing other funding options such as state budget dollars, section 1115(a) SUD demonstrations, and in one case, a state plan amendment (SPA).

The *Final Report to Congress*, which will be the last report in this series, will provide updates on the post-planning period state activities described in this report and findings from the evaluation of the demonstration project.

2 INTRODUCTION

The SUPPORT Act was enacted on October 24, 2018. Section 1003 of the SUPPORT Act authorizes the Secretary of the Department of Health and Human Services (HHS) to conduct a

54-month demonstration project (the section 1003 demonstration) designed to increase the capacity of Medicaid providers qualified to deliver SUD treatment or recovery services.[4] The section 1003 demonstration is led by CMS, in consultation with AHRQ and SAMHSA.

The section 1003 demonstration comprises: (1) a planning period, with planning grants of up to $50 million, in aggregate, originally awarded for an 18-month period to 15 states (Alabama, Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Michigan, Nevada, New Mexico, Rhode Island, Virginia, Washington and West Virginia),[5] and (2) a 36-month post-planning period, with five states (Connecticut, Delaware, Illinois, Nevada, and West Virginia) selected from among the 15 planning grant states.[6] The states participating in the post-planning period receive federal reimbursement equal to 80 percent of the qualified sums[7] expended during each of the quarters in the post-planning period. Exhibit 1 identifies selected characteristics of the post-planning states, including census region, state population, percentage of the population in rural areas, number of Medicaid enrollees, percentage of enrollees in Medicaid managed care, and overdose rates.

Due to the COVID-19 public health emergency, CMS extended the end of the planning period and delayed the start of the post-planning period by six months. Thus, the planning period began on September 30, 2019, and ended on September 29, 2021. The post-planning period began on September 30, 2021, and ends on September 30, 2024.

Exhibit 1. Post-Planning Period State Characteristics

State & Census Area	Population Estimate[a]	Rural Population, %[b]	Medicaid Enrollees[c]	Medicaid Enrollment Percent Increase 10/2019 to 12/2022[c]	Enrollees in Comprehensive Managed Care, %[d]	Rate of Overdose Deaths, 2020[e]	Rate of Opioid-Related Overdose Deaths, 2020[f]
United States (—)	333.3M	20.0	85.9M	32%	72.4	28.3	21.4
Connecticut (Northeast)	3.6M	13.7	998.5K	20%	0	39.1	35.9
Delaware (South)	1.0M	17.4	296.5K	35%	85.3	47.3	43.9
Illinois (Midwest)	12.6M	13.1	3.5M	34%	74.4	28.1	23.4
Nevada (West)	3.2M	5.9	823.8K	38%	77.5	26.0	17.8
West Virginia (South)	1.8M	55.4	613.7K	27%	80.4	81.4	70.0

[a] As of July 1, 2022. Source: U.S. Census Bureau. State Population Totals and Components of Change: 2020-2022. Annual Estimates of the Resident Population for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2022 (NST-EST2022-POP). December 2022. https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[b] As of 2020. Source: U.S. Census Bureau. State-Level Urban and Rural Information for the 2020 Census and 2010 Census. State-Level 2020 and 2010 Census Urban and Rural Information for the U.S., Puerto Rico, and Island Areas sorted by state FIPS code. March 2023. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html

[c] Source for state data: As of January 2023. Centers for Medicare & Medicaid Services. December 2022 Medicaid & CHIP Enrollment Data Highlights. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Source for United States 2019 data: As of December 16, 2020. Centers for Medicare & Medicaid Services. Medicaid and CHIP Enrollment Trends Snapshot through September 2020. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/september-medicaid-chip-enrollment-trend-snapshot.pdf

Source for United States 2022 data: As of May 23, 2023. Centers for Medicare & Medicaid Services. March 2023 Medicaid and CHIP Enrollment Trends Snapshot. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/march-2023-medicaid-chip-enrollment-trend-snapshot.pdf

[d] As of July 1, 2020. Source: Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics, 2020*. Spring 2022. https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf

[e,f]. Source for state data: As of April 19, 2022. Kaiser Family Foundation. State Health Facts: Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Source for United States data: As of December 2022. National Center for Health Statistics. *NCHS Data Brief, Number 457.* https://www.cdc.gov/nchs/data/databriefs/db457-tables.pdf

This *Interim Report to Congress* is the third of four reports required by section 1003 of the SUPPORT Act. The focus of this report is the activities carried out by the five post-planning period states, the extent to which post-planning period states have achieved the goals stated in their applications, and plans for the sustainability of their SUPPORT Act projects. The two previously issued reports were the *Initial Report to Congress* and the *AHRQ Report to Congress*. The *Initial Report to Congress* focused on the selection of the 15 states awarded planning grants and their implementation of the planning grants over the initial 13 months of the 24-month planning period (September 30, 2019–October 31, 2020). The AHRQ Report to Congress provided a summary of the experiences of states awarded planning grants and those selected for the post-planning period covering the planning period and the first four months of the post-planning period (September 30, 2019 – February 1, 2022). The *Final Report to Congress* will provide updates on the post-planning state activities described in this *Interim Report to Congress* and an evaluation of the demonstration project.[8]

2.1 SUD Prevalence and Treatment in the United States

The National Survey on Drug Use and Health found that, in 2022, an estimated 6.1 million Americans aged 12 years or older (2.2 percent) had an opioid use disorder (OUD) in the past year and that an estimated 48.7 million (17.3 percent) had any type of SUD.[9] The effects of the opioid crisis are pronounced throughout the United States, with opioid-related overdoses and overdose deaths growing since the early 2000s. The age-adjusted rate of drug overdose deaths was 31 percent higher in 2020 than in 1999,[10] and continued to increase another 15 percent in 2021.[11] In 2017, the costs associated with OUD and fatal opioid overdoses were estimated at $1.02 trillion.[12] The impact of SUD extends beyond the individual substance user, as indicated by the prevalence of neonatal abstinence syndrome,[13] and fetal alcohol spectrum disorder.[14] In addition, injection opioid use is associated with increased rates of infectious diseases, such as human immunodeficiency virus (HIV) and hepatitis.[15]

Effective treatments for SUD exist but remain highly underutilized. An approach incorporating both medication and psychosocial treatment and/or supports is the gold standard for treating OUD and can also be effective for treating alcohol use disorder.[16] The specific medications approved by the Food and Drug Administration (FDA) to treat OUD include buprenorphine or buprenorphine-naloxone (collectively, buprenorphine), methadone, and naltrexone. Medications

approved to treat alcohol use disorder include acamprosate, disulfiram, and naltrexone. For SUDs other than opioid or alcohol use disorder, there are currently no approved medications and treatment relies largely on psychosocial interventions.[17] Further, access to recovery support services can be important for achieving and maintaining recovery from SUD.[18,19,20]

Despite the prevalence of SUD and evidence-based treatments for SUD, significant capacity shortfalls in SUD treatment or recovery services are widespread across the United States, particularly in rural areas.[21,22,23] The 2022 National Survey on Drug Use and Health found that, of the 54.6 million people in the United States aged 12 years or older who needed SUD treatment in the prior year, only 13.1 million received any substance use treatment during that period.[24] This lack of treatment availability exists across the spectrum of services, as well as across geographic locations. Thus, despite some progress, opioid treatment programs that provide methadone treatment and the current pool of qualified providers willing and able to prescribe buprenorphine do not meet the demand for these treatments in many locations.[25,26] In rural areas, researchers report a variety of limitations to accessing services resulting from a lack of appropriate resources in the community, including clinics and physicians.[27]

The public health emergency declaration due to the COVID-19 public health emergency led to a temporary relaxation of certain requirements related to using telehealth, prescribing buprenorphine, and providing take-home methadone for OUD treatment.[28] Toward the end of 2022, the federal government took steps to make some of the public health emergency-related flexibilities permanent. For example, Congress eliminated the requirement for providers to obtain a specific waiver under the Drug Addiction Treatment Act (the DATA Act) to prescribe buprenorphine.[29,30] SAMHSA also finalized updates[31] to opioid treatment program standards, but these changes alone likely will not address all SUD treatment provider shortages over the long term.

2.2 Purpose of the Demonstration

The SUPPORT Act was enacted in response to the number of individuals in the United States with OUD and/or another SUD, high rates of fatal and nonfatal overdoses, and the other human and economic costs associated with the opioid crisis. The purpose of the section 1003 Demonstration Project to Increase Substance Use Provider Capacity is to increase the capacity of

Medicaid providers qualified to deliver SUD treatment or recovery services through the following activities:

- Ongoing assessment of the state's behavioral health treatment needs.
- Activities supporting the recruitment, training, and provision of technical assistance for qualified Medicaid providers that offer SUD treatment or recovery services.
- Improved reimbursement for and expansion of the number or treatment capacity of qualified Medicaid providers who: (1) are authorized to dispense drugs approved by the FDA for individuals with SUD who need withdrawal management or maintenance treatment, (2) have a DATA waiver to prescribe buprenorphine[32] or (3) are qualified under applicable state law to provide SUD treatment or recovery services.
- Improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers qualified to address the treatment or recovery needs of infants with neonatal abstinence syndrome, pregnant women, postpartum women, and infants, adolescents, and young adults aged 12 to 21 years, or American Indian and Alaska Native individuals.

Medicaid is important in addressing SUD because a substantial percentage of adults with SUD in the United States are enrolled in Medicaid, with 7.3% of Medicaid enrollees ages 12-64 years old having at least one SUD in 2019.[33] However, in 2019, only eight percent of Medicaid beneficiaries aged 12 years and older with a SUD received SUD treatment.[34] Capacity shortages in SUD services can have consequences for Medicaid beneficiaries, and states may face significant limitations in addressing these shortages.

The 2019 Notice of Funding Opportunity for this demonstration project included the following examples of the limitations that state Medicaid programs may need to overcome to build SUD treatment or recovery service capacity.[35]

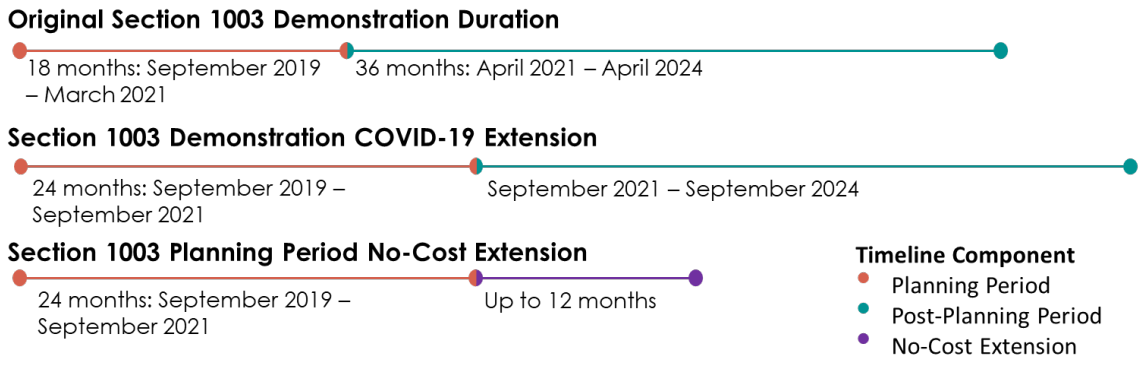
- **Lack of qualified providers:** lack of Medicaid providers trained in prescribing MOUD and behavioral health services, and lack of technical support to help primary care providers integrate SUD services.
- **Provider willingness**: lack of qualified providers who are willing to provide SUD treatment or to serve Medicaid beneficiaries, as well as stigma among providers about SUD treatment.

- **Financial impediments**: beneficiary cost sharing, limits on diagnosis codes for which primary care providers may receive reimbursement, low reimbursement, and burdensome provider reimbursement requirements.
- **Access limitations**: transportation impediments, laws that limit where SUD providers can be located, and lack of qualified providers in specific geographic areas.
- **Other care provision impediments**: enrollment caps, prior authorization requirements, lack of care coordination between qualified SUD providers and other providers, cultural barriers, limits on treatment duration, and step therapy criteria.[36]

2.3 Critical Context for the Demonstration

The section 1003 demonstration began a few months before the emergence of COVID-19. As the effects of COVID-19 began to spread across the United States, CMS modified the deadlines and timetables set forth in section 1003 of the SUPPORT Act to enable states to complete planning grant activities amid the disruption and limitations caused by the public health emergency, including competing financial and resource pressures to address the spread of COVID-19. Specifically, for all participating states, CMS extended the end date of the planning period of the demonstration by six months to September 29, 2021. CMS also delayed the start of the 36-month post-planning period by six months to September 30, 2021, and provided the option to apply for an added no-cost extension for up to 12 months to complete planning grant activities for states that did not participate in the post-planning period. No-cost extensions are typical for discretionary grants when there are unobligated funds available. The timeline updates, shown in Exhibit 2, were based on an assessment of the impact of the COVID-19 public health emergency on grantee activities.

Exhibit 2. Section 1003 Demonstration Project Timeline



The COVID-19 public health crisis corresponded with an increase in the incidence of opioid-related overdoses in many parts of the United States.[37] As need increased, the states' intended section 1003 planning grant activities were curtailed by public health considerations related to the public health emergency, which impacted the demonstration. As outlined in the *Initial* and *AHRQ Reports to Congress*, some specific examples of how the public health emergency affected states participating in the SUPPORT Act demonstration included delays in data collection activities, delays in implementation timelines, and shifts in resources in that staff had to be reassigned to focus on the public health emergency response. Additionally, across the health care continuum, the public health emergency worsened health care shortages and increased provider burnout.[38]

The presence of other state and federal initiatives also affected Medicaid SUD treatment or recovery service provider capacity. The Section 1003 Demonstration Notice of Funding Opportunity required applicants to identify other programs and funding sources at the local, state, and federal levels that were related to the applicants' proposed section 1003 project and address how they would ensure that funding for section 1003 would not duplicate those other services or funding. In addition, applicants were asked to identify how they would monitor and mitigate potential duplication.[39] Examples of related initiatives include the CMS Comprehensive Primary Care Plus Model, Accountable Health Communities Model, State Innovation Model, Maternal Opioid Misuse Model, and Integrated Care for Kids Model, CMS section 1115(a) SUD demonstrations, and SAMHSA State Targeted Response and State Opioid Response grants. Participation in any of these initiatives may have overlapped with section 1003 demonstration activities and influence outcomes.

3 METHODS

3.1 Evaluation Questions

This *Interim Report to Congress* addresses the evaluation questions in Exhibit 3.

Exhibit 3. Evaluation Questions, Data Sources, and Analytic Approaches to Assessing the Experiences of States Participating in the Post-Planning Period

Evaluation Question	Data Sources	Analytic Approach
What were the activities carried out under the demonstration?	Applications, progress reports, and stakeholder interviews	Qualitative analysis: narrative and thematic analysis
How is the demonstration coordinated with other state activities, including other federally funded activities and initiatives, to address SUD?	Progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Have states made progress on achieving the aims of their demonstration applications, and how/why not?	Progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis
Has the number of Medicaid SUD providers and SUD services provided increased?	Progress reports	Quantitative analysis: aggregate descriptive analysis
How did legislation and policies of the individual states influence the decisions of the states on how they would expand treatment?	Stakeholder interviews	Qualitative analysis: narrative analysis
What are the strengths and limitations of the demonstration?	Applications, progress reports, and stakeholder interviews	Qualitative analysis: narrative and thematic analysis
What is the plan for the sustainability of the demonstration?	Progress reports, stakeholder interviews	Qualitative analysis: narrative and thematic analysis

3.2 Data Sources

This report draws from two primary data sources: post-planning period state documents and stakeholder interviews. Post-planning period state documents include: (1) applications for the post-planning period, (2) quarterly progress reports (QPRs), and (3) semiannual progress reports. Progress reports contain a mixture of qualitative and quantitative data. The qualitative data includes narrative descriptions of activities states are conducting as well as descriptions of the risks and limitations they are facing. The quantitative data includes the number of Medicaid beneficiaries with SUD, the number of enrollees receiving SUD services, and the number of Medicaid providers qualified to deliver SUD treatment across Form CMS-64[40] service categories.

The analyses for this report included three rounds of stakeholder interviews. The 5 post-planning period states' section 1003 program leadership participated in two rounds of interviews (January 2022, and December 2022). Representatives from the post-planning period states'

Single State Agency for Substance Abuse participated in an additional set of interviews (between July and October 2022). Together, the interviews captured the post-planning period states' goals, partnerships, implementation processes and progress, and limitations and facilitators encountered during the planning period and the first 14 months of the post-planning period. The qualitative analysis included primarily data from post-planning period QPRs (Exhibit 4). The quantitative analysis included data from all QPRs to identify trends in service and provider counts over the planning period and the first 14 months of the post-planning period (September 30, 2019–December 31, 2022).

Exhibit 4. QPR Data Analysis

QPR Reporting Period	Quantitative Analysis	Qualitative Analysis
Q4 2019 (FFY Q1 2020)	x	—
Q1 2020 (FFY Q2 2020)	x	—
Q2 2020 (FFY Q3 2020)	x	—
Q3 2020 (FFY Q4 2020)	x	—
Q4 2020 (FFY Q1 2021)	x	—
Q1 2021 (FFY Q2 2021)	x	—
Q2 2021 (FFY Q3 2021)	x	—
Q3 2021[a] (FFY Q4 2021)	x	x[b]
Q4 2021 (FFY Q1 2022)	x	x
Q1 2022 (FFY Q2 2022)	x	x

Abbreviations: Q-quarter, QPR-Quarterly Progress Report, FFY-federal fiscal year.

[a] Beginning of post-planning period.

[b] The qualitative analysis also included a review of the Q1 2021 and Q2 2021 QPRs to capture any additional contextual information about activities ongoing during the post-planning period.

3.3 Methods of Analyses

As indicated in Exhibits 3 and 4, the analyses for this report incorporated both qualitive and quantitative methods. Qualitative methods included using a qualitative research and analysis platform to code stakeholder interview notes and post-planning period state documents. 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 they became available to ensure that the post-planning period analyses 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. The team conducted a content analysis across post-planning period state progress reports, application materials, and stakeholder interviews to identify common themes across the evaluation questions. In this report, results from the qualitative analyses summarize key themes and do not account for every state's response to each evaluation question. The level of detail offered in state reports and during stakeholder interviews varied; thus, the state-specific chapters also vary in the level of detail provided.

The quantitative analysis examined data from the QPRs on the number of qualified SUD treatment providers and services for the following metrics:

- The number of beneficiaries receiving services provided by service type.[41]
- The number of qualified SUD Medicaid service providers by service type (aggregated across fee-for-service and managed care services where relevant.)
- The number of Medicaid SUD service providers who met the standards to prescribe MOUD (buprenorphine or methadone) by service type.

Descriptive statistics were used to characterize the data. The quantitative analysis used data from each state's QPR from the beginning of the SUPPORT Act demonstration period through the latest quarter for which data were available (10/1/2019–3/31/2022, federal fiscal year (FFY) Q1 2020–FFY Q2 2022) to identify trends. Additionally, aggregate numbers across all reporting periods for all post-planning period states were calculated for the quantitative metrics.

3.4 Limitations

Specifications for reporting the QPR measures were based on the Form CMS-64 service categories. However, because each state Medicaid agency may cover different services within each service category, states were permitted to use state-specific reporting specifications where there was no federal standard. In cases where states reported uninterpretable data or where there were obvious reporting errors (e.g., a service type only reported in one quarter out of the 10 quarters for which data were received), we removed these data points. In cases where outliers or incorrect data were suspected, states were asked to review their data for quality and accuracy and re-submit the report, if necessary.

The next five chapters (4 – 8) are specific to each post-planning period state and address the evaluation questions as they relate to the states' unique demonstration projects. The state chapters include information about each state's unique goals as described in their post-planning period applications that tie to the overall goals of the demonstration. Following these state-specific chapters is a chapter that provides an aggregate analysis across all five post-planning period states to highlight trends across the demonstration and a conclusions chapter.

Appendix A contains the instructions that states received for completing the SUPPORT Act QPRs. Appendix B contains detailed tables for the quantitative metrics.

4 CONNECTICUT

Connecticut's Department of Mental Health and Addiction Services has focused its efforts to transform the state's opioid treatment system during the demonstration on the following goals:

- Increase identification of SUD, allowing beneficiaries to access SUD services earlier.
- Increase beneficiary access to and engagement with quality treatment for SUD.
- Increase capacity of providers furnishing SUD services.
- Monitor drug overdose deaths among Medicaid beneficiaries.

This chapter describes the activities Connecticut has carried out under the demonstration, its progress toward achieving the demonstration's goals, the strengths and limitations of its approach, and the state's sustainability plan.

4.1 Connecticut's Post-Planning Period Demonstration Activities

During the post-planning period, Connecticut has conducted activities focused on the ongoing assessment of SUD prevalence and behavioral health treatment needs (Exhibit 5). The state has also explored approaches to creating long-term and sustainable SUD provider networks.

Exhibit 5. Connecticut Post-Planning Period Activities

Activity	Approach
Assessment of SUD prevalence and behavioral health treatment needs	• Began review of community health needs assessments and similar reports to identify trends, gaps, limitations, and innovative ideas. • Established production of quarterly data reports to assess the prevalence of SUD, service utilization, beneficiary needs, and trends in SUD diagnoses. • Initiated review of county datasets with a focus on social determinants of health and health outcomes. • Began attending Overdose Data to Action grantee meetings to identify trends and promising practices.
Increase the number of qualified SUD providers	• Developed recommendations to increase the capacity of qualified SUD providers working with the population transitioning from incarceration, including workforce development, technical assistance, and the creation of telehealth hubs. • Added coverage for optional SUD services under the rehabilitative state plan benefit.
Training, education, and support for providers to deliver SUD treatment or recovery services	• Conducted a provider assessment to identify training opportunities and developed a training menu to support independent practitioners. • Developed a plan for ongoing engagement and feedback loops to better understand provider needs and the impact of the trainings. • Offered a statewide training to residential treatment providers that is now covered by Medicaid through the section 1115(a) SUD demonstration, to familiarize them with American Society of Addiction Medicine levels of care. • Researched digital tools to enhance SUD services to understand utilization, data collection, and outcomes for youth/young adults and created a digital library for resource sharing with providers. • Trained providers on Culturally and Linguistically Appropriate Services (CLAS).

Activity	Approach
Consultation with relevant stakeholders	• Hosted discussions with SUD providers, community-based organizations, and recovery support providers in designated regions of the state via weekly, biweekly, and monthly collaborative meetings. • Collaborated with regional and statewide workgroups focusing on suicide prevention, criminal justice advocacy, and alcohol and drug policy to promote alignment of efforts statewide, and engaged with regional and statewide overdose workgroups. • Attended emergency department MOUD induction research conference to identify best practices and innovative ideas. • Developed a forum to engage independent practitioners and to share provider announcements and training opportunities, understand provider needs, and provide networking opportunities. • Developed informational data briefs synthesizing findings from stakeholder engagement and other grant activities thus far and presented to key stakeholders to encourage feedback and ongoing engagement. • Participated in Opiate Task Force meetings in rural areas of the state to share resources and troubleshoot beneficiary and provider struggles. • Attended weekly Regional Community Care Team meetings and connected with stakeholders (e.g., hospitals, law enforcement, housing authorities, and SUD providers) to understand limitations and successes, care coordination practices between providers, and new SUD treatment initiatives. • Engaged with a local drop-in center to better understand community-based harm-reduction initiatives (e.g., naloxone access, training for local businesses).
Data collection and reporting enhancement	• Developed dashboards to look at trends in utilization and prevalence for populations of interest, including pregnant/postpartum women and infants with neonatal abstinence syndrome or neonatal opioid withdrawal syndrome. • Shared data with stakeholders, including Connecticut's provider network, to help interpret the data and inform performance improvement activities. • Shared a data dashboard with providers that reveal disparities across race and ethnicity to help providers learn about and address disparities. • Identified current and potential overdose data sources and post-overdose intervention initiatives and practices.
Coordination with other federal or state initiatives	• Collaborated with other state agencies to develop the section 1115(a) SUD demonstration which was approved on April 14, 2022 and subsequently enrolled private nonprofit residential SUD treatment providers into the program. • Partnered with the Connecticut Housing Engagement and Support Services, which combines Medicaid health coverage with housing services for state residents facing homelessness and chronic health issues, including SUD.

