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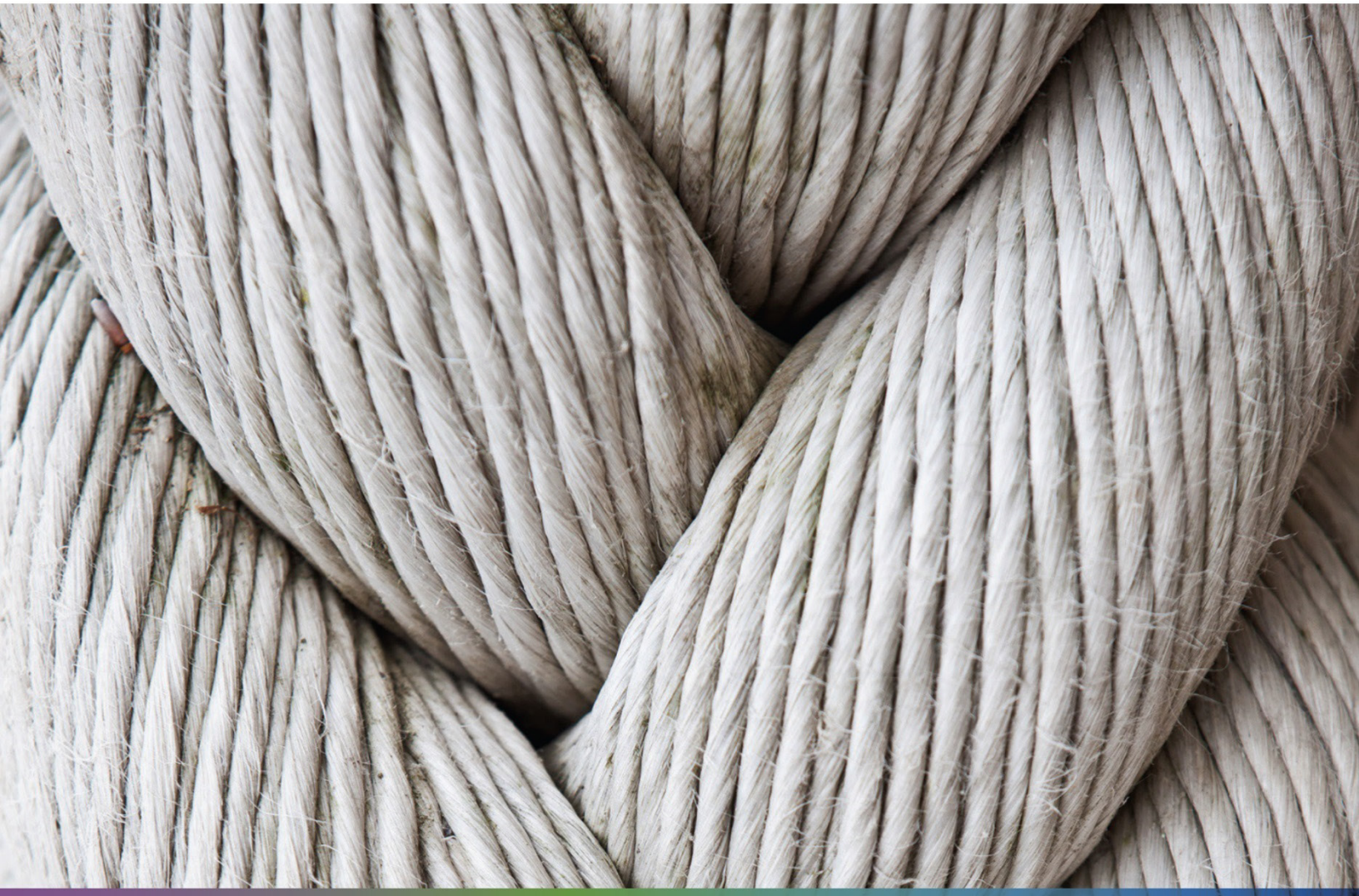

Examining the Use of Braided Funding for Substance Use Disorder Services

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgement

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Financing Reform and Innovation (CFRI) under contract number HHSS283201700031I/75S20322F42003 with SAMHSA, U.S. Department of Health and Human Services (HHS). Asha Stanly served as contracting officer representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration: *Examining the Use of Braided Funding for Substance Use Disorder Services*. Publication No. PEP23-06-07-002 Rockville, MD: Center for Substance Abuse Treatment. Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, Publication No. PEP23-06-07-002.

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Publication No. PEP23-06-07-002
Released 2024

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Executive Summary

Braided funding models are those that use one or more sources of funding in a coordinated fashion to support a single individual or program. The different sources retain their specific spending requirements and are kept separate for reporting purposes.

This report is multi-site case study identifying relevant braided funding themes and best practices. It is a resource for states and program managers that are interested in the benefits of braided funding for the provision of substance use disorder (SUD) services but need more information about what funding sources may be available and how they can be managed effectively. In the realm of SUD services, braided funding models are commonly used to provide a wide range of services and programs that prevent, treat, and support recovery from SUD.

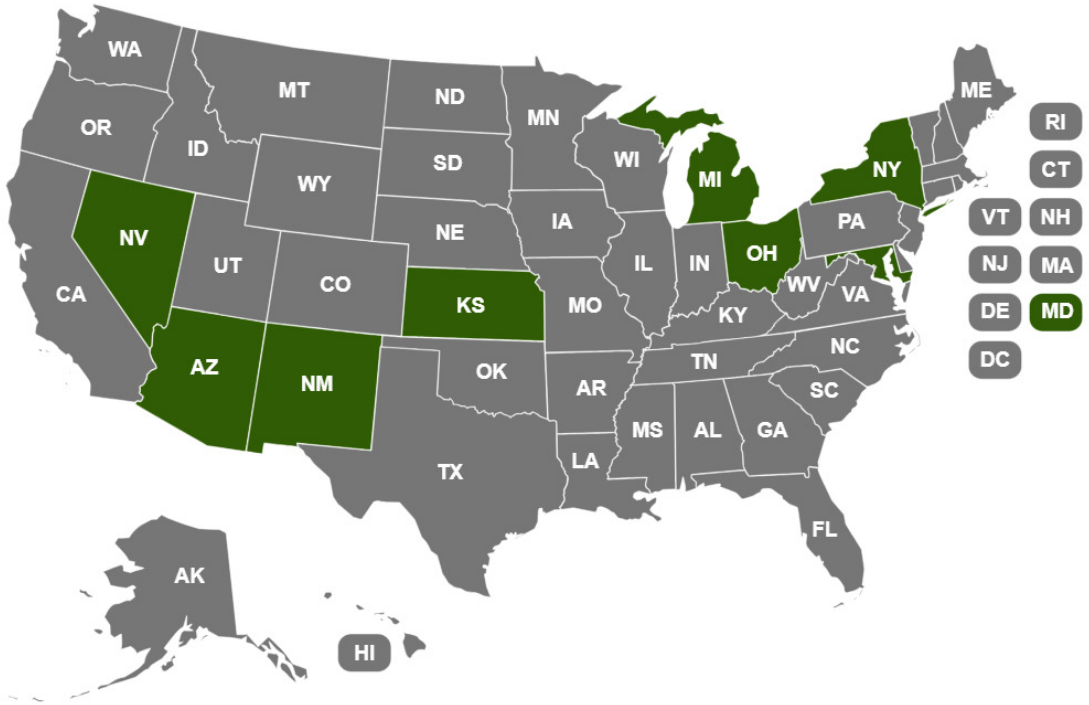
This report presents case studies from eight U.S. states (Arizona, Kansas, Maryland, Michigan, Ohio, New Mexico, New York and Nevada) to illustrate how states and programs use braided funding to address the challenges associated with combining multiple SUD funding sources.

Rewards and Challenges of Braiding Funds

Braided funding models are useful because they allow states and programs to:

- **Optimize resource allocation** by layering different funding sources in a way that maximizes available funding.
- **Promote sustainability** by diversifying revenue streams and aligning partnerships for long-term stability.
- **Improve outcomes** by creating integrated and flexible systems of care for patients with SUD and funding prevention services that reduce the incidence of substance misuse and use disorders.
- **Address gaps in service provision** by working with administrative authorities to monitor spending data and make adjustments to allocations.

Case Study Locations



Braided funding models are also challenging because states and programs may experience:

- **Reduced fungibility** of funds because of administrative requirements associated with one or more funding sources.
- **Administrative burdens** associated with fulfilling multiple data collection and reporting requirements. Providers may need additional training or support to separately bill correctly for each service and client type and to avoid duplicate billing.
- **Unpredictability** of grants or time-limited state or local funding can introduce uncertainty that makes it difficult to plan far ahead.
- **Evaluation challenges** associated with measuring return on investment when multiple funding sources are used.

Sources of Braided Funding for Substance Use Disorder

Many SUD treatment providers and programs receive funding from public or private insurance. Many also receive funding from formula-based block grants, discretionary grants or state general funds. Increasingly, settlement funds received from pharmaceutical companies are available for SUD prevention and treatment, as well as fees or taxes on alcohol or marijuana.

Policies and Funding Mechanisms for Braiding Funds

State agencies can pursue policy changes or funding mechanisms that support their ability to braid funding. Commonly cited funding mechanisms and practices for braiding funding are:

- Medicaid Section 1115 demonstrations
- Block grant funds
- Legal settlements with opioid producers and distributors
- Interagency/intergovernmental agreements

Best Practices for Braiding Funds

Approaches to braiding funds vary, but there are several best practices that significantly enhance funding models:

- **Needs assessments** help states and programs identify the specific objectives required to meet their goals and are the foundation for all subsequent work.
- **Strategic planning** helps states and programs understand, apply for, and manage appropriate funding sources that align with their objectives. Formal agreements, such as memoranda of understanding, help foster strategic planning partnerships.
- **Fiscal mapping** can help program developers determine where funds originate, where they are directed, and what services they are meant to support. This process can also be used to identify the eligible populations for the various funding streams and their requirements.
- **Ongoing coordination and cooperation** is critical to the success of braided funding. Regular communication and collaboration between funding agencies, service providers, community organizations, and other relevant parties ensures a shared understanding of project goals and objectives.
- **Management of funding streams** is essential to optimize the braided funding process. Administrative organizations are often enlisted to help administer contracts, track funding utilization, and report outcomes.
- **Decision-making plans** can help address service gaps and ensure that resources are distributed equitably. By having a plan in place to serve people not typically covered by insurance or block grant funds, program developers increase transparency and consistency in service provision.
- **Integrated data systems** are necessary to document spending and service provision data that must be reported to funders and state authorities regularly. Outcome data can be used to evaluate the impact of the program.

- **Supportive infrastructure,** such as state-level agencies or administrative organizations, can facilitate the braiding of funds and promote collaboration between providers.

The case studies in this report show how varied braided funding models can be. Different approaches may be based on the needs of the community, the administrative structure of state and local governments, and the types of programs and providers available.

CHAPTER 1

Introduction

About this Report

This report is a multi-site case study identifying relevant braided funding themes and best practices. It is a resource for states and program managers that are interested in learning how to use braided funding to support SUD service provision. Braided funding models are those that use one or more sources of funding in a coordinated fashion to support a single individual or program. The different sources retain their specific spending requirements and are kept separate for reporting purposes.

This report presents case studies from eight U.S. states (Arizona, Kansas, Maryland, Michigan, Ohio, New Mexico, New York and Nevada) to illustrate how states and programs use braided funding to address the challenges associated with combining multiple SUD funding sources. While *blended* funding can be used to support SUD services, it is less common, and is not the focus of this report.

Sections of the report include:

- Chapter 1: Introduction and a summary of the literature on braided funding.
- Chapter 2: Eight case studies of braided funding at the state agency level, Managed Care Organization (MCO) level, or provider level.
- Chapter 3: Conclusions, including best practices for navigating the complexities and opportunities associated with the braided funding approach.

Funding for Substance Use Disorder Services

A wide range of services and programs help prevent, treat, and support recovery from SUD. These services and supports include:

- Education
- School-based programs
- Screening
- Harm reduction
- Withdrawal management
- Outpatient, intensive outpatient, inpatient, and residential care
- Pharmacological treatments for SUD and co-occurring conditions
- Case management
- Peer recovery support
- Recovery housing
- Employee support
- Childcare
- Transportation

Braided funding occurs when one or more sources of funding are used in a coordinated fashion to support a single individual or program. The different sources retain their specific spending requirements and are kept separate for reporting purposes.

Blended funding occurs when dollars from multiple funding sources are combined to create a single pool subject to a single set of spending and reporting requirements that is used to fund a program or to purchase one or more specific services to support individuals with SUD.

SUD services are provided in numerous settings by various types of providers. The case studies featured in this report provide some examples of those settings and provider types.

Programs that provide SUD services commonly rely on several different types of funding because addiction impacts all aspects of people's lives, and many types of services are required to help them recover. No single funding source covers all types of SUD services that are needed.

Coordinating the use of more than one funding source to support a single individual or program is referred to as braiding funds. Braiding can occur at the state agency level, at the provider level, or levels in between.

The extent to which SUD programs and providers braid funds may depend on the program or setting. While some providers may only offer services that are funded by a single source such as private insurance (thus no braiding is needed), other providers offer several types of services and braid several funding streams to fund the program.

Why State Agencies and Programs Braid Funds

There are many reasons that state agencies and programs braid funding for SUD services. As discussed above, the need for comprehensive programs to address SUD often necessitate braiding as a funding strategy. Braided funding offers a comprehensive and coordinated approach that enables states and programs to leverage diverse funding streams in a synergistic manner, ultimately fostering a more robust and responsive system of SUD services.

By strategically combining multiple funding sources, states and programs can optimize resource allocation, enhance service accessibility, and maximize the effectiveness of their efforts to address the multifaceted needs of individuals and families affected by SUD.

The case studies presented in this report show that braiding funding can be challenging. However, braiding funds is often the only way to completely fund the wide range of SUD services needed to help families meet their treatment needs. These essential services and supports play a crucial role in helping individuals and families overcome the challenges posed by SUD as they work toward achieving lasting recovery.[1]

The eight case studies in this report illustrate how states and programs use braided funding to address the challenges associated with multiple SUD funding sources.