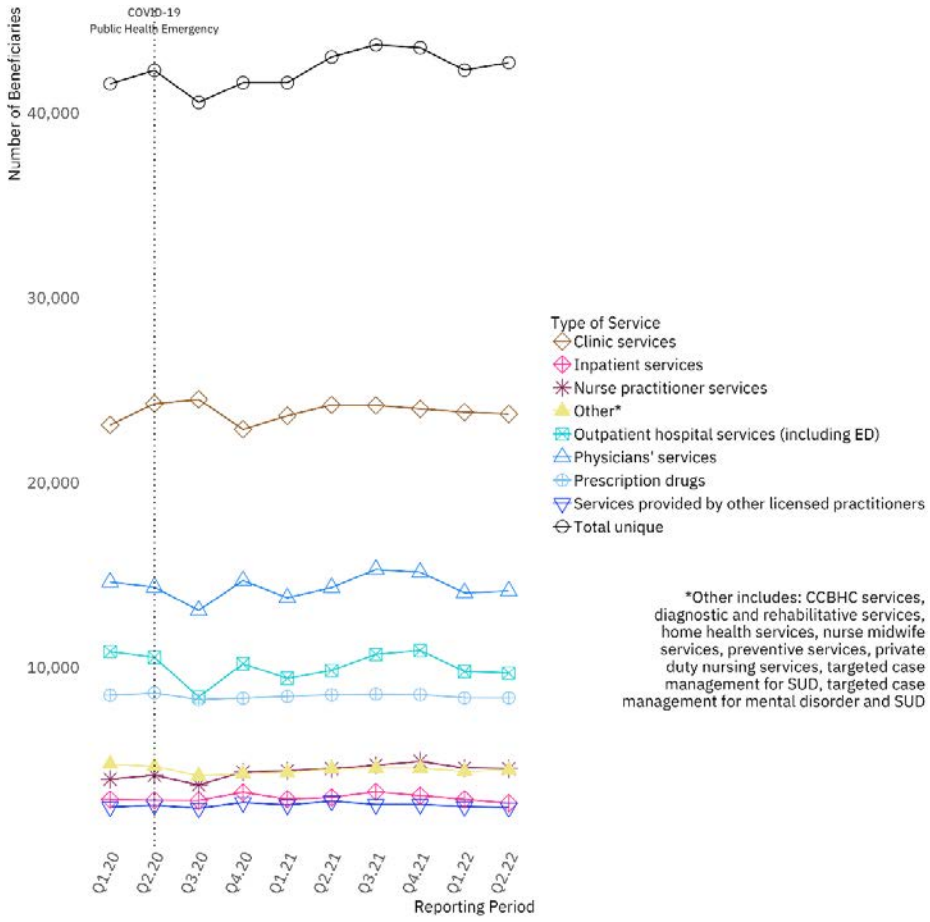
Abbreviations: MOUD-medication for opioid use disorder, SUD-substance use disorder.

4.2 Progress on Goals Identified in Application

4.2.1 Number of Medicaid Beneficiaries Who Received SUD Services

As shown in Exhibit 6,[42] the total number of unique Medicaid beneficiaries who received SUD services in Connecticut increased slightly across the reporting period. The number of Medicaid beneficiaries receiving SUD services remained relatively constant across service types, except for decreases in the number of beneficiaries receiving services at the start of the COVID-19 public health emergency for clinic services, physicians' services, and outpatient hospital services (including emergency department services).

Exhibit 6. Trends in the Number of Medicaid Beneficiaries Who Received SUD Services in Connecticut by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

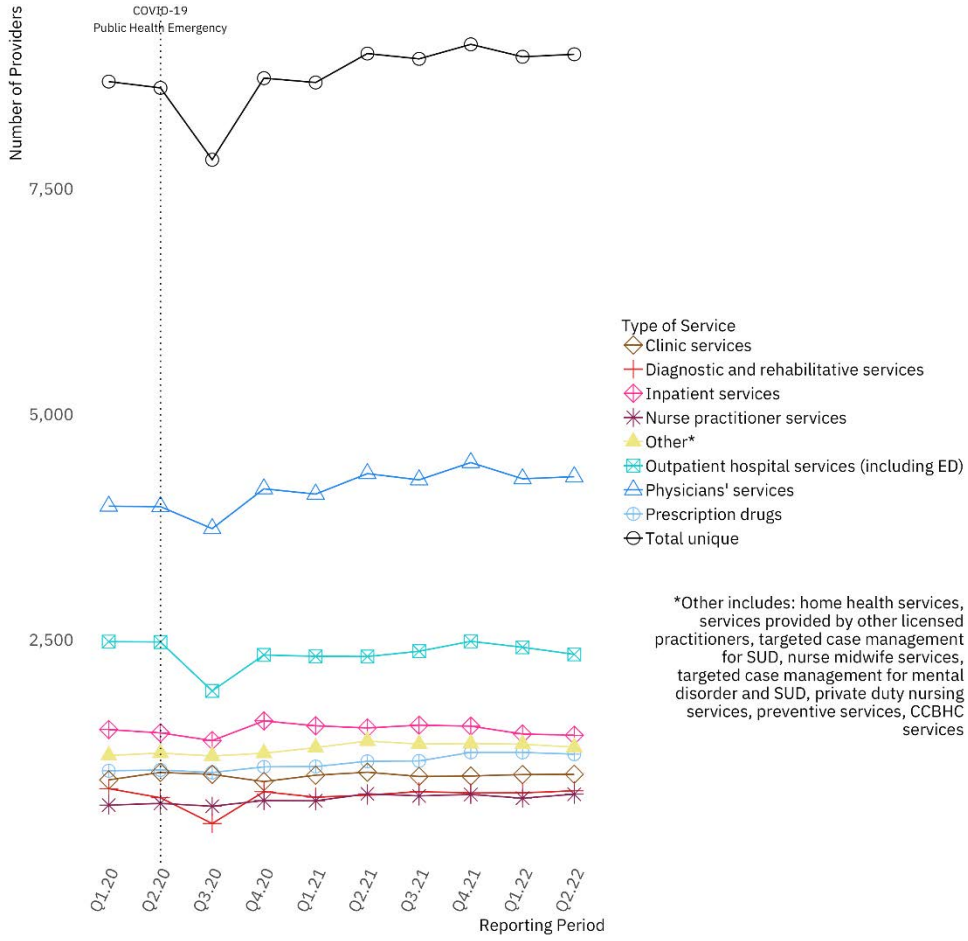


Data for figure in Appendix Table B1.

4.2.2 Number of Medicaid Providers Qualified to Deliver SUD Services

Exhibit 7 shows that the total number of unique Medicaid providers qualified to deliver SUD services in Connecticut increased across the reporting period. The number of Medicaid SUD providers qualified to deliver physicians' services and prescription drugs increased, and there were also increases to the number of Medicaid providers qualified to deliver clinic services and nurse practitioner services that are not visible in the graphic due to scale. The number of Medicaid SUD providers qualified to deliver services remained relatively constant for the other categories, except for a drop in services at the start of the COVID-19 public health emergency for physicians' services, outpatient hospital services (including emergency department services), and diagnostic and rehabilitative services.

Exhibit 7. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services in Connecticut by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

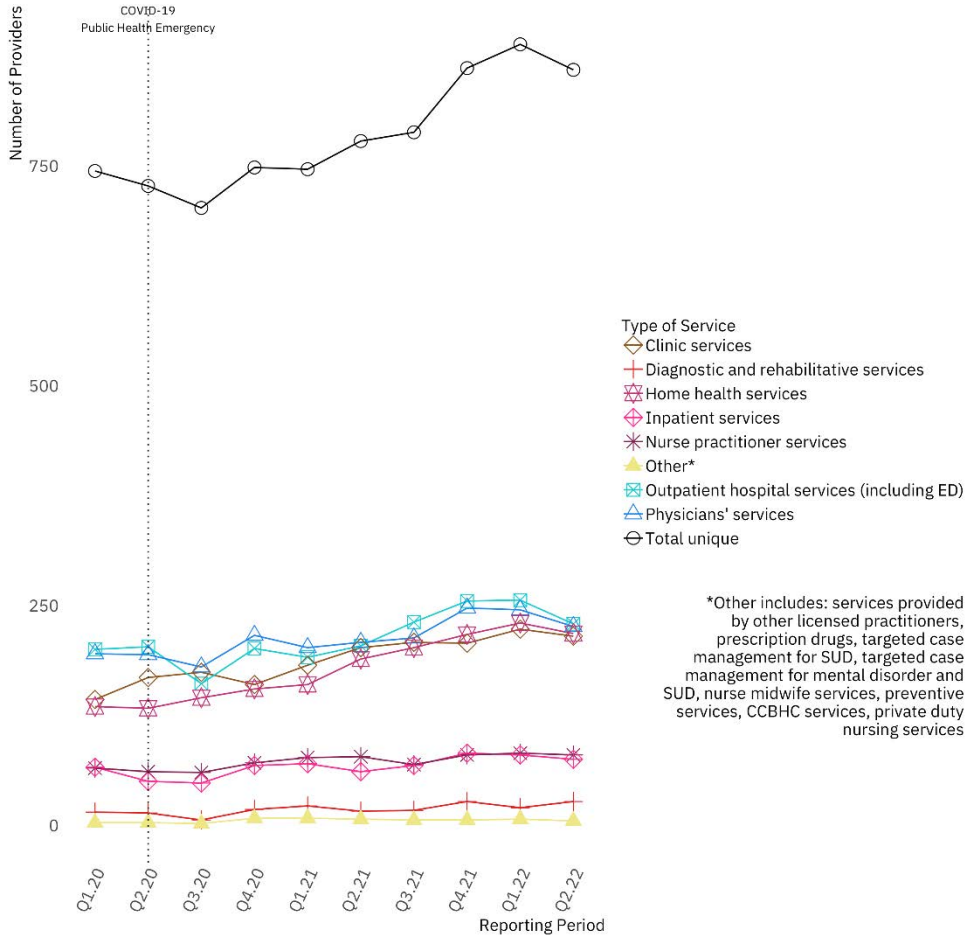


Data for figure in Appendix Table B2.

4.2.3 Number of Medicaid SUD Providers Who Met MOUD Provision Standards

The total number of unique Medicaid SUD providers who met the standards to provide MOUD (buprenorphine or methadone) increased across the reporting period and increased for all service types except for the "Other" service category as shown in Exhibit 8. The increase to inpatient services may not be visible in the graphic due to scale.

Exhibit 8. Trends in the Number of Medicaid SUD Providers Who Met MOUD Provision Standards in Connecticut by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B3.

4.2.4 Strategies to Advance SUPPORT Act Section 1003 Goals

The Department of Mental Health and Addiction Services coordinates with sister state agencies and initiatives to find common goals and challenges. These networking and collaboration activities are supporting the states' goals to increase identification of SUD, monitor drug overdose deaths, increase Medicaid SUD provider capacity, and increase beneficiary access to

quality SUD services. This successful collaboration is evidenced by the design of the section 1115(a) SUD demonstration that was approved by CMS in the first year of the post-planning period on April 14, 2022. Additionally, changes were added to SUD services in the Medicaid state plan which enable Connecticut to implement coverage and payment for SUD services across the full continuum of outpatient and residential levels of care. The state moved the outpatient SUD services that were under the Medicaid clinic state plan benefit into the rehabilitative services state plan benefit, giving providers more flexibility on where they can deliver SUD services. This shift supports models that provide primarily in home care to provide more comprehensive services to families who are likely connected to child and protective services. In addition to enrolling private nonprofit residential SUD treatment providers into Medicaid, Connecticut is expecting additional increases to SUD provider enrollment, as some provider agencies have expressed interest in opening new programs or new levels of care. Additionally, through activities under the section 1115(a) SUD demonstration, the state is conducting a capacity assessment to identify gaps in bed availability across levels of care. Addressing these gaps will ensure transitions between the levels of care are smooth for beneficiaries.

Some of the research findings from the planning grant informed the decision to move outpatient SUD services under Connecticut's Medicaid clinic state plan benefit into a rehabilitative services state plan benefit. This change offers certain Medicaid providers greater flexibility in where they can deliver services, allowing for more in-home care.

4.3 Impact of Connecticut's Legislation and Policies on Decisions for How to Expand SUD Treatment

Two policies related to the expansion of telehealth and benefits for pregnant and postpartum women have impacted how Connecticut is expanding provider capacity for SUD treatment and recovery services. The state is currently considering expansion of telehealth services beyond the COVID-19 public health emergency. Additionally, their Medicaid and CHIP program expanded benefits and coverage to undocumented pregnant and postpartum women, which aligns with Connecticut's planning grant focus on infants with neonatal abstinence syndrome.

4.4 Strengths and Limitations of Connecticut's Approach

The greatest strengths the state leveraged during the post-planning period were access to rich data sources and extensive stakeholder involvement. Connecticut has enlisted stakeholders including sister state agencies, established subcommittees, workgroups, councils, and relevant provider groups, such as MOUD prescribers, independent practitioners, and recovery support providers. These stakeholders collaborated closely during the COVID-19 public health emergency. The state has also engaged Medicaid beneficiaries through their participation in focus groups and advisory councils.

The State of Connecticut maintains an open data system where each state agency has access to the same dataset, including both qualitative and quantitative data. This infrastructure enables cross-agency collaboration and thoughtful, data-driven planning. Additionally, the state shares data with each stakeholder group for feedback and interpretation. Involving stakeholders at this level has resulted in greater buy-in and productive discussions leading to actionable steps.

Regarding limitations to their SUPPORT Act work, Connecticut described difficulty hiring licensed behavioral health clinical staff across all levels of care, a lack of centralized data related to harm reduction and overdose, a need to incentivize data collection and reporting, and funding source limitations. The COVID-19 public health emergency created a major limitation to Connecticut's demonstration, including its lingering impacts on ensuring adequate staffing and capacity and conducting community outreach and engagement. For example, the state has reported a reduction in residential SUD treatment capacity and even some facility closures. Connecticut also had to roll back its routine harm reduction and community outreach efforts due to restrictions of COVID-19 protocols. In addition, Connecticut was limited by inconsistent overdose data reporting and difficulties engaging stakeholders about the state's overdose response.

4.5 Connecticut's Plans for Sustainability

Connecticut is using various strategies to sustain the progress made through its section 1003 demonstration. The state is working to continue coordination across agencies to implement the section 1115(a) SUD demonstration and put into place a new SUD value-based Medicaid

payment strategy. The state is dedicated to re-investing any cost savings realized through these efforts back into SUD services. Connecticut is also looking ahead to future opportunities.

State leaders who oversee federal grant initiatives for child and adolescent substance use issues and are responsible for implementation of the Child Abuse Prevention and Treatment Act are working with the state leaders directing grant initiatives related to adults with substance use issues. Together, they are coordinating efforts in support of the SUPPORT Act section 1003 demonstration and participating in the implementation of the section 1115(a) SUD demonstration.

The state is maintaining the current level of state funding for SUD services and adding federal funding from the section 1115(a) SUD demonstration into the SUD service system. For example, Connecticut has a plan to leverage its approved section 1115(a) SUD demonstration to sustain provider capacity of residential and inpatient SUD services in their state Medicaid program.

The state identified SUD workforce capacity as the greatest limitation to sustaining the initiative. Thus, Connecticut made a public commitment to system transformation that will address workforce challenges. One of the ways Connecticut is demonstrating this commitment is by working to advance a sustainable SUD value-based Medicaid payment strategy that allows providers to hire qualified staff while also creating value from the payers' perspective (i.e., improved beneficiary outcomes, reduced hospitalizations). Connecticut is also in the advanced stages of developing an alternative payment model with its outpatient behavioral health services.

Finally, Connecticut is considering a recently-announced CMS opportunity to implement a section 1115(a) demonstration that authorizes Medicaid eligibility to be effective for individuals at 60 days or 90 days before their release from incarceration. The state may apply for this waiver if other states are successful with gaining CMS approval.

5 DELAWARE

Delaware's Division of Medicaid & Medical Assistance has focused its efforts to transform the state's opioid treatment system during the demonstration on the following goals:

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

This work builds on the planning grant activities focused on assessment of capacity and gaps within the SUD/OUD treatment system, SUD/OUD prevalence analysis of Medicaid beneficiaries, technical assistance to outpatient medical practices on office-based opioid treatment (OBOT), several special reports, and other key activities. This chapter describes the activities that Delaware has carried out under the demonstration, its progress toward achieving the demonstration's goals, the strengths and limitations of its approach, and the state's sustainability plans.

5.1 Delaware's Post-Planning Period Demonstration Activities

Throughout the demonstration project, Delaware has continued its efforts to conduct an ongoing assessment of SUD prevalence and behavioral health treatment needs (Exhibit 9). The state is also working to create long-term and sustainable provider networks that can offer a continuum of care for SUD.

Exhibit 9. Delaware's Post-Planning Period Activities

Activity	Approach
Assessment of SUD prevalence and behavioral health treatment needs	• During the planning phase, produced an annual prevalence report (2014-2019) for SUD among Medicaid beneficiaries and a SUD treatment system capacity and gaps analysis. • Produced a report detailing all the recommendations to increase provider capacity that were developed during the planning grant. • Created a SUD/OUD monitoring and surveillance system to be implemented in 2024, to assess SUD/OUD prevalence among the Delaware Medicaid population, SUD provider availability (across all American Society of Addiction Medicine levels of care), SUD service utilization, and performance relative to SUD quality measures. • Created the SUPPORT Evaluation and Reporting Team, which is divided into subgroups focused on Division of Medicaid & Medical Assistance leadership and finance, Transformed Medicaid Statistical Information System data, and Form CMS-64 reporting.
Approaches to increase the number of Medicaid SUD providers	• Effective January 1, 2023, implemented provider rate increases (identified as a need by the SUPPORT Act planning grant-funded needs assessment) across 15 distinct services funded by the American Rescue Plan Act (ARP) of 2021 section 9817. • Completed an OBOT innovation scan to inform the design of a new payment model and provider standards for a statewide OBOT program, modeled after other state Medicaid programs' effective initiatives. • Designed an evidence-based contingency management program for persons with stimulant use disorders for inclusion in its section 1115(a) SUD demonstration amendment.
Training, education, and support for providers qualified to deliver SUD treatment or recovery services	• Developed new MOUD operational and policy guidance for providers, including billing and coding guidance, prescriber and dispensing site regulations, and medication coverage options. • Convened a conference, *Clinical Guidance in Treating Pregnant and Parenting Women with OUD and Their Infants*, in February 2022 with clinical experts, attended by over 300 attendees. • Trained 103 prescribers and practice administrators in outpatient medical settings across Delaware on providing gold-standard buprenorphine treatment to people with OUD. • Developed guidance for prescribers and managed care organizations (MCOs) on addressing the needs of pregnant and parenting people with OUD, including a clinical guidance brief and virtual trainings for 150+ client-facing managed care staff to reduce stigma toward pregnant and parenting people with OUD. • Created an existing technical assistance initiative inventory, including for peer-to-peer support for providers, that is being vetted by state partners.

Activity	Approach
Consultation with relevant stakeholders	• Partnered with a physician to create technical assistance opportunities for clinicians serving pregnant and parenting people with SUD. • Engaged an OBOT Technical Expert Panel to assist in the design of a statewide OBOT model. • Presented a "Medicaid 101" presentation to provider stakeholders in March 2022, to the Behavioral Health Consortium in October 2022, and to the Ability Network of Delaware in November 2022. • Presented draft rate models to SUD providers in January and April 2022.
Coordination with other federal or state initiatives	• Helped plan and host a MOUD Extension for Community Healthcare Outcomes (ECHO) clinic with the Division of Substance Abuse and Mental Health in May 2022, as well as a series of self-paced learning modules available to interested providers. • Coordinated with the State Opioid Response grant team to allow SUPPORT Act–funded office-based opioid treatment fellowship providers to receive State Opioid Response funds to implement and increase their capacity to support same-day initiation of buprenorphine. • Supported Division of Substance Abuse and Mental Health's creation of a comprehensive statewide behavioral health provider directory by analyzing records and correcting discrepancies between public and internal systems. • Planned to submit a renewal of its 1115(a) SUD demonstration. Their demonstration to expand SUD residential services was approved July 31, 2019 for an effective date of August 1, 2019.
Data collection and reporting enhancement	• Completed data dashboards in September 2022 that included aggregate beneficiary-level data (e.g., rate of SUD/OUD by ZIP Code, substance type, and age group), provider-level data (e.g., number of waivered prescribers by ZIP Code), and quality measure data. • Met with data analytics vendors to identify data infrastructure gaps and had vendors create "process guides" outlining their data analytic approaches and limitations with their analyses.

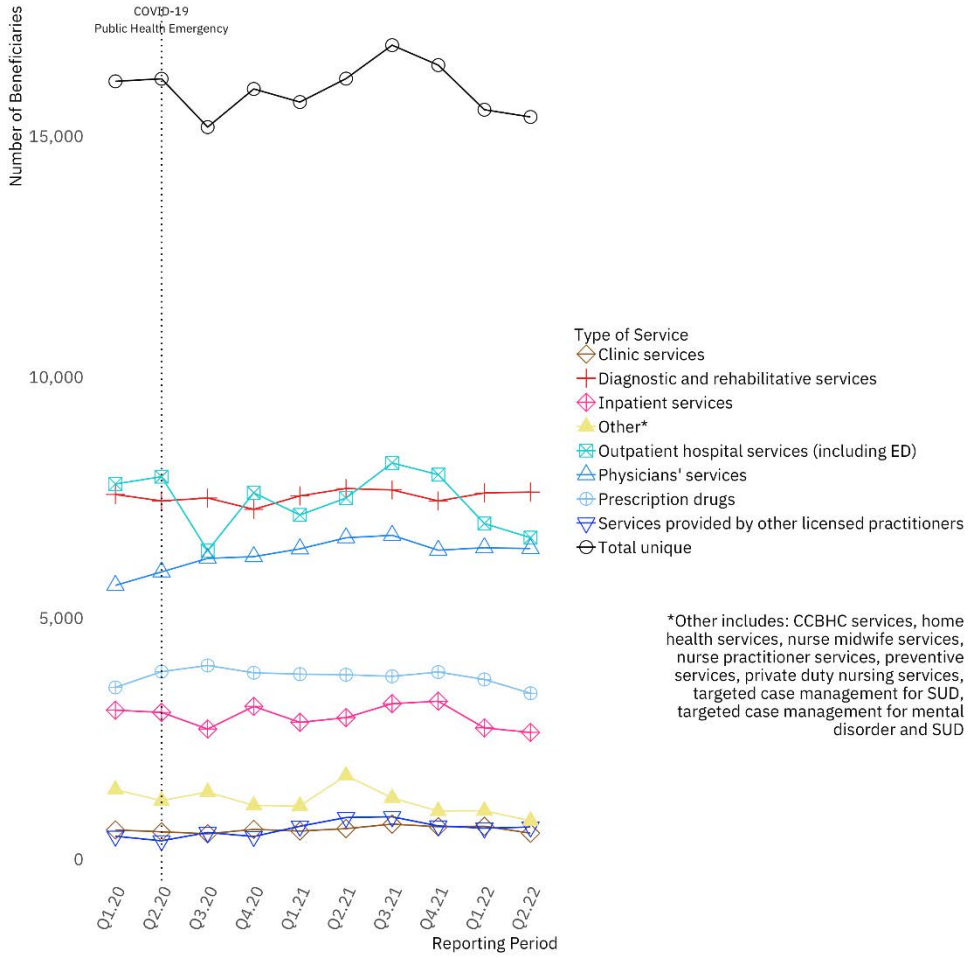
A highlight of Delaware's efforts is the completion of a SUD rate analysis. Delaware leveraged the results of the rate analysis into a reimbursement rate increase for the administration of methadone in 2022 and for Medicaid SUD providers more generally in 2023. The rate study, which began during the planning period, included collecting SUD provider data to understand the costs of providing treatment, formulating rate models, securing funding for the increase, engaging stakeholders via formal public comment, and adjusting capitation rates.

5.2 Progress on Goals Identified in Application

5.2.1 Number of Medicaid Beneficiaries Who Received SUD Services

As shown in Exhibit 10, the total unique number of Medicaid beneficiaries receiving SUD services in Delaware across the reporting period decreased. The number of Medicaid beneficiaries receiving SUD services remained relatively constant across service types, except for decreases in beneficiaries receiving services at the start of the COVID-19 public health emergency for outpatient hospital services (including emergency department services) and inpatient services.