Funds can be braided at the *state agency level* when multiple agency-managed funds are strategically distributed to a single program (or several programs). At the state agency level, braided SUD funding can be used to:

- Support pilot or start-up programs or initiatives.
- Enhance services or initiatives to make them more comprehensive or sustainable.
- Co-locate different services in a single site.
- Address service gaps created by existing funding sources or payment structures to promote equity between the insured and uninsured populations.[2]
- Reduce the clinical and administrative barriers between programs in state behavioral health service systems.[2]
- Strengthen existing programs by funding capital improvements or increasing staff capacity through training or additional hiring.

While there are some tools and publications on best practices for braiding public dollars, there is limited specificity and guidance for SUD providers. **This report serves as a resource for state and local policy makers, agency leadership, providers, and independent organizations seeking to enhance funding of SUD services through the braiding of multiple funds.**

What does the Literature Have to Say about Braided Funding?

This report is informed by a review of publicly available primary and secondary resources on the subject of braided funding, including peer-reviewed manuscripts; white papers; the grey literature; and state, federal, and provider policy and resource documents. The research questions that guided this literature review are:

- Why do state agencies or programs use braided funding for SUD services?
- What are the sources of braided and blended funding for SUD?
- What are the advantages/disadvantages of braided and blended funding in general? Are there practical remedies or alternatives to overcome the disadvantages?
- What federal or state policies promote braided funding for SUD services?
- What are the best practices associated with braided funding for SUD services? Have states or programs evaluated how well braided funding works for the provision of SUD services?

Funds can be braided at the *program level* when programs receive and use multiple funding sources, some of which they receive directly from the funder (such as grant funding). At the program level, braided SUD funding can be used to:

- Enhance services or initiatives to make them more comprehensive or sustainable.
- Promote collaboration and coordination with state agencies or other programs.
- Reduce administrative burden for providers.

Funds can be braided at the *provider level* when more than one funding source is used to support a single client. At the provider level, braided SUD funding can be used to:

- Provide more options for treatment.
- Ensure equity in service provision.

Braided Funding Sources for Substance Use Disorder Services

Financing SUD services requires significant contributions from governments at the federal, state, and local levels. Federal sources include safety net programs like Medicaid, formula-based block grants such as the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, and discretionary grants like the State Opioid Response (SOR) grants. States typically allocate general funds for administering state programs and paying for services. Increasingly, states use settlement funds received from litigation, as well as fees or taxes on alcohol or marijuana.

Table 1. Sources of SUD Funding

Source Name	Description
Insurance	**Medicaid** is a public assistance program that pays for medical care (including certain SUD treatments) for qualified low-income and disabled people. Medicaid does not cover inpatient and residential substance use treatment provided by certain behavioral health providers known as "Institutions for Mental Diseases" (IMDs).[I,II] IMDs are hospitals, nursing facilities, or other institutions of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The exclusion applies to all IMD patients under age 65, except for payments for inpatient psychiatric services provided to beneficiaries under age 21. See Medicaid Statute Section 1905(a)(b) of the Social Security Act. As of 2023, 35 states use Section 1115 Medicaid Demonstrations to waive the IMD exclusion.[III]
	Medicare is a federally administered health insurance program primarily for people over age 65, as well as younger people who receive disability benefits. SUD services and medications may be covered by Medicare when they are considered "reasonable and necessary" but there is no SUD treatment benefit category.[IV] Medicare covers early intervention, outpatient, and inpatient treatment, but lacks coverage for more intermediate levels of care. Except for opioid treatment programs, Medicare does not cover community-based treatment facilities that are not affiliated with a hospital system.[V]
	Commercial Insurance covers SUD services. Specific benefits vary depending on the plan. Insurers cannot deny coverage based on a pre-existing SUD or mental health condition.[VI]
SAMHSA Funding	**Block grants** such as the SUPTRS Block Grant and the Mental Health Block Grant (MHBG) are formula-based grants awarded annually to all states and territories. Funds are intended to help with the planning, implementation and evaluation of specific activities or programs. SUPTRS funds must be the funding of last resort for SUD treatment services. SUD treatment providers are required to exhaust all efforts to collect payment for services from any eligible Medicaid, private insurance, or third-party program before billing the SUPTRS for services.[VII]
	Discretionary grants are also available to eligible applicants based on need and capacity. These include SOR grants and State Targeted Response to the Opioid Crisis (STR) grants as well as others.

Table notes:

I Congressional Research Service. *Medicaid: An Overview*. Updated February 22, 2021. Accessed May 31, 2023. Medicaid: An Overview (congress.gov)

II In general, when Medicaid enrollees have other sources of insurance/payment (including Medicare), Medicaid is the payer of last resort for most services. States can provide Medicaid coverage to individuals whose existing health insurance is limited (sometimes referred to as underinsured). In these cases, Medicaid wraps around that coverage (i.e., additional coverage for services covered under Medicaid but not under the other source of coverage). Medicaid covered services are those that are described in the approved Medicaid state plan or another Medicaid authority. State policy manuals may provide further detail about Medicaid covered services.

III Medicaid.Gov. Section 1115 Demonstrations: Substance Use Disorders, Serious Mental Illness, and Serious Emotional Disturbance Section 1115 Demonstrations: Substance Use Disorders, Serious Mental Illness, and Serious Emotional Disturbance | Medicaid.

IV Centers for Medicare and Medicaid Services. *February 2023 Medicaid and CHIP Enrollment Data Highlights, 2023*. Accessed May 31, 2023. Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data | Medicaid.

V CMS Medicare Learning Network. Items & Services Not Covered Under Medicare. Section I. Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider. cms.gov; 2020. Items & Services Not Covered Under Medicare (cms.gov)

VI Mental Health & Substance Abuse Coverage. Centers for Medicare and Medicaid Services. 2023. Accessed May 31, 2023. Mental health and substance abuse health coverage options | HealthCare.gov.

VII Subpart L—Substance Abuse Prevention and Treatment Block Grant. 45 CFR §96.124(e) and 45 CFR §96.137(a)(1-2).

Table continued on next page.

Table 1. Sources of SUD Funding (continued)

Source Name	Description
Other Federal Block Grant Funding	Other block grants, such as the Maternal and Child Health Block Grant (administered by the Health Resources and Service Administration) or the Community Services Block Grant (administered by the Administration for Children and Families) have been used by states to support certain SUD services.
Federal One-time Discretionary Funding	Sources of non-recurring funding used for SUD services, such as the American Rescue Plan Funds or COVID-19 Relief Funds.
State Funding	Every state dedicates some portion of general funds to support SUD services.[VIII] Additionally, most states also provide state funding specifically intended for primary prevention activities. In some states, revenue for SUD prevention, intervention, and treatment is generated through fees or taxes imposed on alcohol or marijuana.
Opioid Pharmaceutical Settlement Funds	Following a legal settlement with multiple pharmaceutical companies in 2021, a total of $26 billion will be allocated to states over an 18-year period to support prevention and treatment efforts related to opioid use disorder (OUD). This funding distribution encompasses both litigating and non-litigating states, with each state's allocation being determined based on factors such as population size and the impact of the crisis within the state.[IX]
Local or Private Foundation Funds	Some cities and counties allocate general funds for administering programs and/or provide grant funding for treatment or overdose response. Private foundations also support SUD programs.[X]

Table notes:

[VIII] SUPTRS State Application Data. Web Block Grant Application System (WebBGAS). Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed May 2023. Welcome To WebBGAS (samhsa.gov)

[IX] Opioids. National Association of Attorneys General. Accessed May 31, 2023. Opioids – National Association of Attorneys General (naag.org)

[X] If the private entity/foundation is a health care provider, or related to a health care provider, donations made by these entities are subject to the federal regulations at 42 CFR 433.54, 433.56 and 433.67. Additionally, if the entity/foundation is a health care provider, they may fund services through the application of a provider tax subject to the requirements at 42 CFR 433.55, 433.56, 433.68, 433.70, and 433.72.