Exhibit 10. Trends in the Number of Medicaid Beneficiaries Who Received SUD Services in Delaware by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

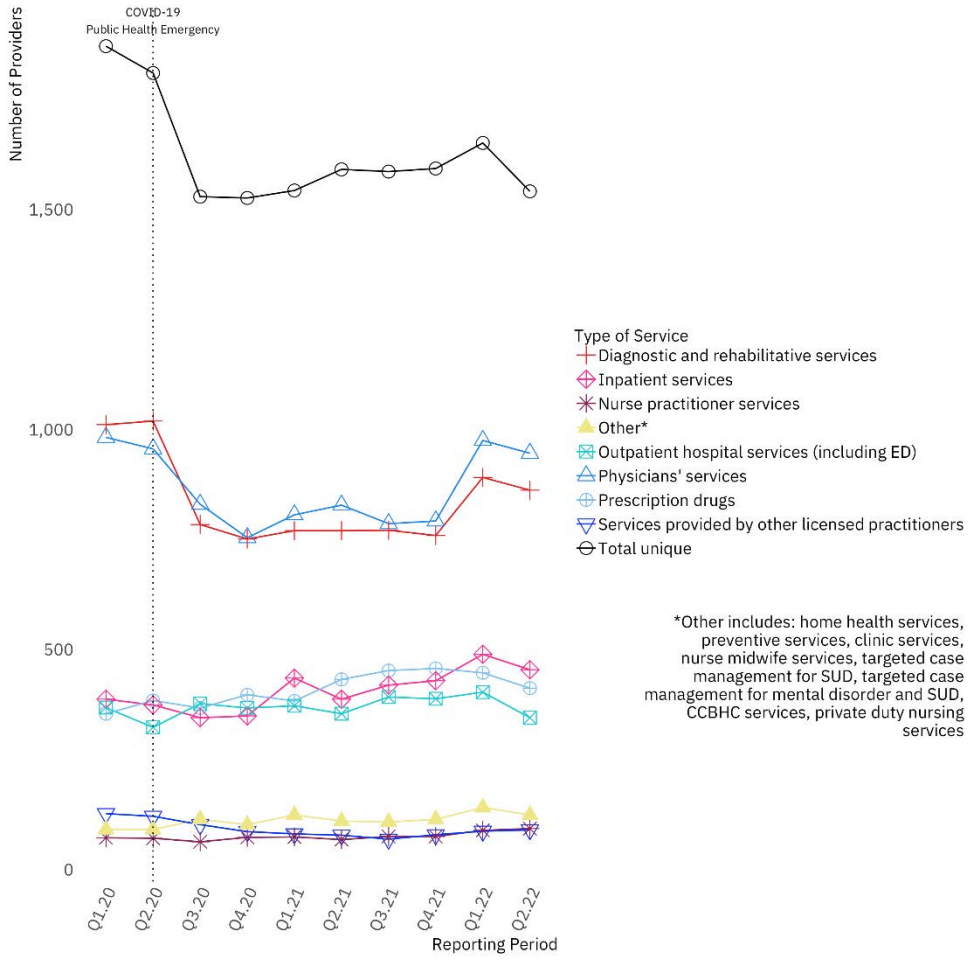


Data for figure in Appendix Table B5.

5.2.2 Number of Medicaid Providers Qualified to Deliver SUD Services

Exhibit 11 shows that the total number of unique Medicaid providers qualified to deliver SUD services in Delaware decreased across the reporting period. The number of Medicaid providers qualified to deliver prescription drugs, inpatient services, and nurse practitioner services increased over time. Despite decreasing slightly over the entire reporting period, physicians' services and diagnostic and rehabilitative services increased toward the end of the reporting period.

Exhibit 11. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services in Delaware by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



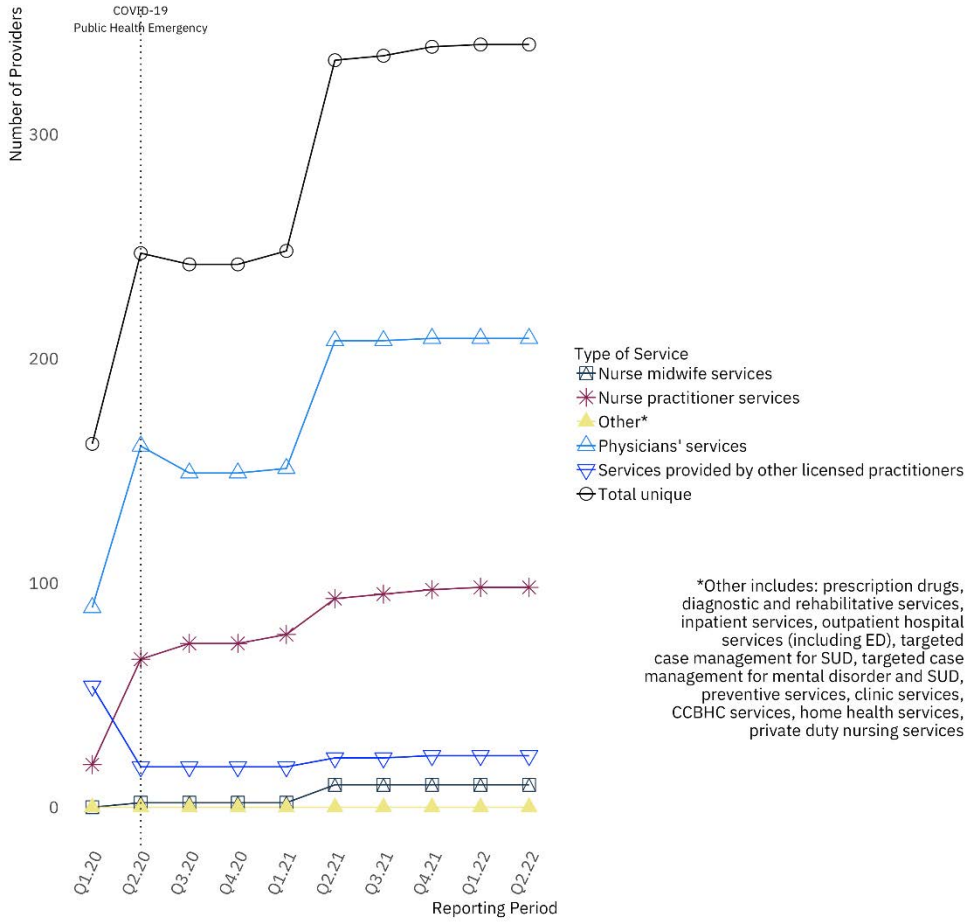
Data for figure in Appendix Table B6.

Note: Delaware explained the increase in physician services and diagnostic and rehabilitative services as related to an office based opioid treatment fellowship, which incentivized obstetricians/gynecologists and service providers to provide SUD treatment services, and the state held multiple training sessions for providers during that time.

5.2.3 Number of Medicaid SUD Providers Who Met MOUD Provision Standards

As shown in Exhibit 12, the total number of unique Medicaid SUD providers in Delaware who met the standards to provide MOUD (buprenorphine or methadone) increased across the reporting period. The number of Medicaid providers meeting MOUD provision standards for almost every service category increased over time, except for services provided by other licensed practitioners, which showed a slight decrease over the reporting period.

Exhibit 12. Trends in the Number of Medicaid SUD Providers Who Met MOUD Provision Standards in Delaware by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B7.

Note: Delaware explained the increase in physician services and diagnostic and rehabilitative services as related to an office based opioid treatment fellowship, which incentivized obstetricians/gynecologists and service providers to provide SUD treatment services, and the state held multiple training sessions for providers during that time.

5.2.4 Strategies to Advance SUPPORT Act Section 1003 Goals

Over the course of the post-planning period, and in part supported by the flexibility to use funds carried over from the planning grant, Delaware has continued to make progress on achieving the aims identified in its post-planning period demonstration application. This includes many of the activities identified in Exhibit 9. However, the state did indicate that some of its planned demonstration activities were contingent on the post-planning period federal reimbursement, which has taken longer to receive than anticipated due to the following administrative realities:

(1) SUD treatment and recovery services are not a single category on Form CMS-64 (where states report Medicaid expenditures), which necessitated the use of Medicaid claims data to identify SUD expenditures.

(2) Managed care expenditures claimed on Form CMS-64 are not tied to specific service utilization, and post-planning period states had to work with actuaries to develop a methodology to identify the component of the capitation payment associated with SUD services.

(3) Leadership turnover and general staffing capacity challenges.

(4) The need for additional technical assistance/guidance on the reporting and claiming processes.

5.3 Impact of Delaware's Legislation and Policies on Decisions for How to Expand SUD Treatment

Using the results of their planning grant rate study, Delaware was able to develop a robust case for securing funds for the rate increase in the state budget, as well as an increase in funds for general SUD services expansion.

5.4 Strengths and Limitations of Delaware's Approach

The Medicaid SUD prevalence study completed during the planning grant was a major facilitator for progressing the state's post-planning period activities. The study identified a need to address rates of neonatal abstinence syndrome and OUD among pregnant women and parenting people and was used to inform the State Opioid Response grant's special populations of focus and resultant programmatic initiatives. The statewide impact of the prevalence study data has served

to illustrate the potential of the Medicaid program as a collaborator with other state leaders as they discuss the design and implementation of effective treatment system transformation efforts. The data infrastructure the state created ensures that SUD remains a focus of state policy and programming. Other strengths include deeper engagement with outpatient medical practices to spur adoption of OBOT models, starting with technical assistance in the planning period and resulting in a statewide OBOT payment and delivery reform effort that is currently under development in the demonstration period.

The state considers its strategy of taking advantage of the relative flexibility of the SUPPORT Act grant design to be a strength of its approach. For example, after CMS permitted the use of planning grant carryover funds, the state used those funds to support the continuation of its planning grant work into the post-planning period while it moved forward on other programmatic efforts and explored new funding opportunities. These funding opportunities include the aforementioned ARP section 9817 home and community-based services (HCBS) spending plan, which Delaware used to fund their rate increase, as well as the inclusion of a contingency management program in their section 1115(a) SUD demonstration renewal, both of which the state hopes will have positive impacts on the wider SUD treatment system. The state described the limitations with implementing the rate changes arising from its relative unfamiliarity with the process. The effort required engaging new Division of Medicaid & Medical Assistance units and finalizing their administrative processes and rules for provider billing.

5.5 Delaware's Plans for Sustainability

The state's sustainability plan is centered on prioritizing activities that can eventually be incorporated into its Medicaid program without having to secure additional funding. Delaware generally relies on grant funds to design and implement programs that can then be supported through the state budget, such as managed care capitation payments or fee-for-service payments. Delaware's next steps for the demonstration include exploring the role of opioid treatment programs and their potential to provide low-barrier access to MOUD and building the state's preferred OBOT model.

6 ILLINOIS

The Illinois Department of Healthcare and Family Services has focused its efforts to transform the state's opioid treatment system during the demonstration on the following goals:

- Implement the activities identified through the planning grant through the qualitative provider needs assessment, and included in the Statewide Overdose Action Plan, and demonstrate, utilizing identified metrics, that the increased infrastructure has increased service capacity, increased the number of SUD providers, and reduced the number of overdoses in Illinois.
- Identify an alternative payment model to address provider-identified barriers to providing MOUD services and expand the number of providers willing to provide such services.
- Continue activities supporting an ongoing assessment of the behavioral health treatment needs of the state.
- Support the development of the state infrastructure with activities, including training and technical assistance to providers.

This chapter describes the activities Illinois has carried out under the demonstration, its progress toward achieving the demonstration's goals, the strengths and limitations of its approach, and the state's sustainability plan.

6.1 Illinois's Post-Planning Period Demonstration Activities

Illinois's post-planning period activities have centered on assessing SUD prevalence and behavioral health treatment needs, creating long-term and sustainable Medicaid provider networks that can deliver a continuum of care for SUD, and collecting data to predict trends in beneficiary and provider demographics and treatment (Exhibit 13).

Exhibit 13. Illinois's Post-Planning Period Activities

Activity	Approach
Assessment of SUD prevalence and behavioral health treatment needs	• Contributed to a University of Illinois at Chicago report on OUD/SUD prevalence and MOUD treatment needs in the state; gathered data, including MCO data, and developed analysis plans. • As part of the needs report in collaboration with University of Illinois at Chicago, interviewed 1,700 Medicaid providers and collected Medicaid beneficiary survey, email, and telephone responses.

Activity	Approach
Increase the number of SUD providers	• In collaboration with Healthcare and Family Services, as of September 2022, Medicaid reimbursement was allowed for additional medical services (physician services) delivered at an OTP. • Developed processes for internal medicine residents to provide MOUD in their primary care clinics and to manage patients taking buprenorphine for OUD in supervised resident clinics. • Began development of an inpatient Addiction Medicine team for the main Cook County system hospital. • Convened meetings with specialty pharmacies, a health system pharmacy director, and pharmacy team members to develop processes for providing long-acting buprenorphine in ambulatory settings. • Began initiation of MOUD in emergency departments, including assessment, referral to ongoing care, and connection to supportive services. • Initiated chart review project with medical students to assess the integration of MOUD patients into family medicine resident primary care clinics.
Training, education, and support for providers to deliver SUD treatment or recovery services	• Completed extended-release naltrexone guidelines and quick-start guides for dissemination to clinicians across Cook County Health. • Met with community partner leadership, staff, and hospital clinical staff around integrated service delivery and warm hand-offs for patients receiving MOUD in emergency department and inpatient settings. • Began planning to provide long-acting naltrexone at primary care clinics and developed and implemented nurse training in long-acting naltrexone administration at primary care clinics. • Developed harm and stigma reduction trainings, MOUD/SUD presentations, workshops and lectures for 550 attendees, experiential training in MOUD/SUD, including shadowing, reverse shadowing, and observation, for 85 trainees, and technical assistance in MOUD/SUD, including remote consultation, coaching, and mentoring, for 69 mentees. • Developed continued education related to SUD for care coordinators of CountyCare Medicaid health plan. • Supported the creation of the Illinois Helpline, a subject matter expert–curated OUD telehealth/electronic resource to support new MOUD providers with one-on-one mentorship, training, and technical assistance. • Supported the creation of a new SUPPORT Act program buildout for a health insurer's website where providers can register for trainings, request technical assistance with prescribing MOUD, and receive updates on the SUPPORT Act and other regional SUD/OUD activities.
Consultation with relevant stakeholders	• Joined Illinois Harm Reduction & Recovery Coalition monthly meetings to discuss mechanisms to identify beneficiary and provider experiences. • Attended nonprofit health system Southern Illinois Healthcare's pain management committee meetings to conduct outreach and update providers and support staff on Illinois's SUPPORT Act 1003 demonstration activities. • Met with successful community partners to develop background knowledge about providing long-acting buprenorphine in primary care settings.

Activity	Approach
Coordination with other federal or state initiatives	• Collaborated with sister agency, Substance Use Prevent & Recovery, to permit licensed opioid treatment programs to submit claims for reimbursement for physician services tied to the initiation of MOUD.
Data collection and reporting enhancement	• Worked with the University of Illinois at Chicago/NORC to conduct MOUD provider interviews, an MOUD provider survey, and a Medicaid MCO beneficiary survey, and produce a report on findings.

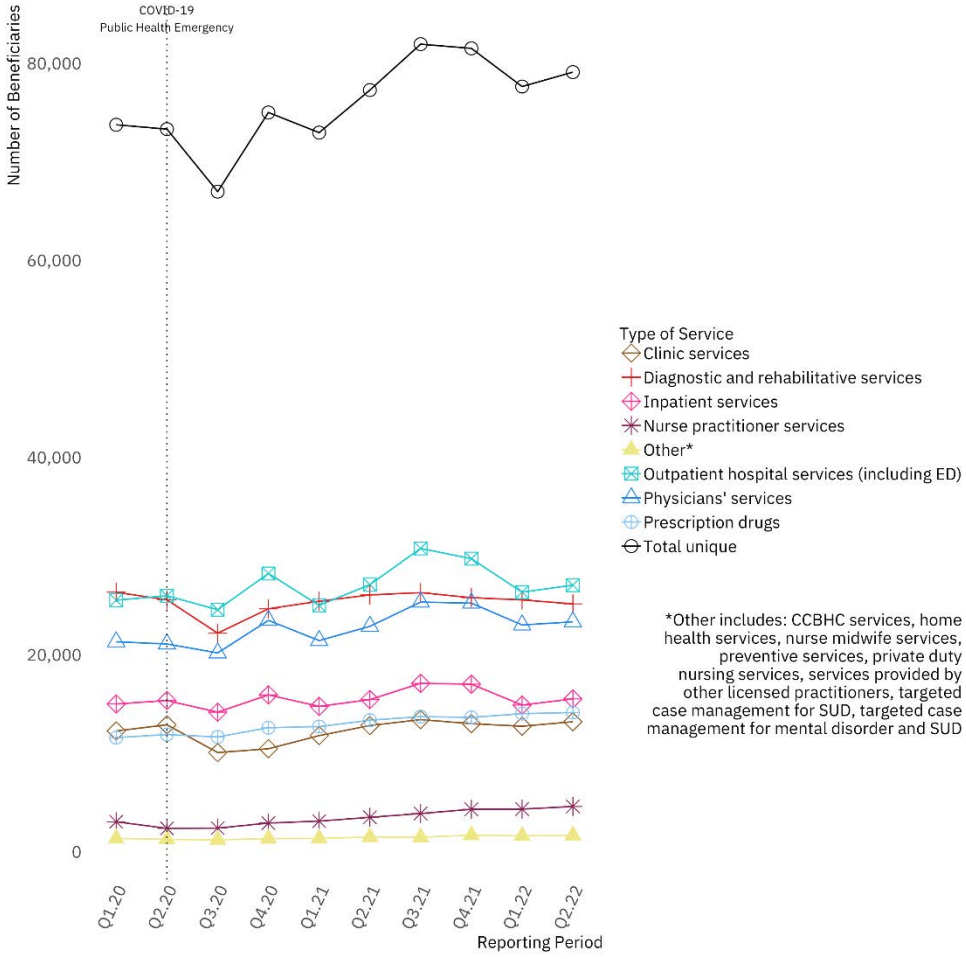
The state has prioritized their SUPPORT Act demonstration resources to develop the Illinois Helpline for Opioids & Other Substances for providers and maintain the associated calendar, library, toolkit, and provider network features. The Helpline connects patients with providers and offers technical assistance services with trained specialists to answer questions, provide support, and connect patients to services in Illinois. For example, a subcontractor Technical Assistance Associate working for the Helpline completed a comprehensive update of the office-based buprenorphine provider list in September 2022, doubling the number of identified locations in Illinois that currently provide buprenorphine for OUD and eliminating more than 400 inaccurate listings.

6.2 Progress on Goals Identified in Application

6.2.1 Number of Medicaid Beneficiaries Who Received SUD Services

As shown in Exhibit 14, the total number of unique Medicaid beneficiaries receiving SUD services in Illinois across the reporting period increased over time. The number of Medicaid beneficiaries receiving specific service types generally increased or remained stable, except for a decrease in services at the start of the COVID-19 public health emergency. The services that increased include physicians' services, clinic services, outpatient hospital services (including emergency department services), nurse practitioner services, and prescription drugs.

Exhibit 14. Trends in the Number of Medicaid Beneficiaries Who Received SUD Services in Illinois by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

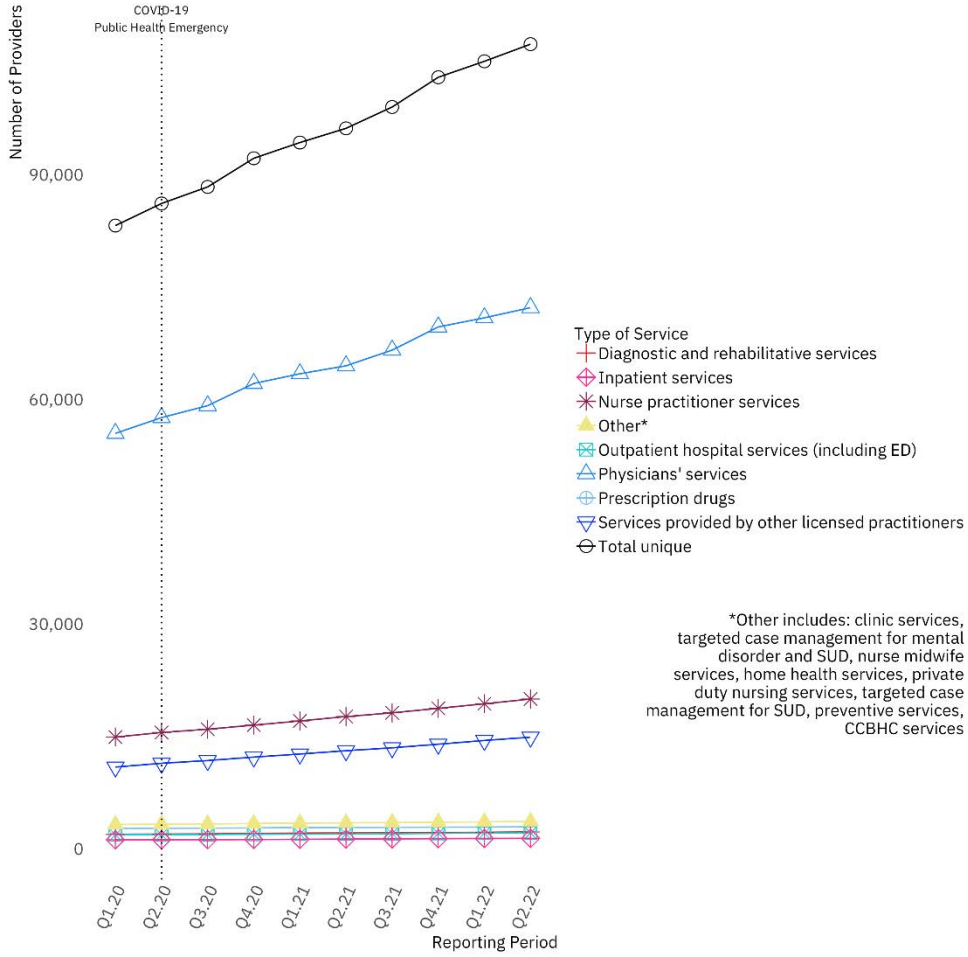


Data for figure in Appendix Table B9.

6.2.2 Number of Medicaid Providers Qualified to Deliver SUD Services

Exhibit 15 shows that the total number of unique Medicaid SUD providers qualified to deliver services in Illinois increased across the reporting period. By category, the number of qualified Medicaid providers increased over time for physicians' services, nurse practitioner services, and services provided by other licensed practitioners. There were also increases in the number of Medicaid providers qualified to deliver diagnostic and rehabilitative services, outpatient hospital services (including emergency department services), inpatient services, prescription drugs, targeted case management for individuals with mental disorder and SUD, nurse midwife services, clinic services, home health services, and private duty nursing services that are not visible in the graphic due to scale.

Exhibit 15. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services in Illinois by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

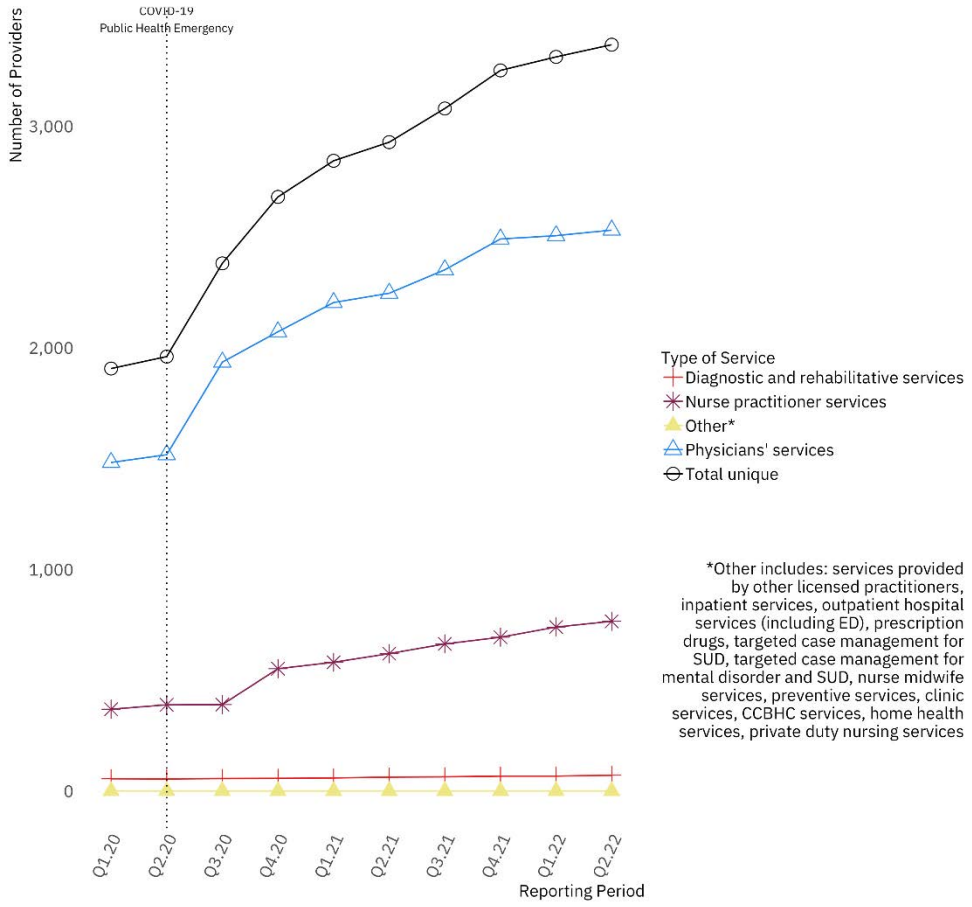


Data for figure in Appendix Table B10.

6.2.3 Number of Medicaid SUD Providers Who Met MOUD Provision Standards

As shown in Exhibit 16, the total number of unique Medicaid SUD service providers in Illinois who met the standards to provide MOUD (buprenorphine or methadone) increased over time. The number of Medicaid SUD service providers meeting MOUD provision standards increased for every service category for which providers of this type were reported, including physicians' services, nurse practitioner services, and diagnostic and rehabilitative services.

Exhibit 16. Trends in the Number of Medicaid SUD Providers Who Met MOUD Provision Standards in Illinois by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B11.

6.2.4 Strategies to Advance SUPPORT Act Section 1003 Goals

Illinois has engaged in activities to reinforce its infrastructure and increase utilization of MOUD services. The state also plans to continue collaborating with vendors and stakeholders to ensure the structures put in place during the planning grant, such as the Helpline and various training and support resources for providers, are sustainable.

6.3 Strengths and Limitations of Illinois's Approach

A significant strength of the Illinois approach has been its collaboration. Illinois has been conducting regular meetings with community partner leadership to discuss integrated service delivery and warm hand offs for patients receiving MOUD in emergency department and inpatient settings and partnering with physicians and hospitals. These collaborations have led to

the successful development and implementation of protocols and processes to empower providers in delivering MOUD services in a sustainable way.

Illinois encountered several limitations during the post-planning demonstration period, including problems finding funding, contractual delays, and general issues concerning the COVID-related public health emergency. The Department of Healthcare and Family Services previously faced a sizeable limitation in reimbursement for providers initiating MOUD services prior to its collaboration with Illinois's Division of Substance Use Prevention & Recovery. Opioid treatment program providers with staff qualified to prescribe buprenorphine may not have had a mechanism for receiving reimbursement for MOUD services outside of existing payment for methadone. This collaboration resulted in additional medical services (physician services) delivered at an OTP becoming eligible for Medicaid reimbursement as of September 2022, including services for comorbidities associated with opioid use disorders such as wound care.

Illinois reported a lack of understanding of how services for individuals with OUD are provided in their managed care program. Illinois indicated that limited information was contained in its planning grant needs assessment related to the mechanisms its MCOs had in place to expand treatment of patients with OUD. The state attributed these gaps in understanding their managed care plans' MOUD services to a delay in analysis of the managed care data, due to the time required for approval of carryover funding and processing of updated data sharing agreements.

Illinois completed its planning grant activities, although the COVID-19 public health emergency impacted the state's ability to complete training and technical assistance in person and delayed the implementation of the statewide beneficiary survey.

Illinois plans to use other state funds, including State Opioid Response and state budget dollars, for continued funding of the state Helpline website for providers and ongoing maintenance of the calendar, library, toolkits, and provider networks. However, sustaining the cadre of experts and keeping the Helpline website updated with provider information and training material may be challenging.

6.4 Impact of Illinois's Legislation and Policies on Decisions for How to Expand SUD Treatment

Two areas of policy that have impacted Illinois's SUD provider capacity expansion decision-making include recent legislation requiring Medicaid reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT)[43] in a primary care setting and for the initiation of MOUD at the time of an emergency room visit. Illinois hopes changes to reimbursement policies influence the number of providers delivering these services.

6.5 Illinois's Plans for Sustainability

Illinois has sustainability plans primarily focused on developing and maintaining the Illinois Helpline. For example, Illinois plans on curating a pool of state subject matter experts to provide mentoring, training, and technical assistance on MOUD. The state currently has six physicians with expertise in MOUD available as mentors for clinicians using the Illinois Helpline to sustain the knowledge base built during the planning grant. Ultimately, the state will use State Opioid Response grant funds and additional sources of state budget funding to sustain the programs in the long term.

Illinois also plans to collaborate with its Division of Substance Use Prevention & Recovery to develop more initiatives and expand the provision of services related to MOUD. This coordination will allow the state to focus on holistic approaches to behavioral health care.

7 NEVADA

Nevada's Division of Health Care Financing Policy has focused its efforts to transform the state's opioid treatment system during the demonstration on the following goals:

- Strengthen and sustain Nevada's health care continuum infrastructure to expand provider capacity for SUD treatment and recovery services.
- Increase Nevadans' access to and delivery of SUD treatment and recovery services.
- 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.

This chapter describes the activities that Nevada has carried out under the demonstration, its progress toward achieving the demonstration's goals, the strengths and limitations of its approach, and the state's sustainability plan.

7.1 Nevada's Post-Planning Period Demonstration Activities

Nevada is engaged in various activities aimed at the ongoing assessment of SUD prevalence and treatment needs and creating long-term, sustainable provider networks capable of offering a continuum of care for SUD (Exhibit 17).

Exhibit 17. Nevada's Post-Planning Period Activities

Activity	Approach
Assessment of SUD prevalence and behavioral health treatment needs	• Monitored SBIRT utilization within the fee-for-service and managed care populations. • Met with MCOs monthly to review SBIRT utilization findings and discuss recommendations for increasing utilization. • Performed annual review of prior authorization requirements/utilization. • In collaboration with the Nevada Board of Pharmacy, working to identify the challenges for pharmacies in obtaining buprenorphine for beneficiaries and determining whether these challenges disproportionately impact pregnant people with SUD.
Increase the number of SUD providers	• Presented SUD provider survey results assessing administrative burden and limitations perceived by providers in treating individuals with SUD to CMS. • Received approval to use ARP funding to develop a new Medicaid provider type and individual specialties for SUD treatment providers. • Working to expand the peer recovery and support specialist provider type and individual enrollment. • Conducted a provider survey on MOUD services, educational needs, assessment of social determinants of health, use of SBIRT, electronic health records, and telehealth.

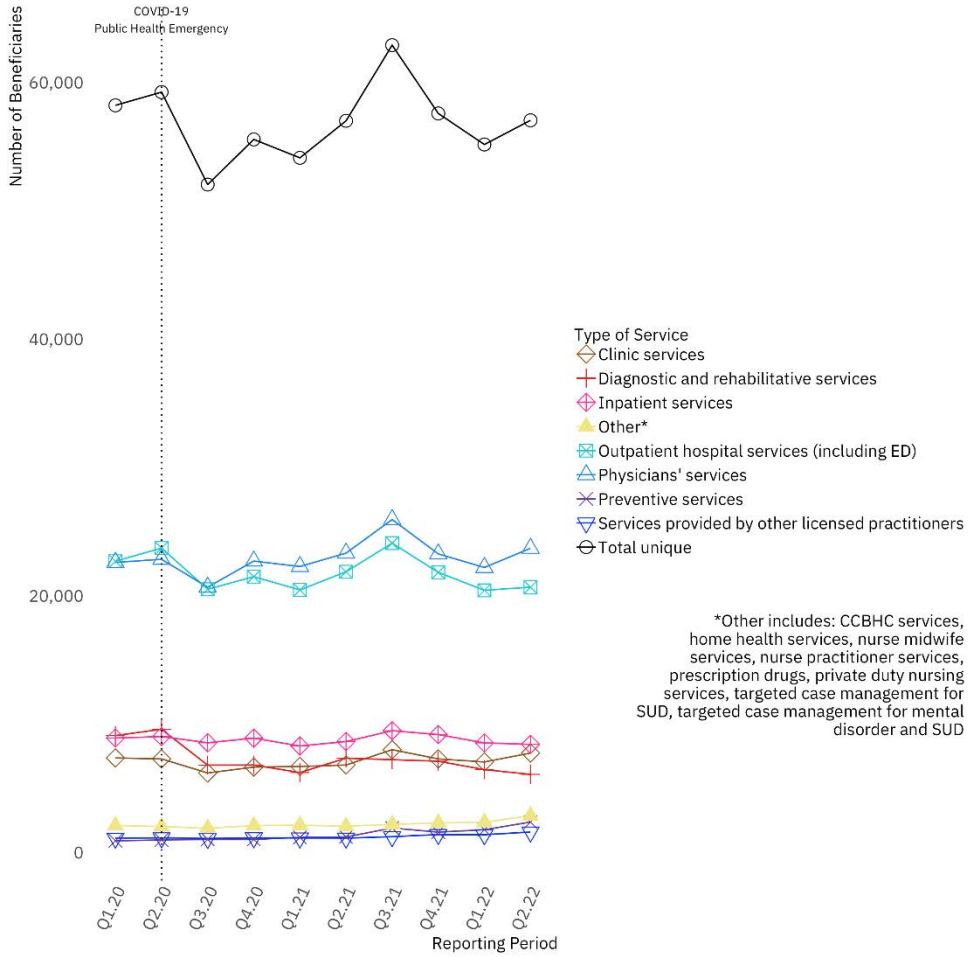
Activity	Approach
Training, education, and support for providers to deliver SUD treatment or recovery services	• Developed and improved MOUD/SUD policies and billing guides based on recent substance abuse bulletins and best practices. • Updated reference guides, including best practice care standards, guidelines, and protocols for medical professionals caring for pregnant women with SUD and infants with neonatal abstinence syndrome. • Developed a recurring six-part SBIRT for Health Professionals educational series. • Identified training needs based on a needs assessment completed by Federally Qualified Health Centers. • Provided technical assistance and SUD provider capacity building through quarterly Promoting Innovation in State Maternal Child Health Policy Making meetings. • Updated policies in harm reduction principles for individuals with SUD/OUD.
Consultation with relevant stakeholders	• Conducted stakeholder engagement initiatives to understand limitations to SUD provider capacity expansion and used findings to update the Nevada SUD and OUD Treatment and Recovery Services Provider Capacity Expansion Strategic Plan. • Attended the Northern Nevada Harm Reduction Summit presented by Overdose Data to Action. • Attended meetings of the Perinatal Health Initiative, where discussion focuses on SBIRT use by OB/GYNs and nurse midwives, as well as strategies for increased use of the screening.
Coordination with other federal or state initiatives	• Awarded a 1-year planning grant to support community-based mobile crisis intervention services using available ARP funding. • Prioritized the completion of its section 1115(a) SUD demonstration – approved and effective October 18, 2023 – which included changes to the program requirements developed as part of the SUPPORT Act planning grant. • Participating in initiatives occurring through the Division of Public and Behavioral Health, including decision-making around provision of MOUD services in the emergency room.
Data collection and reporting enhancement	• Used the Dimensional Data Model to provide a faster, more accurate, and more consistent approach for Medicaid data reporting by enabling direct querying of fee-for-service and managed care encounter claims via the same database. • Published the Nevada SUD Data Book.

7.2 Progress on Goals Identified in Application

7.2.1 Number of Medicaid Beneficiaries Who Received SUD Services

As shown in Exhibit 18, the total number of unique Medicaid beneficiaries receiving SUD services in Nevada over the reporting period decreased. There were increases for physicians' services, as well as increases for preventive services, clinic services, and services provided by other licensed practitioners that are not visible in the graphic due to scale. Services decreased for diagnostic and rehabilitative services, outpatient hospital services (including emergency department services), and inpatient services.

Exhibit 18. Trends in the Number of Medicaid Beneficiaries Who Received SUD Services in Nevada by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

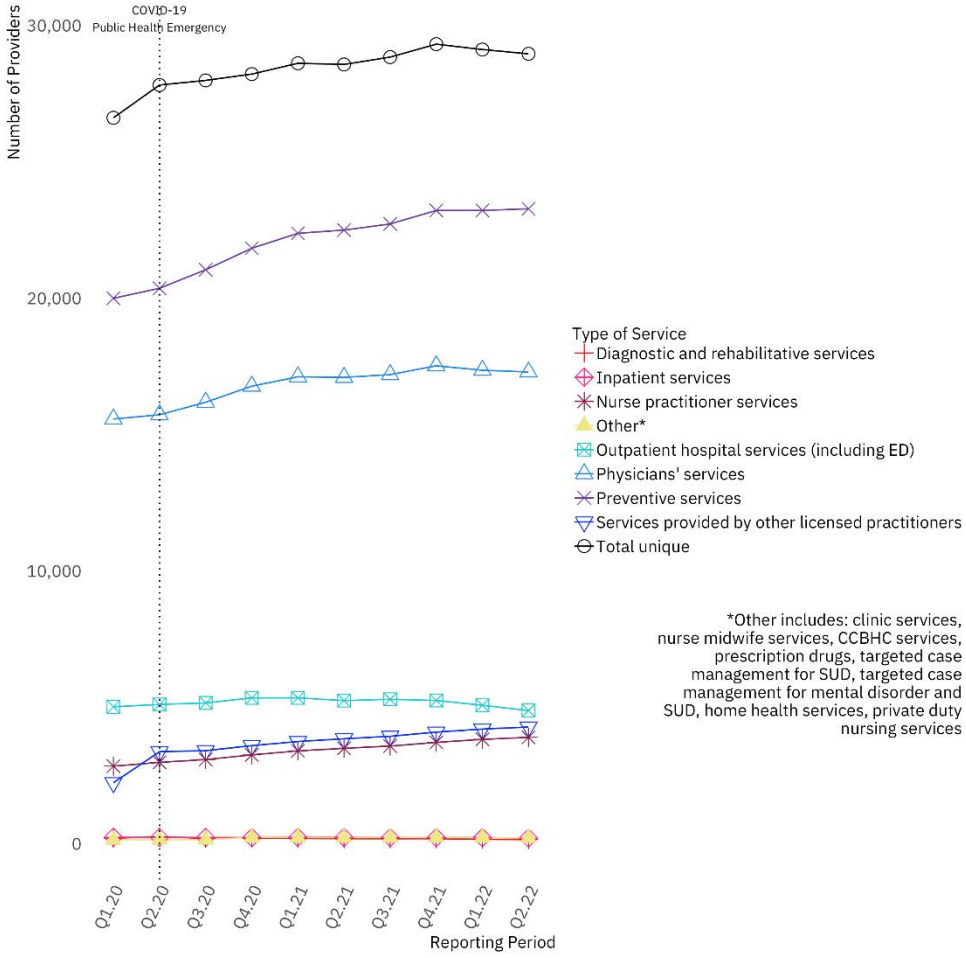


Data for figure in Appendix Table B13.

7.2.2 Number of Medicaid Providers Qualified to Deliver SUD Services

Exhibit 19 shows that the total number of unique Medicaid SUD providers qualified to deliver services in Nevada increased over time. The service categories that increased included preventive services, physicians' services, services provided by other licensed practitioners, and nurse practitioner services. Decreases in Medicaid SUD providers reported by service category occurred for outpatient hospital services (including emergency department services). There were also decreases in inpatient services and diagnostic and rehabilitative services that are not visible in the graphic due to scale.

Exhibit 19. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services in Nevada by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



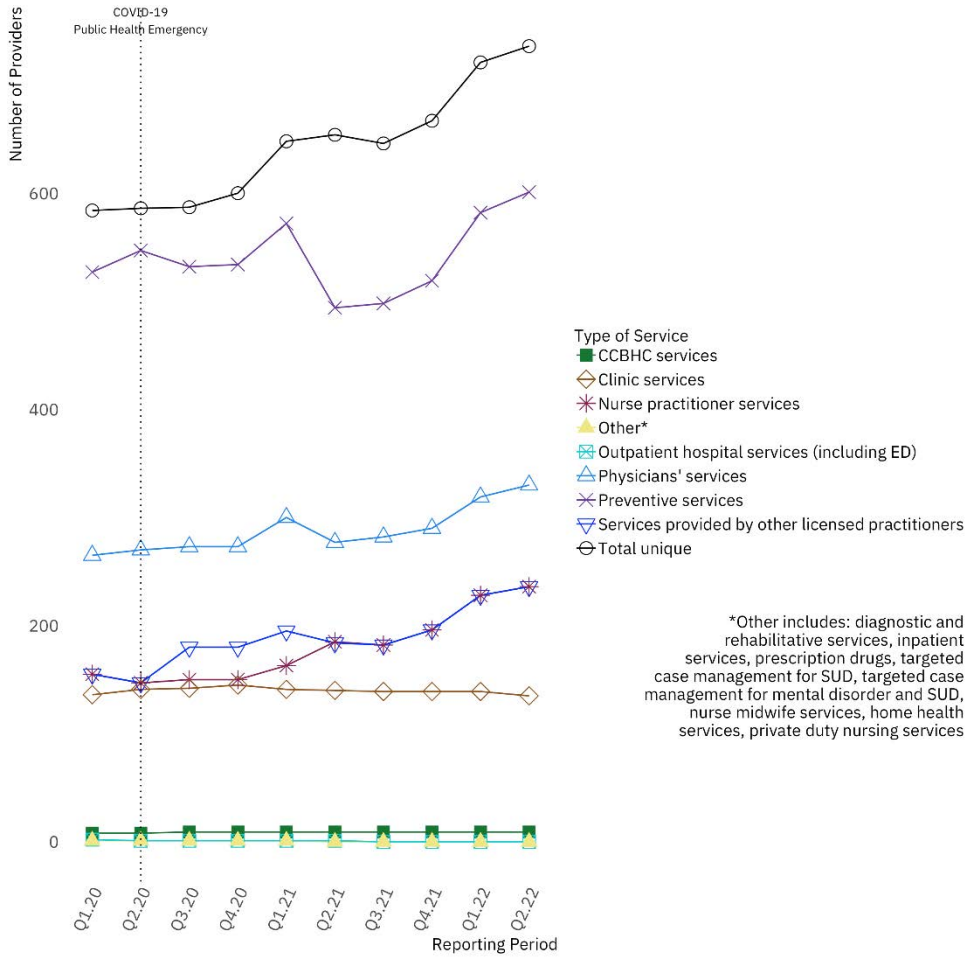
Data for figure in Appendix Table B14.

Note: Out-of-state providers could practice in the state due to COVID-related flexibilities in where providers could practice.

7.2.3 Number of Medicaid SUD Providers Who Met MOUD Provision Standards

As shown in Exhibit 20, the total number of unique Medicaid SUD providers in Nevada who met the standards to provide MOUD (buprenorphine or methadone) increased over the reporting period. There were increases for almost every service category for which providers of this type were reported, including preventive services, physicians' services, services provided by other licensed practitioners, and nurse practitioner services. There was also an increase in Certified Community Behavioral Health Clinics **(**CCBHC)[44] services that is not visible in the graphic due to scale. The number of MOUD providers decreased slightly for clinic services.

Exhibit 20. Trends in the Number of Medicaid SUD Providers Who Met MOUD Provision Standards in Nevada by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B15.

7.2.4 Strategies to Advance SUPPORT Act Section 1003 Goals

Nevada is continuing to make progress on the aims outlined in the state's demonstration application. A key component of Nevada's plan to strengthen and sustain its SUD continuum of care infrastructure and increase SUD provider capacity is approval of its section 1115(a) SUD demonstration. Thus, much of the state's efforts have focused on submitting its section 1115(a) SUD demonstration application and responding to CMS's feedback on the application. Nevada received application approval on December 29, 2022, with Implementation Plan approval received on May 2, 2023. Nevada continues to work with CMS on the required deliverables, such as the Monitoring Protocol and the Evaluation Design. Medicaid Management Information System (MMIS) implementation updates have been developed to accommodate billing for the Institution for Mental Disease population exclusion.

Additionally, the state has been focused on plans to implement a new Medicaid provider type and specialties by working with the state's Substance Abuse Prevention and Treatment Agency (SAPTA) and the Center for the Application of Substance Abuse Technologies in the School of Public Health at the University of Nevada, Reno, that has a primary mission of improving prevention and treatment services for individuals with addictive behaviors by helping states, organizations, students, and the existing workforce apply research-based practices. These initiatives are intended to facilitate Nevada enrolling its alcohol and drug counselors as individual providers in Medicaid.

Finally, Nevada has published its SUD data book online. The state acknowledged that one of its key lessons learned from participating in the SUPPORT Act demonstration project is how critical data are. Nevada also noted how important it is to capture what providers are qualified to deliver SUD treatment and recovery services. The state plans to continue work on the SUD data book in the post-planning period, with focus on beneficiary accessibility.

7.3 Strengths and Limitations of Nevada's Approach

Nevada intends to incorporate the Patient-Centered Opioid Addiction Treatment (P-COAT) alternative payment model into its Medicaid SUD treatment system. However, there have been delays in implementing P-COAT primarily due to the need for dedicating resources to the section 1115(a) SUD demonstration application process. The state is also focused on doing MMIS

updates for the new provider type and wants to finish those updates before adding more complexity to the SUD treatment billing procedures.

Nevada experienced unexpected transitions in its SUPPORT Act team and lost some key expertise and experience around grants and contracts that slowed the state's progress in implementing the SUPPORT Act demonstration activities. This necessitated creating partnerships with other areas of the state Medicaid agency (specifically the fiscal unit) to effectively implement the post-planning period. The SUPPORT Act team credits the coordination requirements of the demonstration in bringing together the statewide efforts to increase SUD treatment provider capacity.

7.4 Impact of Nevada's Legislation and Policies on Decisions for How to Expand SUD Treatment

Recent legislation that impacted Nevada's decisions on how to expand SUD provider capacity for treatment and recovery services include Senate bills supporting their section 1115(a) SUD demonstration and requiring the state to implement reimbursement for crisis stabilization centers, which are required to treat individuals with SUD who are experiencing a crisis. Additionally, the state developed a certification requirement for peer supports that became effective in August 2023. There is also support for developing a center for behavioral health workforce through a bill draft request in the 2023 legislative session.

7.5 Nevada's Plans for Sustainability

The focus of Nevada's sustainability plan is to obtain approval of its section 1115(a) SUD demonstration, which will remain a priority for the next few years as implementation and monitoring plans are drafted. In parallel with the development of the section 1115(a) SUD demonstration implementation plans, Nevada is also prioritizing the inclusion of well-defined SUD treatment services in their Medicaid state plan to ensure future state policies support providers as they implement SUD treatment services. The state will remain diligent at monitoring evidence-based practices and policies relating to substance use treatment. Nevada also intends to periodically evaluate its short-term, mid-term, and long-term goals.

8 WEST VIRGINIA

The West Virginia Bureau for Medical Services has focused its efforts to transform the state's opioid treatment system during the demonstration on the following goals:

- Increase the number of people with OUD receiving MOUD.
- Increase the number of individuals receiving stimulant use disorder treatment.
- 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, and at-risk and transition-aged youth).
- Increase the capacity to serve rural residents, as more than 50 percent of West Virginia's population resides in rural areas.

To achieve these goals, West Virginia's demonstration application identified the following strategies:

- Develop a SUD Center of Excellence–type program to address OUD and stimulant use disorder.
- Provide training, technical assistance, and management of performance data for demonstration project activities.
- 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 CCBHCs, and work with the West Virginia Department of Corrections to reduce the number of overdoses.