Policies and Funding Mechanisms that Promote Braided Substance Use Disorder Funding

State agencies can pursue policy changes or adopt new funding mechanism that support their ability to braid funding. Several key funding mechanisms and practices that states commonly cite as helpful for braiding funding are Medicaid Section 1115 demonstrations, use of block grant funds, and use of legal settlements with opioid producers and distributors. States can also enter into interagency/intergovernmental agreements to support braided funding.

Medicaid Section 1115 Demonstrations

Medicaid is the largest payer of SUD treatment services in the United States,[3] significantly shaping the reimbursement and delivery of such services. However, Medicaid does not cover all the services recognized as best practices for addressing the needs of individuals with SUD.[4]

Medicaid 1115 demonstrations provide expenditure authority for services provided in IMDs, normally unallowable under other Medicaid authorities. [*] Demonstrations require states to meet milestones critical to developing and providing comprehensive care strategies, as

[*] When utilizing braiding funding, it is essential to comply with all Federal requirements, including complying and reporting on the expenditure rules of each funding source individually. States must also ensure that they comply with Federal Medicaid requirements, including Medicaid managed care requirements that capitation rates must be developed and paid distinctly for Medicaid managed care enrollees from other separate and distinct contractual requirement related to State funding or other Federal grants.

well as conduct standardized performance metric reporting and evaluation.[2,5,6] Demonstrations offer states the opportunity and flexibility to experiment with new or existing strategies for providing services for beneficiaries with SUD, such as experimentation with value-based payment systems, and development of infrastructure to increase the capacity to deliver services.[7,8]

Section 1115 demonstrations must be approved by the Centers for Medicare & Medicaid Services (CMS). If approved, the demonstrations usually last for a 5-year period with the option to renew. As of 2023, 35 states have been approved for Section 1115 Demonstrations that include waivers of the IMD payment exclusion and another five states have pending demonstrations.[9]

There are several other demonstration provisions that states use to expand select benefits or include reimbursement for activities addressing social determinants of health. Other Section 1115 demonstration opportunities include expenditure authority for transition services for certain incarcerated individuals during a pre-release period, which includes a requirement to provide among other services case management and MAT to improve health outcomes when they return to the community.[10] The Medicaid and CHIP Payment and Access Commission issued a resource guide to Medicaid reimbursement for SUD, including Section 1115 demonstrations.

Interagency/Intergovernmental Agreements

Two or more public entities at the state or local level can enter into agreements to outline the collaborative use of resources (including braiding funds). Elements of the agreements may include:[11]

- Shared definitions of services or supports.
- Detailed descriptions of what funds are to be used for each service and population; which funder is the payer of last resort; and other funding rules.
- Clear assignment of financial and reporting responsibilities.
- Data sharing and performance measurement plans.
- Decision-making and dispute resolution processes.

Interagency agreements can help clarify roles and ensure that all parties comply with the rules and regulations of the funders.

Block Grants

Block grants are allocated by formula and are designed to give state governments broader authority and fewer restrictions over federal funding. These grants shift the decision-making authority for how funds are spent to state and local governments, which can result in more effective programs that meet the unique needs of individual states.[12] All state block grant plans must be approved by a State Planning Council that includes people with lived experience and family members.

There are several ways block grants can be leveraged by states to bolster available resources for implementation and improvement of SUD treatment and prevention services.[13]

- **Flexible Allocation.** Block grants are designed to provide states and localities with the flexibility and autonomy to determine how best to allocate funds within their jurisdictions.[14] By encouraging grantees to direct funds where they determine the most need, block grants can better address acute needs within communities, including provision of services to specific populations or geographic areas.[15]
- **Incentives to Collaborate and Coordinate Resources.** Block grants provide a mechanism for leveraging resources and coordinating activities across many substance use treatment and prevention initiatives.[11] Block grants with interrelated objectives, including the SUPTRS

Block Grant,* MHBG[16] Community Services Block Grant (CSBG),[17] and Maternal and Child Health Services Block Grant (MCHBG),[18] facilitate collaboration and coordination and promote the efficient allocation of resources and the development of a continuum of care for individuals with SUD.

While the SUPTRS Block Grant directly supports states and other grantees in planning, implementing, and evaluating substance use prevention and treatment activities, the other block grants mentioned here are designed to support comprehensive community mental health services, address poverty, and promote maternal and child health. These block grants have objectives that can be furthered by the prevention and treatment of SUD.

By leveraging block grants, interested parties can better pool resources to support comprehensive substance use interventions that address social determinants of health and improve health outcomes for individuals and communities.[19]

The Department of Housing and Urban Development's Community Development Block Grant supports community and housing development for low-to-middle income individuals,[20] and has been leveraged by states to support residential and recovery housing initiatives for individuals with SUD.[21,22]

- **Supplementing State Investment.** The requirement of maintenance of effort (MOE)† for federal block grant recipients ensures that federal funds are used to supplement, rather than supplant, existing funding. Supplementation involves adding block grant funds to existing sources of funding to expand or improve upon services.[23]

  The establishment of MOE requirements is intended to ensure that states' commit to maintaining their own level of investment in substance use services and to promote consistency in funding for these services. The MOE requirements encourage states to prioritize substance use services in their budgets and ensure that state funds are being used to support the goals of the grant program, which is to improve access to substance use services.[23]

What are SUD Prevention Services?

Prevention activities and services are designed to prevent the use and misuse of alcohol, tobacco, and other drugs to prevent the onset of substance use disorders.

SUD prevention activities can include outreach, education, and screening for risk factors. SAMHSA promotes the use of several evidence-based prevention programs, practices, and policies that prevent substance use and its related harms to individuals, families, and communities.

Opioid Settlement Funds

Many states and tribes have reached settlements with opioid manufacturers, distributors, and

* SUPTRS is awarded annually to all states and territories. Funds are intended to help with the planning, implementation, and evaluation of activities that prevent and treat SUD. Grantees must develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for SUD.

† MOE is generally determined through a stated formula in grant funding. For the SUPTRS state agencies are required to maintain expenditures of state funds for authorized activities at a level no less than the average level for the preceding 2 State fiscal years (SFYs). For the MHBG state agencies are required to maintain state expenditures for community mental health services for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) at a level that is not less than the average level for the 2- year period preceding the SFYs. See SAMHSA's Primer on Maintenance of Effort Requirements.

retailers. The majority of states reached a national settlement for a total of $26 billion with major pharmaceutical opioid distributors.[24] The settlement funds provide states with a long-term and flexible source of funding and present an important opportunity to dedicate robust funding toward mitigating the opioid crisis and expanding the service capacity of substance use treatment and prevention initiatives. States and localities have significant discretion in developing individual approaches to allocation, planning, and disbursement, however, several requirements are in place to guide state planning.[25]

- **Allowable Use:** At least 70 percent of funding must be allocated toward opioid remediation activities that treat or mitigate opioid use or related disorders.
- **Advisory Committees:** An Opioid Settlement Remediation Advisory Committee must be established by each state to discuss the best use of funds toward opioid remediation efforts.
- **Distribution Timeline:** Settlement payments will be disbursed over 18 years based on a formula that considers state population, quantity of opioids delivered, and the prevalence of both individuals with SUD and overdose deaths.
- **State Division:** By default, funds will be divided into three sub-funds within each state (15 percent to a state fund controlled by state authorities, 15 percent to a subdivision fund that is controlled by participating cities and counties, and 70 percent to the abatement accounts fund that is distributed throughout the state, sometimes by a state agency or nonprofit trust).
- **Mandatory Reporting:** All expenditures unrelated to opioid remediation must be publicly reported. States have the option to publicly report all settlement expenditures.