This chapter describes the activities that West Virginia has carried out under the demonstration, its progress toward achieving the demonstration's goals, the strengths and limitations of its approach, and the state's sustainability plan.

8.1 West Virginia's Post-Planning Period Demonstration Activities

West Virginia differs from the other post-planning states in that it has focused on one major demonstration goal during the post-planning period: the creation of the SUD Center of

Excellence. The state described the first portion of the post-planning period, which began in September 2021, as a "build year" during which they coordinated the development of a SUD Center of Excellence with another state team tasked with the simultaneous creation of CCBHCs. The planning grant needs assessment revealed that the state has many office-based MOUD providers working in group practices, with caseloads of up to 200 individuals receiving MOUD per provider. These group practices lack the capacity to provide the care coordination necessary to adequately support their caseloads. Through the Center of Excellence program in West Virginia, case management and care coordination will be provided to ensure that individuals seeking treatment can also be connected to resources for housing, food, and other recovery support services if needed.

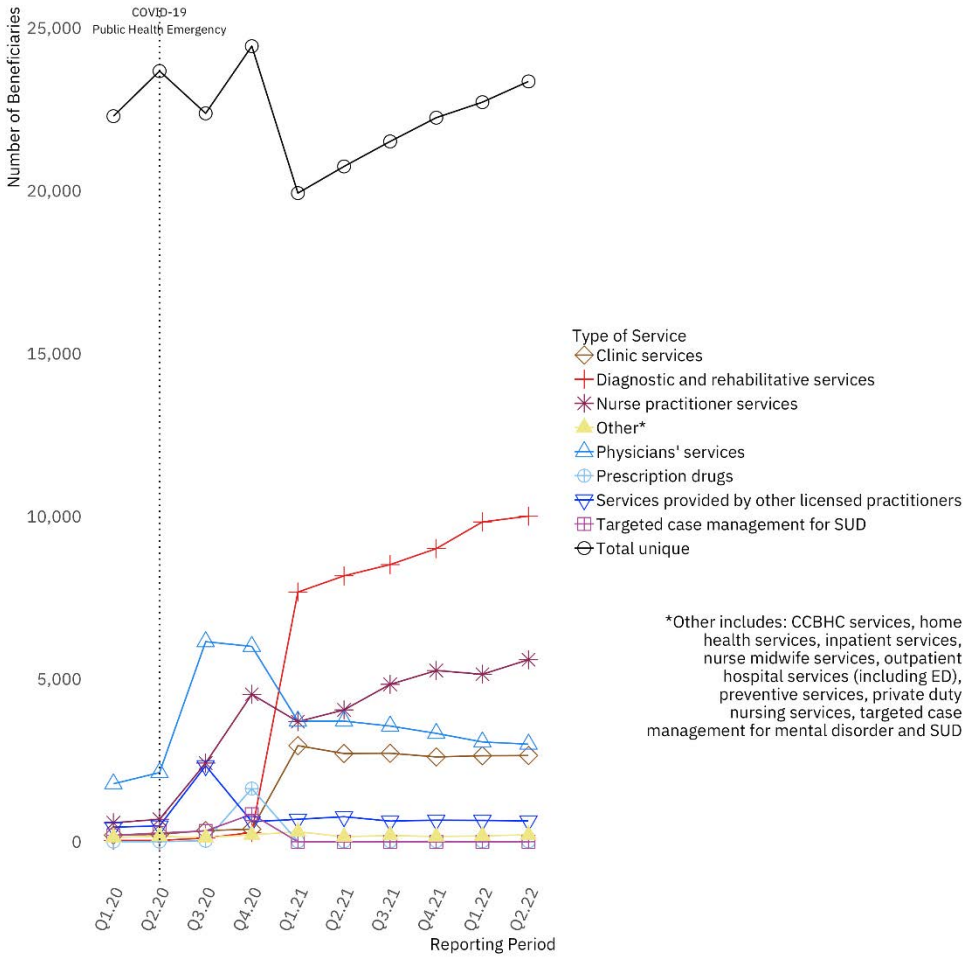
During this building stage, the state also sought Medicaid provider feedback and engaged university partners to review existing Center of Excellence models in other states and provide insight into program aspects that might be relevant to the West Virginia treatment landscape. The state used this feedback to seek additional stakeholder engagement with model experts from Pennsylvania and Rhode Island with the intent of creating a SPA that will be tailored to the needs of West Virginia.

8.2 Progress on Goals Identified in Application

8.2.1 Number of Medicaid Beneficiaries Who Received SUD Services

As shown in Exhibit 21, the total number of unique Medicaid beneficiaries receiving SUD services in West Virginia increased across the reporting period. Across service categories, increases were reported for physicians' services, diagnostic and rehabilitative services, clinic services, and nurse practitioner services. There were also increases in services provided by other licensed practitioners, prescription drugs, and targeted case management for individuals with SUD that are not visible in the graphic due to scale.

Exhibit 21. Trends in the Number of Medicaid Beneficiaries Who Received SUD Services in West Virginia by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



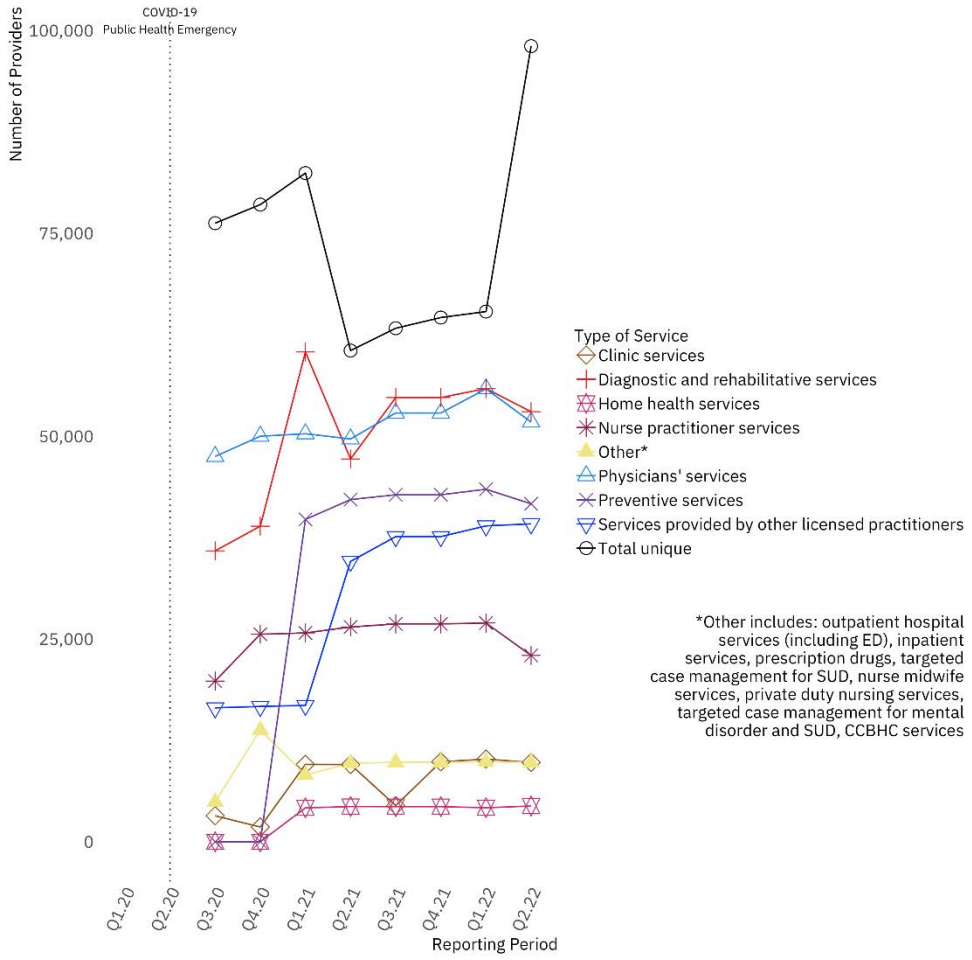
Data for figure in Appendix Table B17.

Note: Challenges in identifying service types by CMS-64 categories account for why West Virginia's unique counts of beneficiaries are higher than the sum of beneficiaries across service types. West Virginia is reviewing the data for number of beneficiaries receiving SUD-related diagnostic and rehabilitation services to explain the substantial increase in this service type in Q3 2020.

8.2.2 Number of Medicaid Providers Qualified to Deliver SUD Services

Exhibit 22 shows that the total number of unique Medicaid SUD providers qualified to deliver services in West Virginia increased over time. There were increases in the number of qualified Medicaid providers for most categories, including physicians' services, diagnostic and rehabilitative services, preventive services, services provided by other licensed practitioners, nurse practitioner services, clinic services, and home health services.

Exhibit 22. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services in West Virginia by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



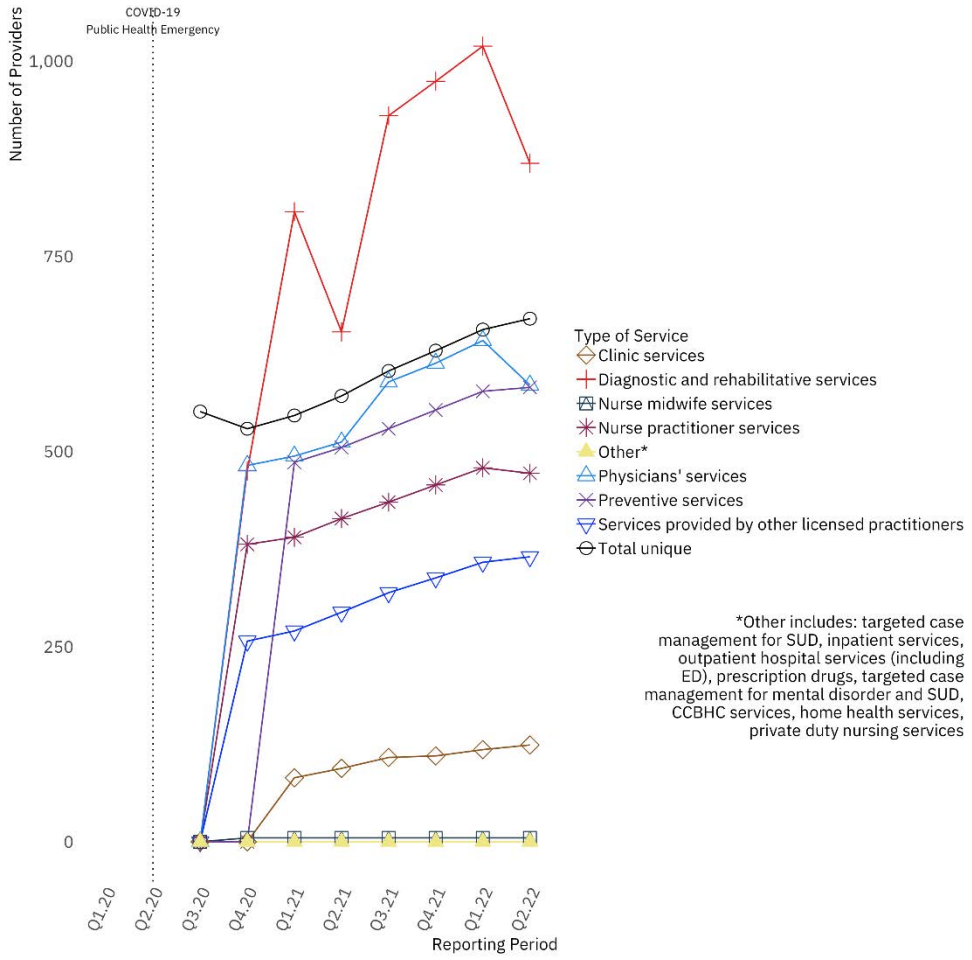
Data for figure in Appendix Table B18.

Note: Most Medicaid providers deliver SUD services, and out-of-state providers could practice in the state due to COVID-related flexibilities in where providers could practice. First two quarters of data were not reported because West Virginia reported challenges in identifying providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

8.2.3 Number of Medicaid SUD Providers Who Met MOUD Provision Standards

As shown in Exhibit 23, the number of unique Medicaid SUD service providers in West Virginia who met the standards to provide MOUD (buprenorphine or methadone) increased over time. Increases occurred for every service category for which providers of this type were reported, including diagnostic and rehabilitative services, physicians' services, preventive services, nurse practitioner services, services provided by other licensed practitioners, and clinic services. Nurse midwife services remained constant across the reporting period although not visible in the graphic due to scale.

Exhibit 23. Trends in the Number of Medicaid SUD Providers Who Met MOUD Provision Standards in West Virginia by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B19.

Note: First two quarters of data were not reported because West Virginia reported challenges in identifying providers who were qualified to provide SUD services and met MOUD provision standards rather than providers that delivered a claim for those quarters.

8.2.4 Strategies to Advance SUPPORT Act Section 1003 Goals

West Virginia initiated development of a SUD Center of Excellence, which provides groundwork for relevant stakeholders' acceptance of the upcoming treatment system change. The state considered the SUD provider outreach and education efforts related to the Center of Excellence to be particularly impactful. For example, in West Virginia's discussions with the Medicaid SUD provider community, the state described the potential benefits that care coordination could have on retaining individuals in treatment, addressing social determinants of health (SDOH) that could be affecting their length of stay in treatment, and potentially lowering

the drug overdose rate by providing more support for whole-person care. As an education tool, the state developed use cases for care coordination to illustrate its impact. For example, an individual receiving treatment may be homeless. In this use case, a care coordinator could help the individual fill out a Housing and Urban Development housing packet and secure housing, which could improve the person's likelihood of remaining in treatment. These efforts were often discussed with attendees of the quarterly meetings of the Governor's Advisory Council on Substance Abuse.

The West Virginia state Medicaid agency has used the demonstration to align its efforts with other state agencies and gain access to wider funding streams across the state. One member of the SUPPORT Act team is an analyst embedded in a sister agency, which allows for real-time access to SUD trend data outside the Medicaid agency's usual purview. The SUPPORT Act team also met monthly with the state's Office of Drug Control Policy, where stakeholders including court representatives, universities, providers, and MCOs discussed the progress made on Center of Excellence development and other SUD-focused activities in the state. These conversations facilitated the necessary differentiation between the Center of Excellence and CCBHC programs that are currently underway. The SUPPORT Act team also reported that its close working relationship with sister agencies, the Bureau for Social Services, and the Bureau for Behavioral Health, helped to widely advertise its Center of Excellence initiative.

West Virginia has also partnered with Marshall University. The partnership will eventually result in collaboration between the Center of Excellence and Marshall University's mobile crisis intervention services funded by the ARP. For example, if an individual receives treatment at a Center of Excellence and the care coordinator learns that the individual is distressed, the Center of Excellence will be able to connect the mobile crisis unit to the individual immediately. In general, the state's ultimate goal is continuity of care across all programs.

8.3 Impact of West Virginia's Legislation and Policies on Decisions for How to Expand SUD Treatment

In West Virginia, the policy landscape is not welcoming toward initiatives that would promote increased use of methadone as an MOUD. As such, the SUPPORT Act team determined that their efforts would be better served on the provision of other MOUDs in the state. The state

legislature passed a law compelling the creation of CCBHCs in the state. The SUPPORT Act team is considering the merit of pursuing a similar route for the creation of their Center of Excellence to bolster the importance of the initiative.

8.4 Strengths and Limitations of West Virginia's Approach

West Virginia's focus on identifying provider perspectives and needs is a strength of its demonstration strategy because the state has garnered an increased level of provider buy-in for the SUD Center of Excellence. Providers have firsthand experience with the need for care management and coordination in their own practices and are on board with implementing changes to their business operations, such as employing case managers with specific degrees or adhering to certain documentation requirements, to meet the application requirements and secure access to those services.

West Virginia is still experiencing impacts from the COVID-19 public health emergency. The effects of the public health emergency on the demonstration were compounded due to the small size of the state's Bureau for Medical Services and staff bandwidth issues. The SUPPORT Act team was forced to pause some of its grant activities during the planning grant to ensure the state response to the COVID-19 public health emergency was fully operational. However, the time spent focused elsewhere allowed the state to determine that a large portion of its patient population could be better served by the Center of Excellence model instead of the CCBHC model already under development; thus, the SUPPORT Act team transitioned its focus toward that effort. Pausing the work also allowed the state to examine its goals and plans, identify any discrepancies or missing elements, and return to the demonstration period with a renewed sense of confidence in its direction.

8.5 West Virginia's Plans for Sustainability

West Virginia began operationalizing a SUD Center of Excellence in 2023. They are working on defining the minimum requirements to be a SUD Center of Excellence, codifying the finalized reimbursement mechanism, and describing minimum service requirements that should be included in the final model.

9 TRENDS IN THE SUPPORT ACT SECTION 1003 DEMONSTRATION

9.1 Activities Carried Out across the Five Post-Planning States

All states participating in the post-planning period are continuing to conduct activities related to the assessment of SUD treatment needs. Many states are using data dashboards or expanding the data infrastructure developed as part of their planning grant. Post-planning period states are also continuing to conduct direct outreach to their providers with drop-in meetings, interviews, surveys, and focus groups to assess provider perspectives on capacity needs or to obtain feedback on planned efforts to expand SUD treatment or recovery services provider capacity. Two states are looking at adding new data metrics, such as opioid overdose spikes or data related to SDOH.

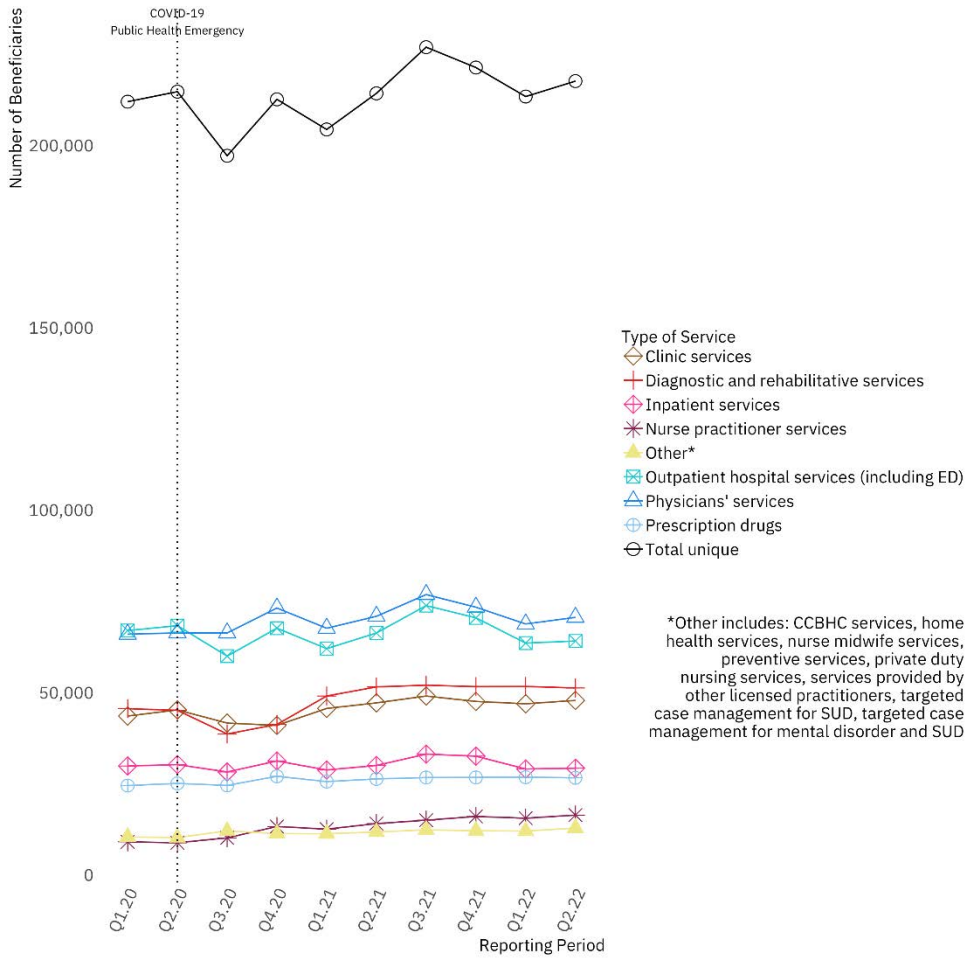
Post-planning period states are also engaging in technical assistance, training, and provider education. Topics covered in these training and technical assistance activities include best practices for providing MOUD, SBIRT, OUD treatment for pregnant and parenting people, and provision of MOUD in the emergency department or by primary care providers.

Collaboration with other entities and stakeholders is another area of focus among all the post-planning period states. The states are collaborating with sister agencies and SUD program leaders around other federally funded initiatives, including section 1115(a) SUD demonstration, State Opioid Response grants from SAMHSA, HCBS activities funded by ARP, and CMS or SAMHSA funded CCBHCs. The state Medicaid agencies are also working across initiatives, such as state opioid task forces and prenatal health initiatives and coordinating with organizations addressing housing and other SDOH.

9.2 Overall Progress on State-Identified Goals

As shown in Exhibit 24, the total number of unique beneficiaries receiving SUD services across the post-planning states increased across the reporting period. There were increases in physician services, diagnostic and rehabilitative services, clinic services, nurse practitioner services, and prescription drugs across the reporting period. The number of beneficiaries receiving SUD services decreased for outpatient hospital services (including emergency department services) and inpatient services. Rates remained relatively consistent for all other service types across the reporting period.

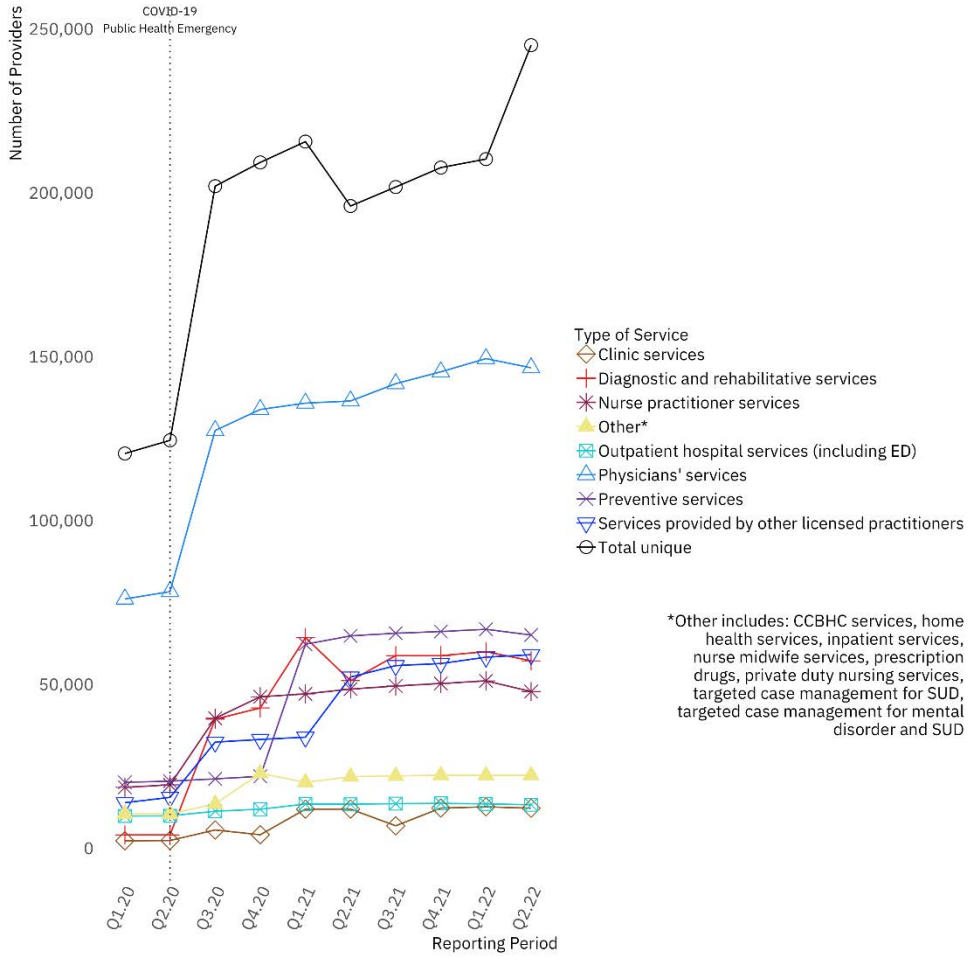
Exhibit 24. Trends in the Number of Beneficiaries Who Received SUD Services across All States Participating in the Post-Planning Period by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B21.

As shown in Exhibit 25, the total number of unique Medicaid providers qualified to deliver SUD services across all states participating in the post-planning period increased across the reporting period. The number of qualified Medicaid providers increased across all service types shown below.

Exhibit 25. Trends in the Number of Medicaid Providers Qualified to Deliver SUD Services Across All States Participating in the Post-Planning Period by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

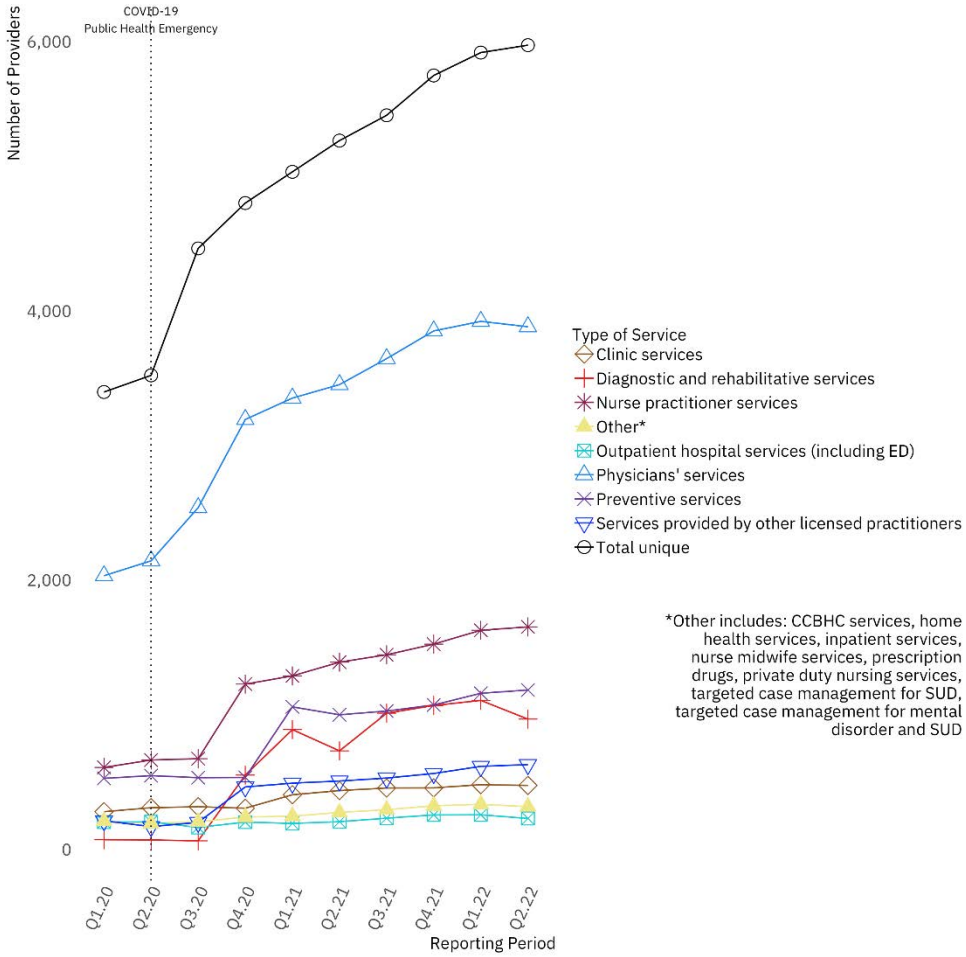


Data for figure in Appendix Table B22.

Note: First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

As shown in Exhibit 26, the total number of unique SUD service providers who met the standards to provide MOUD (buprenorphine or methadone) across all the post-planning period states increased. Physicians' services, diagnostic and rehabilitative services, preventive services, clinic services, services provided by other licensed practitioners, and nurse practitioner services increased across the reporting period.

Exhibit 26. Trends in the Number of SUD Providers Who Met MOUD Provision Standards across All States Participating in the Post-Planning Period by Type of Service, 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)



Data for figure in Appendix Table B23.

Note: First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

9.3 Strengths and Limitations of the Demonstration

The post-planning period states highlighted the flexibility to tailor their projects and the collaboration requirements as key strengths of the SUPPORT Act section 1003 demonstration. They reported feeling empowered to design demonstration projects that fit their specific needs including the option to focus on specific priority populations or on their SUD population more generally. Post-planning period states have also benefitted from CMS's flexibility on permitting funds to be carried over from the planning period to the post-planning period as is common for discretionary grants when there are unobligated funds available.

Post-planning period states were able to leverage their planning grant-funded data collections and reporting, such as their needs assessments and data dashboards, into a deeper understanding of their treatment landscape and provider and beneficiary needs, an increased capacity to collect and analyze state data, and an awareness of other opportunities for data collection sources to mine in the future. States have indicated that data sharing and collaboration with other state-based SUD initiatives has given the state Medicaid agencies important opportunities to engage in other state SUD-related initiatives which they did not have previously. For example, some state Medicaid agencies have shared data findings from the planning grant needs assessments with their sister agencies and therefore showcased the specific needs of Medicaid beneficiaries with SUD. Additionally, states have been able to increase provider capacity for SUD treatment by combining resources with other initiatives, such as the State Opioid Response grants, or using other funding sources, such as the HCBS funding from the ARP, to cover rate increases or provider reimbursement for MOUD services.

The most pervasive limitation of the demonstration noted by the post-planning period states has been the funding mechanism for the post-planning period. The federal reimbursement for the post-planning period is based on a complex formula, and states have had difficulty predicting the amount of federal reimbursement they will receive during the post-planning period. At least one state has elected to delay some post-planning activities until it has more information about the amount of funding it will receive. Some states also reported the lack of administrative funding in the post-planning period as a limitation. These states could no longer afford to keep SUPPORT Act staff after the planning grant ended and struggled to find funding to support program administration and reporting during the post-planning period.

The COVID-19 public health emergency also impacted the SUPPORT Act demonstration resulting in delayed implementation or cancellation of demonstration activities, such as the cancellation of in-person workshops and a pivot to virtual engagements, a reprioritization of resources to states' COVID-19 response from the SUPPORT Act teams, and an increased need for SUD treatment services that coincided with workforce shortages across the health care system.

9.4 Sustainability of the Demonstration Activities and SUD Treatment or Recovery Capacity across Demonstration States

Post-planning period states are using a variety of mechanisms to sustain demonstration activities and gains in SUD treatment or recovery capacity under the SUPPORT Act demonstration. They are working to implement or sustain Medicaid coverage of SUD services through SPAs and the section 1115(a) SUD demonstrations, and incorporating rate increases and new provider types into managed care contracts, or value-based payment strategies. States are also using other sources of federal funding, including HCBS funding from the ARP and State Opioid Response grant funding, to sustain their section 1003 demonstration efforts.

10 CONCLUSIONS

This *Interim Report to Congress*, required under section 1003 of the SUPPORT Act, addresses state activities, progress toward meeting stated goals, the strengths and limitations of the demonstration projects, and plans for sustaining the capacity gains and strategies implemented by the five states participating in the post-planning period of the SUPPORT Act section 1003 demonstration.

States in the post-planning period are conducting activities across the key domains of: (1) ongoing assessment of SUD prevalence and behavioral health treatment needs and (2) developing long-term and sustainable provider networks that can provide a continuum of care for SUD. The variation in tasks across states reflects the unique characteristics and needs of each state. All states are conducting activities and using strategies that are intended to address limits to capacity, and needs identified during their SUPPORT Act planning grant needs assessment.

A frequently noted strength of the SUPPORT Act section 1003 demonstration is the development of new or improved state agency collaborations. These collaborations have

allowed for more momentum than a single agency might have when acting alone and helped states identify other funding sources to support their efforts, such as funding from the ARP and State Opioid Response grants. Sharing resources can aid states in sustaining the SUD treatment and recovery capacity gains and activities initiated under the SUPPORT Act section 1003 demonstration.

Another frequently noted strength of the SUPPORT Act section 1003 demonstration is the increased capacity of state Medicaid agencies to collect, report, and share data. Post-planning period states are continuing to collect data to make informed decisions about responding to opioid-related overdose events and to understand SUD provider needs to build effective treatment and recovery systems. As a result of sharing specific data on the needs of Medicaid beneficiaries with SUD, the state Medicaid agencies participating in the post-planning period have become active participants in statewide SUD initiatives. Their participation in these statewide initiatives ensures the needs of Medicaid beneficiaries are being addressed as treatment systems are being transformed and strengthened.

One of the primary goals of the SUPPORT Act is to increase the number of providers qualified to provide MOUD. Thus far in the post-planning period, all five states have reported increases in the number of providers qualified to provide buprenorphine or methadone as part of MOUD. Some of the specific strategies states have used to increase the number of MOUD providers include initiating office-based opioid treatment provider fellowships, creating MOUD-related trainings and mentoring opportunities for medical residency students, establishing processes for internal medicine residents to provide MOUD in their primary care clinics, and attending research conferences to understand best practices for MOUD induction in the emergency department. One state completed a comprehensive update to a list of office-based buprenorphine providers, doubling the number of identified locations currently providing buprenorphine for OUD and eliminating more than 400 inaccurate entries.

States noted certain limitations of the SUPPORT Act demonstration. Uncertainty about the amount of the federal reimbursement during the post-planning period has made some states cautious about spending during this time. Some states have put plans on hold until they know

how much federal reimbursement they are receiving and have focused on activities for which they can use other funding sources.

The COVID-19 public health emergency has been a challenge across both the planning and post-planning periods for the SUPPORT Act demonstration. Many states' planned activities were delayed or cancelled due to COVID-19, team members were reassigned to COVID-19 response, or had to deal with competing priorities. All states experienced increases in need for SUD treatment, as opioid overdose rates climbed, while workforce shortages worsened across the health system.

The *Final Report to Congress* will provide updates to the information reported here and findings from an evaluation of the demonstration project. In addition to the data sources used in this report, the *Final Report to Congress* will include data from stakeholder interviews conducted with Medicaid managed care plans, if relevant, and state provider organizations. The *Final Report to Congress* will also summarize results from SUD treatment provider surveys, provider focus groups, and a robust analysis of post-planning period states' SUD claims from the Transformed Medicaid Statistical Information System.

11 REFERENCES

[1] Social Security Act, Section 1903(aa)(1),(2).

[2] Social Security Act, Section 1903(aa)(3).

[3] Social Security Act, Section 1903(aa)(4).

[4] Social Security Act, Section 1903(aa)(1),(2).

[5] Social Security Act, Section 1903(aa)(3).

[6] Social Security Act, Section 1903(aa)(4).

[7] Social Security Act, Section 1903(aa)(5)(B). 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.

[8] Social Security Act, Section 1903(aa)(6)(B)(iii).

[9] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. HHS Publication No. PEP23-07-01-006, NSDUH Series H-58. April 2024. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

[10] Hedegaard H, Miniño AM, Spencer MR, Warner M. *Drug Overdose Deaths in the United States, 1999–2020.* NCHS Data Brief No. 428. Centers for Disease Control and Prevention, National Center for Health Statistics. December 2021. https://www.cdc.gov/nchs/products/databriefs/db428.htm

[11] Centers for Disease Control and Prevention, National Center for Health Statistics. U.S. overdose deaths in 2021 increased half as much as in 2020 – but are still up 15%. May 11, 2022. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

[12] Florence C, Luo F, Rice K. The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017. *Drug Alcohol Depend*. 2021;218:108350.

[13] Pryor JR, Maalouf FI, Krans EE, Schumacher RE, Cooper WO, Patrick SW. The opioid epidemic and neonatal abstinence syndrome in the USA: a review of the continuum of care. *Arch Dis Child Fetal Neonatal Ed*. 2017;102(2):F183-F187.

[14] Williams JF, Smith VC; Committee on Substance Abuse. Fetal alcohol spectrum disorders. *Pediatrics.* 2015;136(5):e1395-e1406.

[15] Schwetz TA, Calder T, Rosenthal E, Kattakuzhy S, Fauci AS. Opioids and infectious diseases: a converging public health crisis. *J Infect Dis*. 2019;220(3):346-349.

[16] Substance Abuse and Mental Health Services Administration. *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose.* HHS Publication No. SMA-18-5093. November 2018. https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093

[17] Substance Abuse and Mental Health Services Administration. *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose.* HHS Publication No. SMA-18-5093. November 2018. https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093

[18] Asana OO, Ayvaci ER, Pollio DE, Hong BA, North CS. Associations of alcohol use disorder, alcohol use, housing, and service use in a homeless sample of 255 individuals followed over 2 years. *Subst Abus*. 2018;39(4):497-504.

[19] Department of Housing and Urban Development. *HUD 2019 Continuum of Care: Homeless Assistance Programs: Homeless Populations and Subpopulations.* September 20, 2019. https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf

[20] Harrison J, Krieger MJ, Johnson HA. Review of individual placement and support employment intervention for persons with substance use disorder. *Subst Use Misuse*. 2020;55(4):636-643.

[21] Lister JJ, Weaver A, Ellis JD, Himle JA, Ledgerwood DM. A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. *Am J Drug Alcohol Abuse*. 2020;46(3)273-288.

[22] Stanojlović, M., & Davidson, L. (2021). Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support. *Substance abuse: research and treatment*, *15*, 1178221820976988. https://doi.org/10.1177/1178221820976988

[23] Farhoudian, A., Razaghi, E., Hooshyari, Z., Noroozi, A., Pilevari, A., Mokri, A., Mohammadi, M. R., & Malekinejad, M. (2022). Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. *Substance abuse: research and treatment*, *16*, 11782218221118462. https://doi.org/10.1177/11782218221118462

[24] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. HHS Publication No. PEP23-07-01-006, NSDUH Series H-58. April 2024. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

[25] Joudrey PJ, Chadi N, Roy P, et al. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: a cross-sectional study. *Drug Alcohol Depend.* 2020;211:107968.

[26] Andrilla CHA, Moore TE, Patterson DG, Larson EH. Geographic distribution of providers with a DEA waiver to prescribe buprenorphine for the treatment of opioid use disorder: a 5-year update. *J Rural Health*. 2019;35(1):108-112.

[27] Lister JJ, Weaver A, Ellis JD, Himle JA, Ledgerwood DM. A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. *Am J Drug Alcohol Abuse*. 2020;46(3)273-288.

[28] Centers for Medicare & Medicaid Services. *Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth*. CMCS Informational Bulletin. April 2, 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf

[29] Drug Enforcement Administration. Dear Registrant letter. January 12, 2023. https://www.deadiversion.usdoj.gov/pubs/docs/A-23-0020-Dear-Registrant-Letter-Signed.pdf

[30] As of December 29, 2022, all Drug Enforcement Administration registered practitioners are required to participate in an eight-hour training on the treatment and management of patients with OUD and other SUDs.
https://www.deadiversion.usdoj.gov/pubs/docs/MATE_Training_Letter_Final.pdf

[31] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *SAMHSA Proposes Update to Federal Rules to Expand Access to Opioid Use Disorder Treatment and Help Close Gap in Care*. December 2022.
https://www.samhsa.gov/newsroom/press-announcements/20221213/update-federal-rules-expand-access-opioid-use-disorder-treatment#1

[32] Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removed the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD).

[33] Saunders H: *Look at Substance Use Disorders (SUD) Among Medicaid Enrollees*. KFF, 2023.
https://www.kff.org/medicaid/issue-brief/a-look-at-substance-use-disorders-sud-among-medicaid-enrollees/

[34] Centers for Medicare & Medicaid Services. *T-MSIS Substance Use Disorder (SUD) Data Book: Treatment of SUD in Medicaid, 2019.* Report to Congress. January 2022.
https://www.medicaid.gov/medicaid/data-systems/downloads/2019-sud-data-book.pdf

[35] Notice of Funding Opportunity, Section E1: Centers for Medicare & Medicaid Services. *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

[36] Notice of Funding Opportunity, Section E1: Centers for Medicare & Medicaid Services. *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

[37] Centers for Disease Control and Prevention, National Center for Health Statistics. *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*. 2020. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[38] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce: Challenges and Policy Responses*. Issue Brief No. HP-2022-13. May 2022. https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf

[39] Notice of Funding Opportunity, Appendix G: Centers for Medicare & Medicaid Services. *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

[40] Form CMS-64 Quarterly Statement of Expenditures is the official financial reporting form for Medicaid medical assistance expenditures for the purpose of claiming Federal Financial Participation (inclusive of Form CMS 64.9 Base, Form CMS 64.9 Waiver, and other relevant forms—referred to collectively as the *CMS-64*). Data are accessed through the Medicaid Budget and Expenditure System.

[41] Each of the post-planning period states had increases in their Medicaid enrollment over the time covered in this report, and this measure does not adjust for that increase.

[42] If an empty value was recorded for one of the observations this value was imputed as 0 in the figures, but data as reported are provided in the appendix. Service categories that had a total observation count in the bottom 50th percentile compared to other service categories in the exhibit were combined into an "Other" category. Each figure has a footnote to denote which service categories are categorized as Other.

[43] Substance Abuse and Mental Health Services Administration, Screening, Brief Intervention, and Referral to Treatment (SBIRT), accessed December 29, 2023.

[44] Certified Community Behavioral Health Clinics are designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care

for mental health or substance use, regardless of their ability to pay, place of residence, or age. Of the 5 post-planning period states, Nevada was the only participant in the Section 223 Medicaid CCBHC Demonstration and State Programs.

APPENDIX A: INSTRUCTIONS FOR STATES TO COMPLETE QUARTERLY REPORTS AND REPORT

Instructions for Quarterly Report for Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity

PRA Disclosure Statement: *Planning grant states participating in the 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 Demonstration Project do not currently submit specific Substance Use Disorder information necessary for the statutorily required reports (Section 1903(6)(B) of the Social Security Act) that CMS must submit to Congress. In order to meet the Congressionally mandated reporting requirements, CMS must collect this information, via a standardized template. Planning grant states are required to report this information as a condition of grant funding. The process for collecting information and completing the Quarterly Progress Report (QPR) template is intended to minimize the paperwork burden by or for the Federal Government, and to strengthen the partnership between the Federal Government and the Grantees. Grantees are provided with the QPR template in Excel format, and associated instructions. The completed QPR Excel spreadsheets will be submitted to the Federal Government by the Grantees via an online web-based document sharing repository, thereby streamlining data collection, and minimizing paperwork burden.*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 # 62). The time required to complete this information collection is estimated to average 14 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. All responses are public and will be made available on the CMS website. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

Quarterly Report Workbook Tab 1 – "Quarterly Report Instructions"

In cell A3 type the name of the state. In cell A5, type the first and last name of the Project Director for the grantee team. If another party or individual is responsible for submission, then include that person's full name in the designated space. Otherwise, leave **Name of party submitting report if not Project Director** blank. Finally, include the date of submission in the designated space.

Please note, the current quarter for the purposes of this document, is the most recent quarter (three-month period) for which data are available, and the previous quarter is the quarter (three- month period) prior to the current quarter.

Section I: Milestones

This section is intended to assess the status of all the activities that are required to be completed as part of this grant, the date that activity was scheduled to be completed according to your Project Work Plan and your updated anticipated date of completion. Also, this section should include any potential risks or challenges.

The default selection from the drop-down menu for each activity is "Pull Down to Select." If the activity has not been initiated or conducted within the reporting period, then change the selection in the drop-down menu to "No." If the activity is "No," then move to the next activity.

However, if the activity is applicable and your answer is "Yes," then use the table provided in the corresponding tab, **Tab 2 – "Tables I-1-5."**, to detail the applicable activities.

If the activity has been undertaken in the quarter, then use the first column to briefly describe the specific activity that the grantee team has engaged in, with one activity per row.

In the second column, select the status of the activity from the drop-down menu. The default response is, "Pull Down to Select", so grantees are expected to assess the status of the activity. "In Progress" means an activity is started and the grantee is working to accomplish it by a known end date. "Completed" means the work for an activity has concluded.

In the third column, insert the completion date as specified in the Project Work Plan.

Fourth, provide an updated anticipated completion date for the activity. The anticipated completion date may be the same as the period of performance end date. Anticipated completion dates should be in the past if the activity is completed.

Fifth, briefly describe any known risks or challenges as they relate to the activity.

Last, if additional rows are required to describe all activities, please copy and paste the table into a new tab in the Excel workbook and complete it as needed.

Section II: Enrollee Data

Quarterly Report Workbook Tab 3 – "Tables II-1-3."

This section is related to general Medicaid enrollee data for the current reporting period. The first table contains the target populations specified in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Section 1003 Demonstration Project to Increase Provider Capacity.

In Table II-1 Each subpopulation has a default response of "Yes" under 'Intention To Target'. Grantees must set all subpopulations that they identified as targeted by grant activities in their grant applications to "Yes" in the 'Intention To Target' column. Grantees must set all subpopulations that they did not indicate they would target with grant activities in their grant applications to "No" in the 'Intention To Target' column. Tables II-2 and II-3 in Section II will automatically default rows to "N/A" for all subpopulations with a "No" response in the 'Intention to Target' column of table II-1. Therefore, grantees are not required to report on those subpopulations.

The second table of Section II (Table II-2) is designed to collect information on the Medicaid beneficiaries who had a substance use disorder (SUD) diagnosis or treatment within the reporting period but not in the prior period. The last table in this section is a quarterly snapshot of all Medicaid beneficiaries with a SUD diagnosis, related treatment, or both.

For the second table in Section II (Table II-2), the denominator for the **All Medicaid enrollees'** row is the number of Medicaid enrollees in the state that quarter. The numerator for that row is the number of Medicaid enrollees in the state with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **Opioid use disorder subpopulation** row is the number of Medicaid enrollees in the state that quarter. The numerator for that row is the number of Medicaid enrollees in the state with a diagnosis or treatment for opioid use disorder in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **Infants with neonatal abstinence syndrome** row is the number of Medicaid-enrolled infants born in the state that quarter. The numerator for that row is the number of Medicaid-enrolled infants born with neonatal abstinence syndrome in that quarter.

For the second table in Section II (Table II-2), the denominator for the **Aged 12–21 years** row is the number of Medicaid enrollees aged 12–21 years in the state that quarter. The numerator for that row is the number of Medicaid enrollees aged 12–21 years in the state with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **Pregnant** row is the number of Medicaid enrollees with an identified pregnancy in the state that quarter. The numerator for that row is the number of Medicaid enrollees with an identified pregnancy in the state with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **Postpartum** row is the number of Medicaid enrollees with an identified delivery claim in the state that quarter. The numerator for that row is the number of Medicaid enrollees with an identified delivery in the state with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **Dual eligible under Medicare and Medicaid** row is the number of Medicaid enrollees who were enrolled in both Medicare and Medicaid benefits that quarter. The numerator for that row is the number of Medicaid enrollees who were enrolled in both Medicare and Medicaid benefits that quarter with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the denominator for the **American Indian/Alaska Native** row is the number of Medicaid enrollees identified as American Indian or Alaska Native in the state that quarter. The numerator for that row is the number of Medicaid enrollees identified as American Indian or Alaska Native in the state with a diagnosis or treatment for SUD in that quarter but not the previous quarter.

For the second table in Section II (Table II-2), the **Rate/Percentage** column is always calculated as the numerator for that row divided by the denominator. Describe any issues with calculating or reporting counts for these populations in the last column: **Are there any known reporting issues? If yes, please describe.**

For the last table in Section II (Table II-3), the denominator for the **All Medicaid enrollees'** row is the number of Medicaid enrollees in the state that quarter. The numerator for that row is the number of Medicaid enrollees in the state with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the denominator for the **Opioid use disorder subpopulation** row is the number of Medicaid enrollees in the state that quarter. The numerator for that row is the number of Medicaid enrollees in the state with a diagnosis or treatment for opioid use disorder in that quarter.

For the last table in Section II (Table II-3), the denominator for the **Infants with neonatal abstinence syndrome** row is the number of Medicaid-enrolled infants born in the state that quarter. The numerator for that row is the number of Medicaid-enrolled infants born with neonatal abstinence syndrome in that quarter. This should be the same value as the row for neonatal abstinence syndrome in the second table of Section II.