Several states have enacted laws and devised spending plans to maximize the allocation of the settlement funds, focusing on creating advisory councils and establishing abatement funds.[26]

- Nevada's SB 390 creates the Fund for a Resilient Nevada, distributing grants to address the impact of OUD with a focus on health equity and access to programs and services.[27]
- Texas' SB 1827 establishes an opioid abatement account, trust fund, and statewide settlement agreement, with an overseeing council dedicated to funding evidence-based education and prevention efforts.[28]
- Kansas' HB 2079 forms the Kansas Fights Addiction Fund, administered by the attorney general and supported by a review board, with an annual distribution of $200,000 toward state prescription drug monitoring.[29]

Key settlement provisions discourage states from using the funds to supplant existing funding and encourage allocation toward existing initiatives, expansion of service access, and future innovation.[30] As part of the settlement, states were provided with a non-exhaustive list of suggested expenditures encouraging the diversification of allocation across a range of initiatives including increased distribution of medication for opioid use disorder (MOUD*), expansion of community naloxone training, and expansion of recovery services for individuals with co-occurring SUD and mental health conditions.[31] Additional guidance from national experts emphasizes the importance of settlement allocation on addressing the underlying determinants of substance use,[32] supporting and implementing evidence-based initiatives,[33] and increasing transparency with the public regarding allocation priorities.[34]

* Common medications for the treatment of opioid use disorder include methadone, buprenorphine, and naltrexone. The Substance Use Disorder Prevention that Promotes Recovery and Treatment (SUPPORT) Act requires state Medicaid programs to cover these three medications for opioid use disorder.

Best Practices of Braided Funding for Substance Use Disorder Services

Coordinating funds to support SUD services is a complex endeavor that demands a high level of collaboration among public and private entities. It involves managing various funding streams, understanding their unique requirements, and aligning them to achieve program objectives. The process of braiding funds does not have a one-size-fits-all solution. Instead, it relies on the availability and flexibility of funding streams specific to individual initiatives.

While methods for braiding funds vary, there are several best practices that can significantly enhance the efficacy of this funding strategy. These best practices emphasize the crucial role of strategic planning and coordination in transforming the braided funding process into an instrument of good project management.

Getting Started

For states and providers, a good place to start is with a **needs assessment**, using data to determine the prevalence of SUD, map existing providers and workforce resources, and understand service gaps. The needs assessment can help program developers identify specific objectives and evaluate the effectiveness of their efforts. For more information see the SAMHSA Behavioral Health Treatment Needs Assessment Toolkit for States.

Strategic planning plays a vital role in fund braiding by guiding the identification and selection of appropriate funding sources. This involves conducting a thorough analysis of available resources, understanding their specific requirements and restrictions, and strategically combining them to maximize impact. By aligning funding streams with program objectives, the allocated resources are utilized efficiently and effectively. Formal agreements, such as memoranda of understanding, can be used to define the sources of funding, length of commitment, restrictions on funding, and other relevant shared policies.

Identifying funding streams at the federal, state, and local levels that are consistent with the goals identified by the needs assessment is an important part of program development using braided funding.[35] **Fiscal mapping** can help program developers determine where funds originate, where they are directed to, and what services they are meant to support. This process can also be used to identify the eligible populations for the various funding streams and their requirements. A comprehensive understanding of each funding stream's capabilities and limitations is crucial for program developers. It is essential for them to have clear knowledge of what each funding source can and cannot cover, as well as the specific reporting and auditing requirements associated with each stream. This information empowers program developers to make informed decisions and effectively allocate resources within the program.

Execution

Coordination among all parties is equally critical in the success of braided funding. Regular communication and collaboration between funding agencies, service providers, community organizations, and other relevant parties ensure a shared understanding of project goals and objectives. This collaborative approach facilitates the alignment of resources, eliminates duplicative efforts, and enhances the overall impact of SUD services.

Additionally, proper **management of funding streams** is essential to optimize the braided funding process. For programs and providers, this entails establishing clear guidelines for financial accountability, tracking the allocation and utilization of funds, and implementing robust reporting mechanisms. By ensuring transparency and accountability, agencies, programs and providers can build trust and confidence among

funders and maintain the sustainability of SUD services. These practices include:

- Conduct a needs assessment.
- Identify funding streams.
- Identify eligible populations and compare requirements.
- Align funding requirements.
- Initiate system integration and tracking.
- Evaluate outcomes.
- Support braiding at the provider level.

There are situations in which funding limitations can prevent certain populations from accessing services. For example, individuals who do not qualify for Medicaid but have no means of paying for SUD services can be left without the means to access services due to restrictions on available funding. In that case, program developers can establish a well-defined **decision-making plan** to serve those populations using available funds (state and local funds, discretionary grants, etc.). This plan serves as a strategic framework for addressing potential disparities and ensures that resources are distributed fairly. By having a plan in place, program developers increase transparency and consistency in service provision.

Successful program developers possess a detailed understanding of funding stream parameters and reporting obligations, coupled with a thoughtful decision-making plan to address potential limitations. This knowledge and preparedness enable them to navigate funding complexities and deliver services in the most efficient and equitable manner possible.[36] While program developers typically cannot modify funding stream requirements, they should look for areas of flexibility and promote alignment with funders whenever possible.

Evaluation

To effectively manage the diverse reporting requirements that come with multiple funding sources, implementing an **integrated data system** becomes imperative. This system serves as a central hub for tracking service provision, maintaining documentation, and completing regular reporting on a monthly, quarterly, or annual basis. By consolidating data from various sources, the integrated system streamlines administrative processes, reduces duplication of efforts, and ensures accuracy and efficiency in reporting. The data collected within these systems can be utilized to evaluate program outcomes, providing valuable insights into the effectiveness and impact of the program.

Accountability is a crucial aspect of program management, extending beyond compliance with funding requirements. Programs succeed by demonstrating accountability, showcasing their outputs and performance measures, and illustrating the tangible impact they have on their communities and their clients. By establishing clear program objectives, defining measurable outcomes, and regularly monitoring and evaluating progress, program developers can provide evidence of their program's effectiveness and value.

State agencies can actively support braiding at the provider level. Several case studies presented in this report highlight examples of how states have leveraged state-level organizations to facilitate the braiding of funds, maximizing service provision and promoting operational efficiencies for providers. By creating a **supportive infrastructure**, state agencies enable providers to effectively utilize braided funds, enhancing the quality and reach of services provided to individuals in need.

State agencies play a vital role in supporting braiding at the provider level, fostering collaboration and efficiency to maximize service provision. By adopting these practices, programs can operate with transparency, effectiveness, and a commitment to meeting the needs of their clients.

CHAPTER 2

Case Studies

To fill in gaps in the literature on braided funding for SUD, this report uses case studies to demonstrate some of the various methods of braiding funds. The case studies reflect a diverse set of examples, in terms of geographic location and site characteristics. Some of the characteristics that determined selection were:*

- SAMHSA region
- State Medicaid expansion status
- State Medicaid Demonstrations and state plan amendments (with the exception of New York, which has a pending application, all case study states have approved 1115 SUD demonstrations.
- Percentage of state population living in urban areas, 2010 (a proxy measure for rurality)
- Substance use disorder in the past year: among people aged 18 or older†
- Type of program

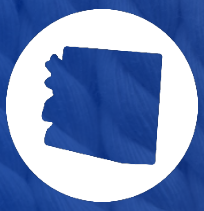
These case studies are informed by discussions with knowledgeable individuals from the funded programs (see Appendix A for a list of case study contributors), and the review of relevant program documents and web pages obtained through a search of the internet. Wherever possible, discussions were conducted with multiple interested parties to understand the use of braided funding from different perspectives. All case studies were reviewed and approved by the contributors.

Table 2. Case Study Site Characteristics

SAMHSA Region	State	Focus	Program Examined	Medicaid Expansion State?	Level Braiding Occurs
2	New York	Harm reduction	Drug User Health Hubs	Yes	Provider
3	Maryland	Treatment	Opioid Treatment Provider	Yes	State
5	Ohio	Recovery	Family-based Recovery Housing	Yes	Local and Provider
5	Michigan	Treatment	Pre-Paid Inpatient Health Plans	Yes	Regional
6	New Mexico	Treatment	Behavioral Health Collaborative	Yes	State
7	Kansas	Treatment	Administrative Service Organization	No	State and Provider
9	Nevada	Prevention/ Treatment	Sober Moms and Healthy Babies	Yes	State
9	Arizona	Treatment	Residential Treatment Programming	Yes	State and Provider

* We also made numerous efforts to include tribal nations and U.S. territories in our case studies but were unable to successfully connect with sites that could collaborate within the specified timeframe.

† Obtained from the 2018-2019 National Surveys on Drug Use and Health (model-based estimated totals, in thousands, from 50 States and the District of Columbia).



CASE STUDY

Arizona: Residential Treatment Centers

Arizona's statewide system of community-based residential treatment programs support individuals with SUD using a diverse array of alternatives to inpatient treatment, from short-term crisis programs lasting 1-14 days, to intensive support and full-day treatment lasting up to 2 years.[37]

Residential treatment is typically financed through braided funding from several sources, including private insurance, Medicaid, SAMHSA block grants, and state general funds.

Key Facts

In Arizona:

- ★ 44,000 adults receive some form of SUD treatment each year
- ★ $16 million in state funding and $1.1 billion in federal funding was allocated for SUD treatment and prevention for 2021-2023

Where Braiding for SUD Occurs:

- ★ Managed Care Organizations
- ★ Regional Behavioral Health Authorities
- ★ Providers

Braided SUD Funds Include:

- $ Insurance
- $ SAMHSA funding
- $ State funding
- $ Local funding

How Braided Funding Works

Arizona's Medicaid agency, **Arizona Health Care Cost Containment System (AHCCCS) administers Medicaid** and works in partnership with seven MCOs that manage contracts with a network of providers. AHCCCS also oversees Arizona's three AHCCCS Complete Care Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs), which help provide many additional services for the underinsured and uninsured.*

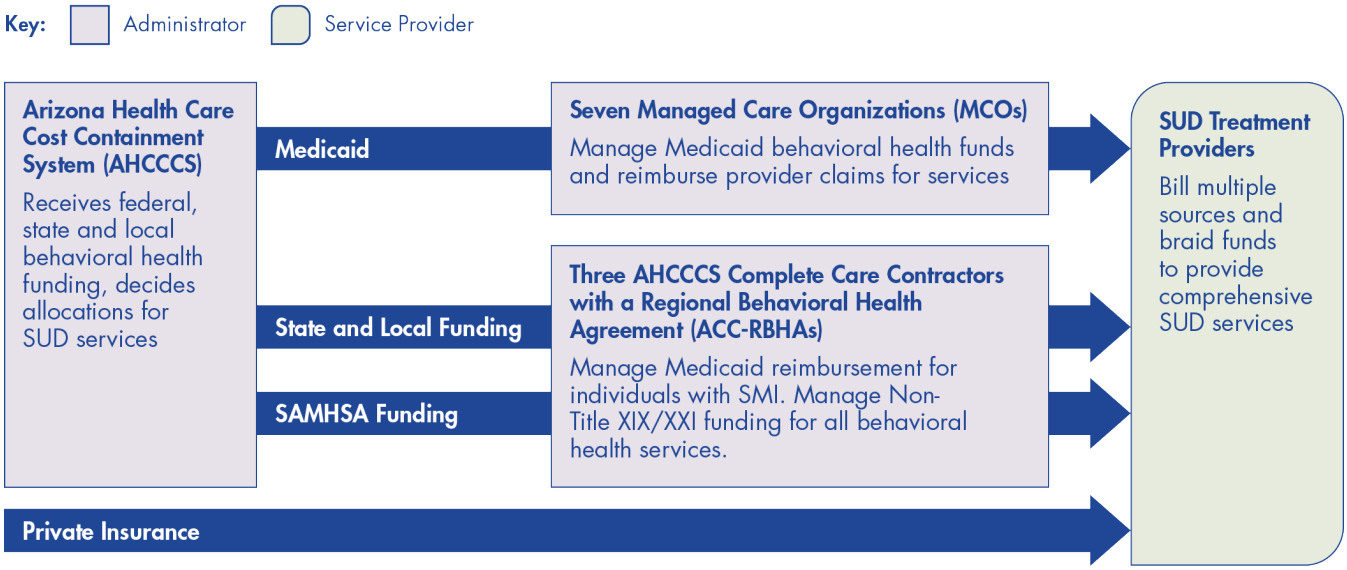
Residential treatment providers submit bills to their MCOs and/or ACC-RBHAs depending on the service type, patient population, and insurance status. Providers braid the funding types as they bill for services for each individual. For example, a treatment center may use Medicaid to pay for a Medicaid-eligible patient's therapies and medication, and block grant funds to pay for their room/board, which is not covered under Medicaid. In doing so, they submit bills to an MCO as well as to an ACC-RBHA.

Residential treatment centers commonly braid funding to cover services for individuals with publicly funded health insurance and those who are underinsured or uninsured. The AHCCCS Medical Policy Manual defines the covered services.† SUD services for the uninsured and

* ACC-RBHAs are health plans that utilize non-Title XIX/XXI funding, including but not limited to State General Fund monies, County and Local funds, Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, Mental Health Block Grant (MHBG), and discretionary grants.

† The Medical Policy Manual is applicable to both Managed Care and Fee-for-Service members.

Flow of Funding: Arizona Case Study



underinsured are typically funded by the SUPTRS Block Grant.[38]

Infrastructure projects, such as building or renovating a treatment center may be funded by certain federal one-time discretionary grants such as the COVID-19 Relief Funds.