For the last table in Section II (Table II-3), the denominator for the **Aged 12–21 years** row is the number of Medicaid enrollees aged 12–21 years in the state that quarter. The numerator for that row is the number of Medicaid enrollees aged 12–21 years in the state with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the denominator for the **Pregnant** row is the number of Medicaid enrollees with an identified pregnancy in the state that quarter. The numerator for that row is the number of Medicaid enrollees with an identified pregnancy in the state with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the denominator for the **Postpartum** row is the number of Medicaid enrollees with an identified delivery claim in the state that quarter. The numerator for that row is the number of Medicaid enrollees with an identified delivery in the state with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the denominator for the **Dual eligible under Medicare and Medicaid** row is the number of Medicaid enrollees who were enrolled in

both Medicare and Medicaid benefits that quarter. The numerator for that row is the number of Medicaid enrollees who were enrolled in both Medicare and Medicaid benefits that quarter with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the denominator for the **American Indian/Alaska Native** row is the number of Medicaid enrollees identified as American Indian or Alaska Native in the state that quarter. The numerator for that row is the number of Medicaid enrollees identified as American Indian or Alaska Native in the state with a diagnosis or treatment for SUD in that quarter.

For the last table in Section II (Table II-3), the **Rate/Percentage** column is always calculated as the numerator for that row divided by the denominator. Describe any issues with calculating or reporting counts for these populations in the last column: **Are there any known reporting issues? If yes, please describe.**

Section III: Substance Use Disorder Treatment or Recovery Services Data

Quarterly Report Workbook Tab 4 – "Table III."

This section is related to services administered during the reporting period. This section corresponds to the Centers for Medicare & Medicaid Services (CMS) Form CMS-64, the statement of expenditures for which states are entitled to Federal reimbursement under Title XIX categories. The table in this section is strictly interested in the number of beneficiaries receiving SUD treatment by each service category for the current reporting period and the number of Medicaid providers furnishing these services.

The first column in Table III is organized by all potential service categories in a state under which services to address substance use disorders would be reimbursed under Medicaid. Grantees should follow CMS 64 reporting for service categories (See https://www.medicaid.gov/sites/default/files/2022-02/cms-649-base-category-of-services-definition-02232022.pdf and how each state covers and claims for these services.

The second column in Table III is for Medicaid enrollees with SUD receiving care in each service category under fee-for-service.

The third column in Table III is for Medicaid enrollees with SUD receiving care in each service category under managed care. Grantees should use their state-specific fee-for-service reporting logic to stratify managed care encounter data into the listed service categories.

The fourth column in Table III is designed to retrieve the number of new Medicaid enrollees receiving care by each category. Please provide the number of Medicaid enrollees receiving care in each category who did not receive care in the same category in the previous quarter.

The fifth and sixth columns in Table III focus on the number of Medicaid providers for each service category.

The fifth column in Table III measures the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period. Please enter the number of providers in each service category offering service to Medicaid enrollees with SUD during that period.

The sixth column in Table III measures the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT during the measurement period. Please enter the number of providers in each service category offering service to Medicaid enrollees in the row corresponding to the service to enrollees with SUD during that period.

The final row in Table III, Row 18, "Total" should be the total number of unique enrollees or providers in the corresponding column. In many instances it will not be the same as the sum of the rows above because an individual may receive or provide services in more than one of the Service Categories in Column A.

In cell 'A34' of Section III on the 'Quarterly Report Instructions' tab, please describe any known reporting issues for any of the service category metrics. Enter "None" in this table if there are no known issues. However, if known issues exist, include the affected column name(s) and/or service category(ies).

Please note that this report does not provide definitions for service categories because these may differ among grantees depending on how a state Medicaid program covers services and seeks reimbursement for these services through CMS 64 reporting requirements.

Section IV: Barrier Data

Quarterly Report Workbook Tab 5 – "Table IV."

This section is related to barriers encountered in state efforts under SUPPORT Act section 1003. Grantees identified known and potential barriers to Medicaid-covered SUD treatment and recovery services identified for focus in their assessments. This section allows grantees to detail their experiences and their work to overcome these barriers in Table IV.

In the first column, 'Barriers Addressed by Grant Funds', select the applicable barriers addressed by grant funds from the drop-down menu(s). If no barriers were addressed during the reporting period, then select "N/A," or not applicable, from the drop-down menu for each row.

In the second column, 'Type of Barrier', describe the type of barrier. Barriers should be consistent with those identified in grant applications. This column will automatically default to "N/A" if the first column is "N/A".

In the third column 'Activities and Results', briefly describe the activities involved to address the barrier. If there are any known results, then please include those as well. This column will automatically default to "N/A" if the first column is "N/A".

In cell 'A38' on the 'Quarterly Report Instructions' tab grantees should briefly describe any activities started or completed in the past quarter to address barriers and to encourage providers to enroll in Medicaid.

Section V: Additional Information

Quarterly Report Workbook Tab 6 – "Table V."

In Table V of this section there is an opportunity for grantees to detail and provide CMS with any additional information relevant to their efforts to increase SUD provider capacity under SUPPORT Act section 1003.

In the first column, 'Changes', select from the drop-down any applicable change information as it pertains to staffing, contracting, or other important changes. The default response is, "[Pull Down to Select]". If none of the changes are relevant, then please select "N/A" for each row."

In the second column, 'Describe', briefly describe the change and actions or activities involved with the change. If a 'Change' is, "N/A", then the 'Describe' field will automatically populate "N/A". If a change other than "N/A" is selected and does not have information in the '**Describe'** column, then the response will be considered incomplete.

Finally, grantees may detail any other information they would like to share with CMS in cell 'A42' on the 'Quarterly Report Instructions' tab. This space is optional but provides an opportunity for grantees to describe any efforts or activities related to SUPPORT Act section 1003 that are not captured in another section of the report. Grantees should not use this cell as additional space to detail activities from another section. If no additional information is needed, then enter "N/A." If the table is left blank, the response will be considered incomplete.

Quarterly Report for Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity
State:
[Enter State Name]
Name of Project Director:
[Enter Project Director]
Name of party submitting report if not Project Director:

[Enter Submitter]
Date:
[Enter Date]
SECTION I: Milestones
In the past three months, have you started or completed activities related to the following?
1) Activities that support assessment of the mental health and substance use disorder (SUD) treatment needs of the state to determine the extent to which providers are needed to address the SUD treatment and recovery needs of Medicaid beneficiaries; please enter in Table I-1 (see Table I-1-5 Tab).
[Pull Down to Select]
If yes, please describe in Table I-1.
2) Activities that support the development of state infrastructure (i.e., recruiting providers, providing training or technical assistance); please enter in Table I-2 (see Table I-1-5 Tab).
[Pull Down to Select]
If yes, please describe in Table I-2
3) Activities to improve reimbursement, training, and education to expand Medicaid provider capacity to deliver SUD treatment and recovery services; please enter in Table I-3 (see Table I-1-5 Tab).
[Pull Down to Select]
If yes, please describe in Table I-3.
4) Activities to develop projections regarding the extent to which the state would increase the number and capacity of Medicaid providers offering SUD treatment or recovery services, as well as the willingness of Medicaid providers to offer SUD treatment or recovery; please enter in Table I-4 (see Table I-1-5 Tab).
[Pull Down to Select]
If yes, please describe in Table I-4.
5) Activities related to the analysis comparing the state's SUD prevalence with the national average, as measured by per capita opioid drug overdoses and the prevalence of substance use and opioid-related diagnoses among Medicaid enrollees; please enter in Table I-5 (see Table I-1-5 Tab).
[Pull Down to Select]
If yes, please describe in Table I-5.
SECTION II: Enrollee Data
Please indicate whether your state intends to target the subpopulations below per your application. Select "Yes" for all applicable subpopulations in Table II-1 (see Table II-1-3. Tab).
Metric: Medicaid Beneficiaries With Newly Initiated SUD Treatment/Diagnosis: number of beneficiaries with an SUD diagnosis and an SUD-related service during the measurement period but not in the three months before the measurement period in Table II-2 (see Table II-1-3. Tab).

Metric: Medicaid Beneficiaries With SUD Diagnosis (Quarterly): number of beneficiaries with an SUD diagnosis and an SUD-related service during the measurement period in Table II-3 (see Table II-1-3. Tab).
SECTION III: Section III: Substance Use Disorder Treatment or Recovery Services Data
SUD Services by Category: Please include number of beneficiaries in the measurement period receiving any SUD treatment service during the measurement period in Table III (see Table III. Tab).
Are there any known reporting issues for data provided in Section III? If yes, please describe below.
[Please enter text]
SECTION IV: Barrier Data
Please describe any efforts in the past quarter to address barriers to providers treating Medicaid beneficiaries with SUD (e.g., provider unwillingness to serve Medicaid beneficiaries, lack of providers' recognition of opioid use disorder in their enrollee populations, and provider understanding of medication-assisted treatment) in Table IV (see Table IV. Tab).
Please describe any activities funded through the grant in the past quarter to address reimbursement or financial incentives to encourage providers to treat patients with or at risk for SUD.
[Please enter text]

SECTION V: Additional Information

Please describe any resource changes in the past quarter (new staff, loss of key staff, new contracts for information technology [IT] infrastructure, relevant partnerships, other) in Table V (see Table V. Tab).

If there is anything else that the Centers for Medicare & Medicaid Services should be aware of related to this grant, then please describe below.

[Please enter text]

PRA Disclosure Statement: Planning grant states participating in the 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 Demonstration Project do not currently submit specific Substance Use Disorder information necessary for the statutorily required reports (Section 1903(6)(B) of the Social Security Act) that CMS must submit to Congress. In order to meet the Congressionally mandated reporting requirements, CMS must collect this information, via a standardized template. Planning grant states are required to report this information as a condition of grant funding. The process for collecting information and completing the Quarterly Progress Report (QPR) template is intended to minimize the paperwork burden by or for the Federal Government, and to strengthen the partnership between the Federal Government and the Grantees. Grantees are provided with the QPR template in Excel format, and associated instructions. The completed QPR Excel spreadsheets will be submitted to the Federal Government by the Grantees via an online web-based document sharing repository, thereby streamlining data collection, and minimizing paperwork burden.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 # 62). The time required to complete this information collection is estimated to average 14 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. All responses are public and will be made available on the CMS website. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

Table I-1. Mental Health and Substance Use Disorder Assessment Activities				
Activity	**Status**	**Grant Completion Date**	**Anticipated Completion Date**	**Risks and Challenges**
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]

Table I-2. State Infrastructure Development Activities				
Activity	**Status**	**Grant Completion Date**	**Anticipated Completion Date**	**Risks and Challenges**
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]

Table I-3. Provider Reimbursement, Training, and Education Activities				
Activity	**Status**	**Grant Completion Date**	**Anticipated Completion Date**	**Risks and Challenges**
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]

Table I-4. Provider Volume and Capacity Projection Activities				
Activity	**Status**	**Grant Completion Date**	**Anticipated Completion Date**	**Risks and Challenges**
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]

Table I-5. State and National Analysis Comparisons				
Activity	**Status**	**Grant Completion Date**	**Anticipated Completion Date**	**Risks and Challenges**
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]
[Please enter text]	[Pull Down to Select]	[Please enter text]	[Please enter text]	[Please enter text]

Table II-1. Target Populations for Analysis	
Subpopulation	**Intention To Target**
Infants with neonatal abstinence syndrome	Yes
Aged 12–21 years	Yes
Pregnant	Yes
Postpartum	Yes
Dual eligible under Medicare and Medicaid	Yes
American Indian/Alaska Native	Yes

Table II-2. Beneficiaries with Newly Initiated SUD Diagnosis				
Population	**Denominator**	**Numerator or Count**	**Rate/Percentage**	**Are there any known reporting issues? If yes, please describe**
All Medicaid enrollees	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Opioid use disorder subpopulation	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Infants with neonatal abstinence syndrome	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Aged 12–21 years	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Pregnant	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Postpartum	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Dual eligible under Medicare and Medicaid	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
American Indian/Alaska Native	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]

Table II-3. Beneficiaries with SUD Diagnosis - Quarterly				
Population	**Denominator**	**Numerator or Count**	**Rate/Percentage**	**Are there any known reporting issues? If yes, please describe**
All Medicaid enrollees	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Opioid use disorder subpopulation	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Infants with neonatal abstinence syndrome	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Aged 12–21 years	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Pregnant	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Postpartum	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Dual eligible under Medicare and Medicaid	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
American Indian/Alaska Native	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]

Service Category	No. of Enrollees With SUD Receiving Care in This Category—Fee for Service	No. of Enrollees With SUD Receiving Care in This Category—Managed Care	No. of Enrollees Who Received Care in This Category This Quarter but Not the Previous	SUD Provider Availability: No. of providers who were enrolled in Medicaid and qualified to deliver SUD services during measurement period	SUD Provider Availability-MAT: No. of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT
Physicians' services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Services provided by other licensed	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Diagnostic and rehabilitative	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Inpatient services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Outpatient hospital services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Prescription drugs	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Targeted case management for individuals with SUD	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Targeted case management for individuals with mental disorder and SUD	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Nurse practitioner	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Nurse midwife services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Preventive services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Clinic services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Certified Community Behavioral Health Center	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Home health services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Private duty nursing services	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]
Total	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]	[Please enter text]

Table IV. Activities to Address Barriers		
Barriers Addressed by Grant Funds	**Type of Barrier (e.g., provider, Medicaid-eligible beneficiary, Medicaid system)**	**Activities and Results**
Provider Capacity	[Please enter text]	[Please enter text]
Provider Willingness	[Please enter text]	[Please enter text]
Financial	[Please enter text]	[Please enter text]
Access	[Please enter text]	[Please enter text]
Care Provision	[Please enter text]	[Please enter text]
Other	[Please enter text]	[Please enter text]
Other	[Please enter text]	[Please enter text]

Table V. Resource Changes	
Changes	**Describe (if applicable**
[Pull Down to Select]	[Please enter text]
[Pull Down to Select]	[Please enter text]
[Pull Down to Select]	[Please enter text]
[Pull Down to Select]	[Please enter text]
[Pull Down to Select]	[Please enter text]

Lookup Table 1. Drop Down Options
Dropdown Options
[Pull Down to Select]
Yes
No
Lookup Table 2. Activity Status
Activity Status
[Pull Down to Select]
In Progress
Completed
Lookup Table 3. Barriers
Barriers
[Pull Down to Select]
Provider Capacity
Provider Willingness
Financial
Access
Care Provision
Other
N/A
Lookup Table 4. Resource Changes
Changes
[Pull Down to Select]
New Staff
Loss of Key Staff
New Contracts for IT Infrastructure
Relevant Partnerships
Other
N/A

APPENDIX B: DETAILED DATA TABLES FOR POST-PLANNING PERIOD STATES

Supplemental Data for Connecticut

Table B1. Number of beneficiaries that received SUD services in Connecticut from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	23113	24262	24494	22881	23610	24195	24174	23983	23802	23706	2.6
Diagnostic and rehabilitative services	2538	2465	2045	2237	2188	2278	2299	2293	2224	2395	-5.6
Home health services	1286	1241	1236	1273	1275	1350	1340	1341	1243	1203	-6.5
Inpatient services	2852	2815	2805	3241	2868	2969	3273	3063	2862	2661	-6.7
Nurse midwife services	26	26	19	15	21	24	28	27	25	22	-15.4
Nurse practitioner services	3954	4163	3652	4340	4413	4526	4715	4920	4567	4526	14.5
Outpatient hospital services (including ED)	10854	10544	8403	10193	9407	9837	10705	10915	9784	9695	-10.7
Physicians' services	14615	14340	13085	14699	13766	14319	15304	15153	14039	14137	-3.3
Prescription drugs	8498	8618	8259	8335	8432	8518	8551	8532	8354	8352	-1.7
Preventive services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	2452	2550	2386	2700	2563	2772	2589	2589	2477	2420	-1.3
Targeted case management for SUD	834	813	746	657	748	771	803	817	796	765	-8.3
Targeted case management for mental disorder and SUD	95	101	94	72	80	86	78	71	81	76	-20.0
Sum total	71117	71938	67224	70643	69371	71645	73859	73704	70254	69958	-1.6
Total unique	41562	42287	40557	41623	41623	43018	43666	43510	42301	42702	2.7

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B2. Number of Medicaid providers qualified to deliver services for SUD in Connecticut from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	943	1026	1004	924	995	1028	981	986	1002	1005	6.6
Diagnostic and rehabilitative services	846	745	459	812	751	774	813	798	799	822	-2.8
Home health services	633	640	655	683	717	752	751	763	761	747	18.0
Inpatient services	1501	1464	1379	1597	1543	1519	1550	1539	1452	1438	-4.2
Nurse midwife services	11	17	14	10	17	14	12	10	13	11	0
Nurse practitioner services	663	682	651	714	711	788	765	781	740	784	18.3
Outpatient hospital services (including ED)	2476	2472	1930	2329	2313	2311	2370	2480	2414	2336	-5.7
Physicians' services	3979	3974	3730	4172	4113	4340	4271	4463	4283	4306	8.2
Prescription drugs	1044	1053	1025	1087	1091	1149	1153	1248	1248	1228	17.6
Preventive services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Private duty nursing services	0	0	0	0	0	0	0	0	0	1	NA
Services provided by other licensed practitioners	526	529	486	506	522	557	526	527	518	504	-4.2
Targeted case management for SUD	38	44	43	33	40	43	43	40	41	37	-2.6
Targeted case management for mental disorder and SUD	6	10	9	7	5	8	8	6	6	6	0
Sum total	12666	12656	11385	12874	12818	13283	13243	13641	13277	13225	4.4
Total unique	8689	8619	7822	8727	8679	9000	8941	9102	8964	8992	3.5

Note: "0" means zero providers or beneficiaries and "NA" means it is not possible to have any count. "Type of Service" categories are not mutually exclusive.

Table B3. Number of SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment in Connecticut from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	143	168	174	160	182	202	208	207	223	215	50.3
Diagnostic and rehabilitative services	15	14	6	18	22	16	17	27	20	27	80.0
Home health services	135	133	145	155	160	189	202	217	230	218	61.5
Inpatient services	66	50	48	68	70	61	68	82	80	75	13.6
Nurse midwife services	0	0	0	0	0	0	0	0	0	0	NA
Nurse practitioner services	65	61	60	71	77	78	69	80	82	80	23.1
Outpatient hospital services (including ED)	200	203	161	201	191	204	231	255	256	229	14.5
Physicians' services	195	194	180	216	202	208	213	247	245	226	15.9
Prescription drugs	0	0	0	0	0	NA	NA	NA	NA	NA	NA
Preventive services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Private duty nursing services	0	0	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	3	3	2	8	8	7	6	6	7	5	66.7
Targeted case management for SUD	0	0	0	0	0	0	0	0	0	0	NA
Targeted case management for mental disorder and SUD	0	0	0	0	0	0	0	0	0	0	NA
Sum total	822	826	776	897	912	965	1014	1121	1143	1075	30.8
Total unique	744	727	702	748	746	778	788	861	888	859	15.5

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B4. Number of Medicaid enrollees with a SUD diagnosis in Connecticut from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by subpopulation

Population	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
Opioid use disorder subpopulation	24904	25090	24596	25229	25314	25632	25604	25358	24920	24801	-0.4
Dual eligible under Medicare and Medicaid	3939	3919	3326	3256	3146	3597	3250	3074	2935	3153	2.0
Aged 12-21 years	2329	2256	1827	2017	1954	2045	2078	2052	1997	2162	-7.2
Pregnant	1319	1323	1119	1279	1167	1267	1296	1305	1091	1103	-16.4
American Indian/Alaska Native	350	357	313	335	331	329	345	342	335	340	3.0
Postpartum	330	342	327	357	346	317	320	364	295	262	-20.6
Infants with neonatal abstinence syndrome	256	260	258	274	304	282	271	266	289	259	1.2
Sum total	33427	33547	31766	32747	32562	33469	33164	32761	31862	32080	-4.0

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count.

Supplemental Data for Delaware

Table B5. Number of beneficiaries that received SUD in Delaware from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	0	0	0	0	0	0	0	0	0	NA
Clinic services	604	565	525	615	581	631	725	670	680	536	-11.3
Diagnostic and rehabilitative services	7562	7429	7489	7254	7533	7685	7656	7428	7593	7613	0.7
Home health services	152	149	189	138	144	154	169	159	138	215	41.4
Inpatient services	3088	3042	2697	3167	2836	2933	3223	3274	2720	2627	-14.9
Nurse midwife services	1	3	5	5	5	4	1	0	0	NA	NA
Nurse practitioner services	649	689	754	466	332	995	427	250	246	237	-63.5
Outpatient hospital services (including ED)	7780	7931	6398	7597	7137	7488	8216	7973	6959	6666	-14.3
Physicians' services	5677	5956	6237	6273	6434	6664	6716	6406	6459	6440	13.4
Prescription drugs	3560	3887	4016	3864	3836	3823	3791	3879	3726	3439	-3.4
Preventive services	639	370	442	502	623	580	669	588	618	343	-46.3
Private duty nursing services	0	0	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	473	379	551	468	681	862	877	687	642	664	40.4
Targeted case management for SUD	0	0	0	0	0	0	0	0	0	0	NA
Targeted case management for mental disorder and SUD	0	0	0	0	0	0	0	0	0	0	NA
Sum total	30185	30400	29303	30349	30142	31819	32470	31314	29781	28780	-4.7
Total unique	16132	16185	15182	15974	15702	16188	16882	16468	15543	15393	-4.6

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B6. Number of Medicaid providers qualified to deliver services for SUD in Delaware from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q2 2021	Q3 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	0	0	0	0	0	0	0	0	0	NA
Clinic services	21	20	24	18	23	18	20	19	33	28	33.3
Diagnostic and rehabilitative services	1011	1019	784	751	770	770	771	759	891	862	-14.7
Home health services	43	47	50	49	55	58	54	51	55	56	30.2
Inpatient services	387	374	345	349	435	387	419	429	489	454	17.3
Nurse midwife services	2	2	3	2	1	3	2	4	0	0	-100.0
Nurse practitioner services	72	71	63	73	74	68	75	75	89	93	29.2
Outpatient hospital services (including ED)	368	323	377	367	372	354	392	388	403	345	-6.3
Physicians' services	982	956	830	754	806	828	786	792	975	946	-3.7
Prescription drugs	354	384	367	397	383	432	452	457	447	412	16.4
Preventive services	25	22	37	33	45	31	32	40	53	40	60.0
Private duty nursing services	0	0	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	127	121	102	86	81	78	69	79	87	90	-29.1
Targeted case management for SUD	0	0	0	0	0	0	0	0	0	0	NA
Targeted case management for mental disorder and SUD	0	0	0	0	0	0	0	0	0	0	NA
Sum total	3392	3339	2982	2879	3045	3027	3072	3093	3522	3326	-1.9
Total unique	1871	1810	1529	1526	1543	1591	1586	1593	1651	1541	-17.6

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B7. Number of SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment in Delaware from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	NA	0	0	0	0	0	0	0	0	NA
Clinic services	0	NA	0	0	0	0	0	0	0	0	NA
Diagnostic and rehabilitative services	0	NA	0	0	0	0	0	0	0	0	NA
Home health services	0	NA	0	0	0	0	0	0	0	0	NA
Inpatient services	0	NA	0	0	0	0	0	0	0	0	NA
Nurse midwife services	0	2	2	2	2	10	10	10	10	10	NA
Nurse practitioner services	19	66	73	73	77	93	95	97	98	98	415.8
Outpatient hospital services (including ED)	0	NA	0	0	0	0	0	0	0	0	NA
Physicians' services	89	161	149	149	151	208	208	209	209	209	134.8
Prescription drugs	0	NA	0	0	0	0	0	0	0	0	NA
Preventive services	0	NA	0	0	0	0	0	0	0	0	NA
Private duty nursing services	NA	NA	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	54	18	18	18	18	22	22	23	23	23	-57.4
Targeted case management for SUD	0	NA	0	0	0	0	0	0	0	0	NA
Targeted case management for mental disorder and SUD	NA	NA	0	0	0	0	0	0	0	0	NA
Sum total	162	247	242	242	248	333	335	339	340	340	109.9
Total unique	162	247	242	242	248	333	335	339	340	340	109.9