State Structure and Policy Landscape

Arizona has an 1115 Medicaid demonstration that allows providers to be reimbursed for both outpatient and residential SUD services in certain circumstances. Medicaid Managed Care Coverage for SUD is carved in (the SUD benefits are an included benefit in the comprehensive MCO contracts).

The state's Medicaid program is divided into three geographic service areas; Northern Arizona, Central Arizona, and Southern Arizona. There are seven MCOs and each may cover no more than two geographic service areas. Each ACC-RBHA covers a single area.

AHCCCS pays the MCOs a per-member per-month capitation rate for those eligible for Medicaid. The MCOs negotiate these rates based on several variables, including costs, past experience, and projected expenditures.

Individual providers can negotiate service rates with MCOs, which may be based on population served and location (e.g., rural providers might negotiate a higher rate for a particular service that they provide much less frequently than urban providers).

Tribal Agreements

Arizona has 22 federally and state-recognized tribes.[39] Five of these tribes have established intergovernmental agreements with AHCCCS that allows them to directly apply for and leverage Medicaid and grant funding for their members.

Arizona has an American Indian Health Plan that Medicaid-eligible people identifying as American Indian or Alaska Native can apply for regardless of tribal affiliation. They also have a Tribal Arizona Long Term Care System (ALTCS) program* for

* The Tribal ALTCS Program provides Medicaid services to elderly and/or physically disabled American Indians who are determined eligible for ALTCS (they meet Medicaid medical and financial requirements, and they lived on a reservation prior to admission at an off-reservation facility).

tribal members. The health plans bill AHCCCS on a fee-for-service basis.*

Braiding Challenges

All major grants used to support Arizona's Medicaid SUD programs typically require that they are the payer of last resort. Arizona adopts a targeted approach by assigning specific groups and activities to each grant. This strategy helps minimize any ambiguity for providers. However, even when the appropriate funding source is evident for each patient, **the practice of braiding funds can present additional administrative complexities for providers,** as they are tasked with tracking which funding source corresponds to each client.

Braiding Advantages

Braided funding has helped treatment centers expand the range of services that they provide to clients. In Arizona, those services are especially important for people with SUD who are pregnant and/or parenting and need support for their growing family.

Because multiple Arizona governmental agencies have an interest in maintaining and strengthening Arizona families, intergovernmental agreements have been developed to coordinate the funding. As a result, **treatment centers in Arizona can seamlessly collaborate with multiple state agencies, facilitating the provision of a comprehensive continuum of care** for women in residential treatment who have children. For example, while a woman is in residential treatment, she is also eligible to obtain family preservation and counseling services, some of which may be funded by state general funds or federal maternal and child health grants.

Data Collection

AHCCCS requires MCOs and ACC-RBHAs to collect and submit data deliverables to be reported to each funding source. This includes encounter/claims data and demographic data. The claims data helps the state make determinations about how to use remaining funds.

The AHCCCS presents data from the MCOs and ACC-RBHAs to legislators, the Governor, and other state partners and reports to federal funders such as SAMHSA (e.g., block grant data requirements).

Lessons Learned

The Arizona AHCCCS staff noted the time and resources it took to build a system in which multiple state agencies with different funders and different priorities can come together to promote the health and well-being of families in Arizona. They advise other states to invest in planning and to design a system that has clear funding and management channels. **They recommend bringing in all partners who can contribute, whether they have dedicated SUD treatment funding or not.** Inclusion in the planning process should be based on what the partner can provide toward the goals of the project. Good planning can help states avoid funding the same services multiple times in multiple places, omitting funding for a particular population, or having other negative unintended consequences.

AHCCCS emphasized the role and importance of building competition into the MCO model. Since selecting the seven MCOs in 2018, none of the original MCOs have left the program, though some have experienced mergers or have changed focus. While Arizona may have more MCOs than many other states, they believe a larger number of MCOs helps reduce cost and encourage innovation.

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* See Arizona fee schedules here. Fee-for-service payments established by the state through the state plan must be comprehensive and states and providers must maintain service documentation sufficient to satisfy audits. The Medicaid program is jointly funded by states and the federal government and states must provide the non-federal share of associated Medicaid payments through permissible sources authorized by statute.

CASE STUDY

Kansas: Braided Funding via an Administrative Services Organization

In 2007, **Kansas' administrative services organization (ASO)** was created to manage federal, state, and local funding for SUD treatment services aimed at uninsured individuals. (An ASO provides administrative support and helps manage health claims.) Initially, the ASO administered Medicaid behavioral health services. In 2013, however, Kansas began a significant redesign of its Medicaid system and Medicaid was no longer administered by the ASO but through Medicaid MCOs instead. Behavioral health services went from "carved out" to "carved in." Today, the ASO oversees SUD services for uninsured individuals statewide through a contractual agreement. Notably, Kansas is not a Medicaid expansion state. The Behavioral Health Service Commission within the Kansas Department of Aging and Disability Services (KDADS) supervises the ASO contract.

Carelon Behavioral Health, the ASO contractor (previously known as Beacon Health Options), receives a monthly payment for its administrative services, which include managing funds, provider reimbursement, a hotline, utilization review, and data reporting.

Key Facts

In Kansas:

- ★ The ASO oversees $14 million in funding and a provider network of 42 behavioral health care providers (of about 200 in Kansas)
- ★ The ASO serves 14,000 Kansans annually

Where Braiding for SUD Occurs:

- ★ ASO
- ★ Providers

Braided SUD Funds Include:

- $ SAMHSA funding
- $ Federal discretionary funds
- $ State and local funding

How Braided Funding Works

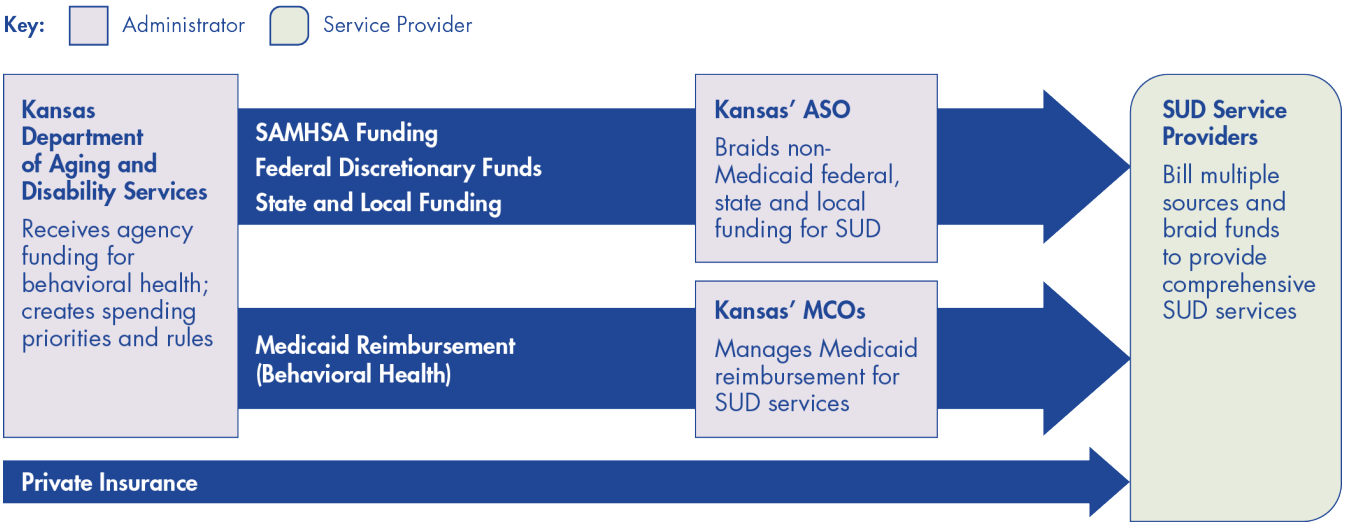
The ASO manages five funding streams (see pie chart on the following page):