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B8. Number of Medicaid enrollees with a SUD diagnosis in Delaware from 10/1/2019–3/31/2022 (FFY Q1 2020–FFYQ2 2022) by subpopulation

Population	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
Opioid use disorder subpopulation	11838	11884	11322	11924	11959	12144	12227	12061	11605	11593	-2.1
Pregnant	643	659	690	639	586	593	641	627	499	512	-20.4
Aged 12-21 years	541	536	364	385	377	331	407	380	397	378	-30.1
Postpartum	214	180	192	217	185	151	153	196	153	140	-34.6
Infants with neonatal abstinence syndrome	84	84	92	117	97	83	83	109	86	79	-6.0
Dual eligible under Medicare and Medicaid	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
American Indian/Alaska Native	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	13320	13343	12660	13282	13204	13302	13511	13373	12740	12702	-4.6

Supplemental Data for Illinois

Table B9. Number of beneficiaries that received SUD services in Illinois from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	12252	12873	10059	10443	11777	12799	13402	12991	12728	13187	7.6
Diagnostic and rehabilitative services	26324	25561	22174	24647	25418	26055	26289	25776	25549	25148	-4.5
Home health services	0	0	0	0	0	0	0	0	0	0	NA
Inpatient services	14986	15340	14156	15910	14745	15434	17085	16997	14880	15503	3.4
Nurse midwife services	4	1	3	1	3	4	0	1	1	0	-100.0
Nurse practitioner services	3035	2367	2394	2902	3101	3487	3873	4301	4320	4584	51.0
Outpatient hospital services (including ED)	25520	25970	24555	28227	25000	27096	30772	29733	26336	27045	6.0
Physicians' services	21299	21077	20170	23472	21423	22868	25327	25226	23008	23321	9.5
Prescription drugs	11574	11889	11642	12578	12697	13340	13701	13626	14009	14115	22.0
Preventive services	0	0	NA	0	0	0	0	0	0	0	NA
Private duty nursing services	0	0	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	329	348	353	416	410	447	450	527	497	516	56.8
Targeted case management for SUD	1	1	0	0	0	21	97	267	257	273	27200.0
Targeted case management for mental disorder and SUD	1005	899	850	904	925	1006	919	882	863	860	-14.4
Sum total	116329	116326	106356	119500	115499	122557	131915	130327	122448	124552	7.1
Total unique	73765	73323	66980	75013	72971	77288	81946	81520	77646	79109	7.2

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B10. Number of Medicaid providers qualified to deliver services for SUD in Illinois from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	0	0	0	0	0	0	0	0	0	NA
Clinic services	1092	1104	1111	1127	1139	1154	1165	1174	1184	1201	10.0
Diagnostic and rehabilitative services	1941	1975	1998	2055	2094	2125	2160	2179	2210	2251	16.0
Home health services	407	411	412	421	423	429	435	444	449	460	13.0
Inpatient services	1210	1215	1226	1249	1274	1297	1326	1354	1378	1402	15.9
Nurse midwife services	485	501	505	514	519	525	535	551	564	578	19.2
Nurse practitioner services	14921	15531	15967	16515	17069	17656	18150	18753	19362	19998	34.0
Outpatient hospital services (including ED)	1889	1898	1913	1943	1968	1995	2030	2067	2098	2130	12.8
Physicians' services	55449	57552	59147	62107	63401	64468	66562	69655	70870	72229	30.3
Prescription drugs	2732	2751	2770	2794	2840	2855	2870	2890	2905	2955	8.2
Preventive services	0	0	0	0	0	0	0	0	0	0	NA
Private duty nursing services	330	336	341	354	357	362	369	378	382	389	17.9
Services provided by other licensed practitioners	10914	11421	11785	12246	12655	13101	13486	13966	14464	14904	36.6
Targeted case management for SUD	2	2	2	2	2	2	2	2	2	2	0
Targeted case management for mental disorder and SUD	930	939	946	967	984	990	1004	1011	1021	1031	10.9
Sum total	92302	95636	98123	102294	104725	106959	110094	114424	116889	119530	29.5
Total unique	83183	86130	88345	92165	94263	96160	99007	102975	105107	107392	29.1

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B11. Number of SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment in Illinois from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	0	0	0	0	0	0	0	0	0	0	NA
Diagnostic and rehabilitative services	55	54	56	57	59	62	64	67	67	71	29.1
Home health services	0	0	0	0	0	0	0	0	0	0	NA
Inpatient services	0	0	0	0	0	0	0	0	0	0	NA
Nurse midwife services	0	0	0	0	0	0	0	0	0	0	NA
Nurse practitioner services	369	389	390	552	581	620	664	694	740	766	107.6
Outpatient hospital services (including ED)	0	0	0	0	0	0	0	0	0	0	NA
Physicians' services	1483	1518	1936	2073	2205	2247	2353	2492	2507	2532	70.7
Prescription drugs	0	0	0	0	0	0	0	0	0	0	NA
Preventive services	0	0	NA	0	0	0	0	0	0	0	NA
Private duty nursing services	0	0	0	0	0	0	0	0	0	0	NA
Services provided by other licensed practitioners	0	0	0	0	0	0	0	0	0	0	NA
Targeted case management for SUD	0	0	0	0	0	0	0	0	0	0	NA
Targeted case management for mental disorder and SUD	0	0	0	0	0	0	0	0	0	0	NA
Sum total	1907	1961	2382	2682	2845	2929	3081	3253	3314	3369	76.7
Total unique	1907	1961	2382	2682	2845	2929	3081	3253	3314	3369	76.7

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B12. Number of Medicaid enrollees with a SUD diagnosis in Illinois from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by subpopulation

Population	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
Opioid use disorder subpopulation	30035	30687	28962	31381	31033	31942	33196	33520	33321	33446	11.4
Dual eligible under Medicare and Medicaid	7593	7836	6949	7646	7435	7698	9099	10027	9523	9589	26.3
Aged 12-21 years	5219	5241	3868	4486	4105	4442	4626	4484	4278	4652	-10.9
Pregnant	2343	2127	2039	2275	2129	2147	2323	2236	2020	2012	-14.1
Postpartum	1083	1044	998	1166	1091	1025	1115	1127	1045	969	-10.5
American Indian/Alaska Native	314	340	308	340	335	411	440	413	413	429	36.6
Infants with neonatal abstinence syndrome	75	81	66	76	60	73	54	64	59	57	-24.0
Sum total	46662	47356	43190	47370	46188	47738	50853	51871	50659	51154	9.6

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count.

Supplemental Data for Nevada

Table B13. Number of beneficiaries that received SUD services in Nevada from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	443	483	401	477	531	455	436	386	444	742	67.5
Clinic services	7352	7279	6179	6639	6688	6802	7996	7278	7040	7733	5.2
Diagnostic and rehabilitative services	9095	9587	6791	6799	6213	7335	7217	7096	6443	6072	-33.2
Home health services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Inpatient services	8905	9021	8535	8895	8284	8632	9471	9174	8524	8410	-5.6
Nurse midwife services	0	0	0	0	0	1	0	0	0	0	NA
Nurse practitioner services	820	870	914	1008	990	985	1123	1266	1245	1433	74.8
Outpatient hospital services (including ED)	22685	23708	20498	21483	20447	21861	24094	21816	20418	20661	-8.9
Physicians' services	22594	22834	20662	22695	22271	23314	25933	23253	22198	23693	4.9
Prescription drugs	828	653	564	595	593	589	614	631	650	681	-17.8
Preventive services	896	958	1005	1001	1158	1196	1891	1569	1757	2355	162.8
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	1096	1123	1071	1126	1114	1102	1216	1384	1372	1578	44.0
Targeted case management for SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	74714	76516	66620	70718	68289	72272	79991	73853	70091	73358	-1.8
Total unique	58215	59245	52041	55558	54124	57007	62904	57582	55162	57046	-2.0

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B14. Number of Medicaid providers qualified to deliver services for SUD in Nevada from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	8	8	9	9	9	9	9	9	9	9	12.5
Clinic services	136	141	142	145	141	140	139	139	139	135	-0.7
Diagnostic and rehabilitative services	200	260	193	204	194	183	181	183	162	152	-24.0
Home health services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Inpatient services	237	228	227	224	232	230	222	224	226	208	-12.2
Nurse midwife services	0	0	0	71	72	73	75	74	73	72	NA
Nurse practitioner services	2844	2983	3086	3258	3404	3498	3580	3716	3826	3901	37.2
Outpatient hospital services (including ED)	5023	5106	5162	5349	5349	5249	5295	5254	5075	4884	-2.8
Physicians' services	15574	15730	16190	16777	17122	17099	17202	17525	17363	17298	11.1
Prescription drugs	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Preventive services	20002	20369	21047	21836	22384	22502	22728	23222	23222	23282	16.4
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	2238	3374	3413	3596	3747	3849	3940	4092	4204	4279	91.2
Targeted case management for SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	46262	48199	49469	51469	52654	52832	53371	54438	54299	54220	17.2
Total unique	26620	27822	27991	28223	28619	28576	28846	29320	29124	28966	8.8

Note: "0" means zero providers or beneficiaries and "NA" means it is not possible to have any count. "Type of Service" categories are not mutually exclusive. Most providers deliver SUD services and out-of-state providers could practice in the state due to COVID-related flexibilities in where providers could practice.

Table B15. Number of SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment in Nevada from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	8	8	9	9	9	9	9	9	9	9	12.5
Clinic services	136	141	142	145	141	140	139	139	139	135	-0.7
Diagnostic and rehabilitative services	1	1	1	1	1	0	0	0	0	0	-100.0
Home health services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Inpatient services	0	0	0	0	0	0	0	0	0	0	NA
Nurse midwife services	0	0	0	0	0	0	0	0	0	0	NA
Nurse practitioner services	155	147	150	150	163	185	182	196	228	236	52.3
Outpatient hospital services (including ED)	2	1	1	1	1	1	0	0	0	0	-100.0
Physicians' services	265	270	273	273	300	277	282	290	319	330	24.5
Prescription drugs	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Preventive services	527	547	532	534	572	494	498	519	582	601	14.0
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	155	147	180	180	195	184	182	196	228	236	52.3
Targeted case management for SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	1249	1262	1288	1293	1382	1290	1292	1349	1505	1547	23.9
Total unique	584	586	587	600	648	654	646	667	721	736	26.0

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B16. Number of Medicaid enrollees with a SUD diagnosis in Nevada from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by subpopulation

Population	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
Dual eligible under Medicare and Medicaid	12837	12414	10155	10060	9296	8611	8814	8520	8180	8406	-34.5
Opioid use disorder subpopulation	8539	8719	8393	9025	8610	8769	8886	8797	8419	8584	0.5
Aged 12-21 years	7667	7486	6508	6217	5698	6055	6414	6107	5966	6187	-19.3
Pregnant	3348	3458	3269	3169	3048	3406	3688	3435	3325	3407	1.8
American Indian/Alaska Native	1181	1230	1016	1097	1037	1097	1130	1179	1108	1221	3.4
Postpartum	718	719	652	687	667	639	726	764	747	635	-11.6
Infants with neonatal abstinence syndrome	62	48	66	84	81	75	75	79	104	109	75.8
Sum total	34352	34074	30059	30339	28437	28652	29733	28881	27849	28549	-16.9

Supplemental Data for West Virginia

Table B17. Number of beneficiaries that received SUD services in West Virginia from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA
Clinic services	202	231	343	388	2952	2711	2719	2606	2642	2650	1211.9
Diagnostic and rehabilitative services	41	42	113	286	7669	8168	8513	9004	9823	10001	24292.7
Home health services	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA
Inpatient services	2	NA	NA	NA	12	16	38	24	22	19	850.0
Nurse midwife services	10	11	24	93	23	20	37	61	69	104	940.0
Nurse practitioner services	584	691	2418	4527	3690	4051	4835	5259	5145	5593	857.7
Outpatient hospital services (including ED)	123	157	101	121	17	10	21	18	28	35	-71.5
Physicians' services	1781	2125	6146	6000	3706	3707	3554	3330	3066	2998	68.3
Prescription drugs	4	6	30	1634	9	11	9	15	10	9	125.0
Preventive services	NA	NA	NA	NA	257	108	102	57	65	54	NA
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA
Services provided by other licensed practitioners	450	486	2337	618	691	770	635	665	657	638	41.8
Targeted case management for SUD	201	269	334	847	NA	NA	NA	NA	0	0	-100.0
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA
Sum total	3398	4018	11846	14514	19026	19572	20463	21039	21527	22101	550.4
Total unique	22285	23671	22372	24435	19922	20741	21509	22239	22715	23353	4.8

Table B18. Number of Medicaid providers qualified to deliver services for SUD in West Virginia from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2020	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q3 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	NA	NA	3207	1821	9541	9522	4464	9857	10196	9777	204.9
Diagnostic and rehabilitative services	NA	NA	35858	38898	60369	47183	54754	54754	55863	53013	47.8
Home health services	NA	NA	NA	NA	4180	4346	4335	4335	4199	4408	NA
Inpatient services	NA	NA	NA	NA	3706	3722	3733	3733	3755	3699	NA
Nurse midwife services	NA	NA	113	117	123	125	125	125	129	133	17.7
Nurse practitioner services	NA	NA	19807	25588	25740	26478	26853	26853	26965	22969	16.0
Outpatient hospital services (including ED)	NA	NA	1830	1830	3404	3417	3432	3432	3451	3489	90.7
Physicians' services	NA	NA	47499	49987	50295	49657	52851	52851	55831	51737	8.9
Prescription drugs	NA	NA	2347	980	979	2373	2473	2473	2485	2419	3.1
Preventive services	NA	NA	NA	NA	39738	42179	42774	42774	43453	41660	NA
Private duty nursing services	NA	NA	NA	NA	38	38	38	38	38	38	NA
Services provided by other licensed practitioners	NA	NA	16506	16682	16806	34560	37617	37617	38936	39189	137.4
Targeted case management for SUD	NA	NA	638	10856	NA	NA	NA	NA	0	0	-100.0
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	NA	NA	127805	146759	214919	223600	233449	238842	245301	232531	81.9
Total unique	NA	NA	76252	78540	82425	60549	63297	64618	65354	98067	28.6

Note: "0" means zero providers or beneficiaries and "NA" means it is not possible to have any count. "Type of Service" categories are not mutually exclusive. Most providers deliver SUD services and out-of-state providers could practice in the state due to COVID-related flexibilities in where providers could practice. First two quarters of data were not reported because West Virginia reported challenges in identifying providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

Table B19. Number of SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment in West Virginia from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q3 2020 to Q2 2022
CCBHC services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Clinic services	NA	NA	NA	NA	82	94	108	110	118	124	NA
Diagnostic and rehabilitative services	NA	NA	NA	475	807	653	930	974	1019	869	NA
Home health services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Inpatient services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Nurse midwife services	NA	NA	NA	5	5	5	5	5	5	5	NA
Nurse practitioner services	NA	NA	NA	381	390	414	435	457	479	472	NA
Outpatient hospital services (including ED)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Physicians' services	NA	NA	NA	482	494	512	589	613	642	585	NA
Prescription drugs	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Preventive services	NA	NA	NA	NA	486	505	529	553	577	582	NA
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	NA	NA	NA	257	270	294	319	338	358	365	NA
Targeted case management for SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	NA	NA	NA	1600	2534	2477	2915	3050	3198	3002	NA
Total unique	NA	NA	551	529	546	571	603	629	656	670	21.6

Table B20. Number of Medicaid enrollees with a SUD diagnosis in West Virginia from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by subpopulation

Population	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
Opioid use disorder subpopulation	21605	21821	22534	24717	22871	23418	23871	24217	24279	24847	15.0
Pregnant	1323	2661	2794	3249	2480	786	1004	1198	1305	705	-46.7
Aged 12-21 years	1280	1215	900	1070	559	451	547	570	535	450	-64.8
Postpartum	1294	1512	1028	582	180	418	527	709	827	447	-65.5
Infants with neonatal abstinence syndrome	275	280	278	288	245	246	254	239	176	213	-22.5
American Indian/Alaska Native	35	34	26	37	31	0	35	33	41	36	2.9
Dual eligible under Medicare and Medicaid	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	25812	27523	27560	29943	26366	25319	26238	26966	27163	26698	3.4

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count.

Supplemental Data for All Post-Planning Demonstration States

Table B21. Number of Medicaid beneficiaries that received SUD services across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	443	483	401	477	531	455	436	386	444	742	67.5
Clinic services	43523	45210	41600	40966	45608	47138	49016	47528	46892	47812	9.9
Diagnostic and rehabilitative services	45560	45084	38612	41223	49021	51521	51974	51597	51632	51229	12.4
Home health services	1438	1390	1425	1411	1419	1504	1509	1500	1381	1418	-1.4
Inpatient services	29833	30218	28193	31213	28745	29984	33090	32532	29008	29220	-2.1
Nurse midwife services	41	41	51	114	52	53	66	89	95	126	207.3
Nurse practitioner services	9042	8780	10132	13243	12526	14044	14973	15996	15523	16373	81.1
Outpatient hospital services (including ED)	66962	68310	59955	67621	62008	66292	73808	70455	63525	64102	-4.3
Physicians' services	65966	66332	66300	73139	67600	70872	76834	73368	68770	70589	7.0
Prescription drugs	24464	25053	24511	27006	25567	26281	26666	26683	26749	26596	8.7
Preventive services	1535	1328	1447	1503	2038	1884	2662	2214	2440	2752	79.3
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	4800	4886	6698	5328	5459	5953	5767	5852	5645	5816	21.2
Targeted case management for SUD	1036	1083	1080	1504	748	792	900	1084	1053	1038	0.2
Targeted case management for mental disorder and SUD	1100	1000	944	976	1005	1092	997	953	944	936	-14.9
Sum total	295743	299198	281349	305724	302327	317865	338698	330237	314101	318749	7.8
Total unique	211959	214711	197132	212603	204342	214242	226907	221319	213367	217603	2.7

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B22. Number of Medicaid SUD service providers across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	**Q1 2020**	**Q2 2020**	**Q3 2020**	**Q4 2020**	**Q1 2021**	**Q2 2021**	**Q3 2021**	**Q4 2021**	**Q1 2022**	**Q2 2022**	**% Change from Q1 2020 to Q2 2022**
CCBHC services	8	8	9	9	9	9	9	9	9	9	12.5
Clinic services	2192	2291	5488	4035	11839	11862	6769	12175	12554	12146	454.1
Diagnostic and rehabilitative services	3998	3999	39292	42720	64178	51035	58679	58673	59925	57100	1328.2
Home health services	1083	1098	1117	1153	5375	5585	5575	5593	5464	5671	423.6
Inpatient services	3335	3281	3177	3419	7190	7155	7250	7279	7300	7201	115.9
Nurse midwife services	498	520	635	714	732	740	749	764	779	794	59.4
Nurse practitioner services	18500	19267	39574	46148	46998	48488	49423	50178	50982	47745	158.1
Outpatient hospital services (including ED)	9756	9799	11212	11818	13406	13326	13519	13621	13441	13184	35.1
Physicians' services	75984	78212	127396	133797	135737	136392	141672	145286	149322	146516	92.8
Prescription drugs	4130	4188	6509	5258	5293	6809	6948	7068	7085	7014	69.8
Preventive services	20027	20391	21084	21869	62167	64712	65534	66036	66728	64982	224.5
Private duty nursing services	330	336	341	354	395	400	407	416	420	428	29.7
Services provided by other licensed practitioners	13805	15445	32292	33116	33811	52145	55638	56281	58209	58966	327.1
Targeted case management for SUD	40	46	683	10891	42	45	45	42	43	39	-2.5
Targeted case management for mental disorder and SUD	936	949	955	974	989	998	1012	1017	1027	1037	10.8
Sum total	154622	159830	289764	316275	388161	399701	413229	424438	433288	422832	173.5
Total unique	83183	86130	164597	170705	176688	156709	162304	167593	170461	205459	147.0

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive. First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

Table B23. Number of Medicaid SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022) by type of service

Type of Service	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CCBHC services	8	8	9	9	9	9	9	9	9	9	12.5
Clinic services	279	309	316	305	405	436	455	456	480	474	69.9
Diagnostic and rehabilitative services	71	69	63	551	889	731	1011	1068	1106	967	1262.0
Home health services	135	133	145	155	160	189	202	217	230	218	61.5
Inpatient services	66	50	48	68	70	61	68	82	80	75	13.6
Nurse midwife services	0	2	2	7	7	15	15	15	15	15	NA
Nurse practitioner services	608	663	673	1227	1288	1390	1445	1524	1627	1652	171.7
Outpatient hospital services (including ED)	202	204	162	202	192	205	231	255	256	229	13.4
Physicians' services	2032	2143	2538	3193	3352	3452	3645	3851	3922	3882	91.0
Prescription drugs	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Preventive services	527	547	532	534	1058	999	1027	1072	1159	1183	124.5
Private duty nursing services	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Services provided by other licensed practitioners	212	168	200	463	491	507	529	563	616	629	196.7
Targeted case management for SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Targeted case management for mental disorder and SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sum total	4140	4296	4688	6714	7921	7994	8637	9112	9500	9333	125.4
Total unique	3397	3521	4464	4801	5033	5265	5453	5749	5919	5974	75.9

Note: "0" means zero providers or beneficiaries and "NA" means it is not possible to have any count. "Type of Service" categories are not mutually exclusive. First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

Table B24. Number of Medicaid enrollees across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

State	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CT	559127	561368	592643	611038	630560	654866	668381	678821	690923	701260	25.4
DE	159209	157716	162883	167978	173975	183398	186766	190392	190409	203455	27.8
IL	3069520	3064965	3129578	3292429	3552043	3735356	3859631	4004949	4251419	3630839	18.3
NV	692237	692207	715100	756409	790420	814932	837743	861271	881751	901563	30.2
WV	631924	549148	574691	599138	622086	601647	621110	641098	659540	644990	2.1
Sum total	5112017	5025404	5174895	5426992	5769084	5990199	6173631	6376531	6674042	6082107	19.0

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B25. Number of unique Medicaid beneficiaries that received SUD services across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

State	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CT	41562	42287	40557	41623	41623	43018	43666	43510	42301	42702	2.7
DE	16132	16185	15182	15974	15702	16188	16882	16468	15543	15393	-4.6
IL	73765	73323	66980	75013	72971	77288	81946	81520	77646	79109	7.2
NV	58215	59245	52041	55558	54124	57007	62904	57582	55162	57046	-2.0
WV	22285	23671	22372	24435	19922	20741	21509	22239	22715	23353	4.8
Sum total	211959	214711	197132	212603	204342	214242	226907	221319	213367	217603	2.7

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive.

Table B26. Number of unique Medicaid SUD service providers across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

State	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CT	8689	8619	7822	8727	8679	9000	8941	9102	8964	8992	3.5
DE	1871	1810	1529	1526	1543	1591	1586	1593	1651	1541	-17.6
IL	83183	86130	88345	92165	94263	96160	99007	102975	105107	107392	29.1
NV	26620	27822	27991	28223	28619	28576	28846	29320	29124	28966	8.8
WV	NA	NA	76252	78540	82425	60549	63297	64618	65354	98067	NA
Sum total	120363	124381	201939	209181	215529	195876	201677	207608	210200	244958	103.5

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive. First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.

Table B27. Number of unique Medicaid SUD service providers who met the standards to provide buprenorphine or methadone as part of medication assisted treatment across all states from 10/1/2019–3/31/2022 (FFY Q1 2020–FFY Q2 2022)

State	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	% Change from Q1 2020 to Q2 2022
CT	744	727	702	748	746	778	788	861	888	859	15.5
DE	162	247	242	242	248	333	335	339	340	340	109.9
IL	1907	1961	2382	2682	2845	2929	3081	3253	3314	3369	76.7
NV	584	586	587	600	648	654	646	667	721	736	26.0
WV	NA	NA	551	529	546	571	603	629	656	670	NA
Sum total	3397	3521	4464	4801	5033	5265	5453	5749	5919	5974	75.9

Note: “0” means zero providers or beneficiaries and “NA” means it is not possible to have any count. “Type of Service” categories are not mutually exclusive. First two quarters of data do not include West Virginia because the state was unable to identify providers who were qualified to provide SUD services rather than providers that delivered a claim for those quarters.