1. The SUPTRS Block Grant for individuals who meet eligibility requirements
2. SOR II Grant
3. The Problem Gambling and Other Addictions Grant Fund
4. Treatment for Third and Subsequent DUI Clients fund (Senate Bill 6, funded by Kansas Department of Corrections)
5. COVID-19 Medication Assisted Treatment funds (for Naloxone kits)

The SUPTRS Block Grant provides about 67 percent of fund dollars. When available, the ASO also manages COVID-19/American Recovery Act funding, which has nearly doubled the amount of dollars for services.

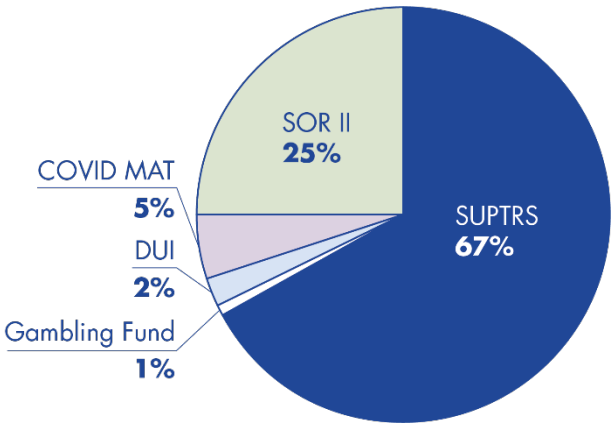
Braiding of the funds managed by the ASO is done based on eligibility and service provision rules set by the federal and state agencies providing the funds. Those rules are designed to help maximize available funding. For example, when a provider sees a patient, they will determine if the individual

Flow of Funding: Kansas Case Study



has Medicaid or commercial insurance, as these sources are to be used first to pay for eligible services. If the individual is not insured or eligible for other types of funding, Block Grant dollars can be used to pay for services. Also, if a low-income individual is insured, but cannot pay the associated co-pays or deductibles, the Block Grant can pay providers for some uncompensated care costs.

Funding Managed by Kansas' ASO, by Source, 2022



Each provider is given an annual allocation of funds by the ASO based on their utilization in prior years. Providers submit claims against their allocation to the ASO and the ASO reviews them for eligibility and matches the service claims with available funds. Allocations can be re-allocated among providers during a fiscal year based on utilization and billing.

Braiding Challenges

There are two major braiding implementation challenges identified in Kansas:

- **Providers do not have real-time information about funding source availability**. Timely and accurate funding information is an ongoing challenge. Provider errors in billing due to inaccurate or unavailable information can lead to a disruption of reimbursement from the ASO. The ASO's Provider Relations Director will provide year-to-date contract funding data upon a provider's request.
- **Providers may not know if their clients are insured by Medicaid or commercial insurance.** Sometimes a patient may not realize they are eligible for insurance, or already have insurance coverage. There is no electronic verification system that providers can use to determine insurance status or eligibility. The ASO has asked the state to provide Medicaid eligibility files for this purpose, but **confidentiality concerns have to-date**

prohibited the sharing of this information. It can take up to 90 days after a claim is submitted to determine if a person is insured by Medicaid, requiring adjustments to the claim.

Braided Advantages

The state authorities, providers, and the ASO identified several major advantages to their method of braiding funding:

- **Braiding maximizes available funding for SUD services in Kansas.** The ASO sets rules for billing and monitors expenditures to ensure all available funding for SUD services is used. Through their partnership with the ASO, Kansas state authorities ensure fiscal responsibility by leveraging federal resources and diversifying funding. When federal funds are maximized, providers working with the ASO can provide more services to those who would not otherwise be able to afford them.
- **Barriers to service are reduced as individuals have more services available to them.** Braided funding facilitates patient engagement, enrollment, and access to a wide range of services. For instance, if an individual seeks help for problem gambling, a network provider can concurrently treat an alcohol use disorder if funds for that service are available.
- **The system reduces costs for providers** as they do not have to produce separate claims for separate funds. All claims go through the ASO. The use of **a centralized authority** that determines the best funding source using criteria set by funding agencies makes the process easier for the state and providers. The system allows for **quick payments** to providers.
- The provider network ensures **statewide availability and accessibility** to a continuum of care for those seeking services. There is uniformity in terms of payment and service availability. Different funding populations are not subject to different service availability.
- **The system provides detailed data** for gap analyses, which can be used to encourage increased funding where it is needed most.

Lessons Learned

KDADS believes that using an ASO for the management of non-Medicaid SUD funds has worked well in Kansas, although no formal evaluation of the process has been completed. Lessons learned include:

- **Communication between all parties is critical.** While the ASO contracts with the network, it is important that the state monitors and maintains communications with providers.
- **Because new funding is often segregated into different pots, braiding provides a mechanism to coordinate funding for providers and clients efficiently and in a timely, accessible manner.** When SOR II grant funds became available, KDADS learned that it was much easier to add these grant funds to those managed by the ASO rather than to try to manage sub-grantee providers themselves.

CASE STUDY

Maryland: Opioid Treatment Provider

Maryland's Recovery Enhanced by Access to Comprehensive Healthcare (REACH) is a comprehensive, outpatient, substance use recovery provider. Services include standard outpatient treatment as well as MOUD. REACH offers a comprehensive range of services supported by grant funding, including employment counseling, HIV testing, and Hepatitis C treatment.

For patients who are insured by Medicaid (about 70% of patients) and are receiving treatment for opioid use, REACH also provides Medicaid Health Home services, such as case management and care coordination.[40]

How Braided Funding Works

REACH receives funding from several sources:

- Commercial insurance
- Medicaid and Medicare
- Maryland Workforce Development Grant
- Opioid Use Disorder Medical Patient Engagement, Enrollment in Treatment, and Transitional Supports (OUD MEETS) Grant
- Medication-Assisted Treatment Grant*
- HIV SAMHSA Grant
- Baltimore City Health Department Grant

If a patient has Medicaid and participates in Health Home services,† REACH gets paid a per-member per-month rate for Health Home services. Other services are paid on a fee-for-service arrangement.

Maryland uses a single ASO to manage its Medicaid and some of the other federal and state behavioral health funding. The ASO braids some of the funding before it reaches the OUD provider. This simplifies billing, especially for uninsured individuals. REACH services for uninsured clients

Key Facts

Maryland's REACH:

★ Is an Opioid Treatment Program (OTP) hub in Baltimore, MD, and functions as a health home for eligible patients

★ Serves about 1,600 patients each year, employs 48 staff, and hosts 25-30 nursing interns and 2-5 medical school fellows

Where Braiding Occurs:

★ Treatment Programs

★ ASO

Braided SUD Funds Include:

$ Insurance

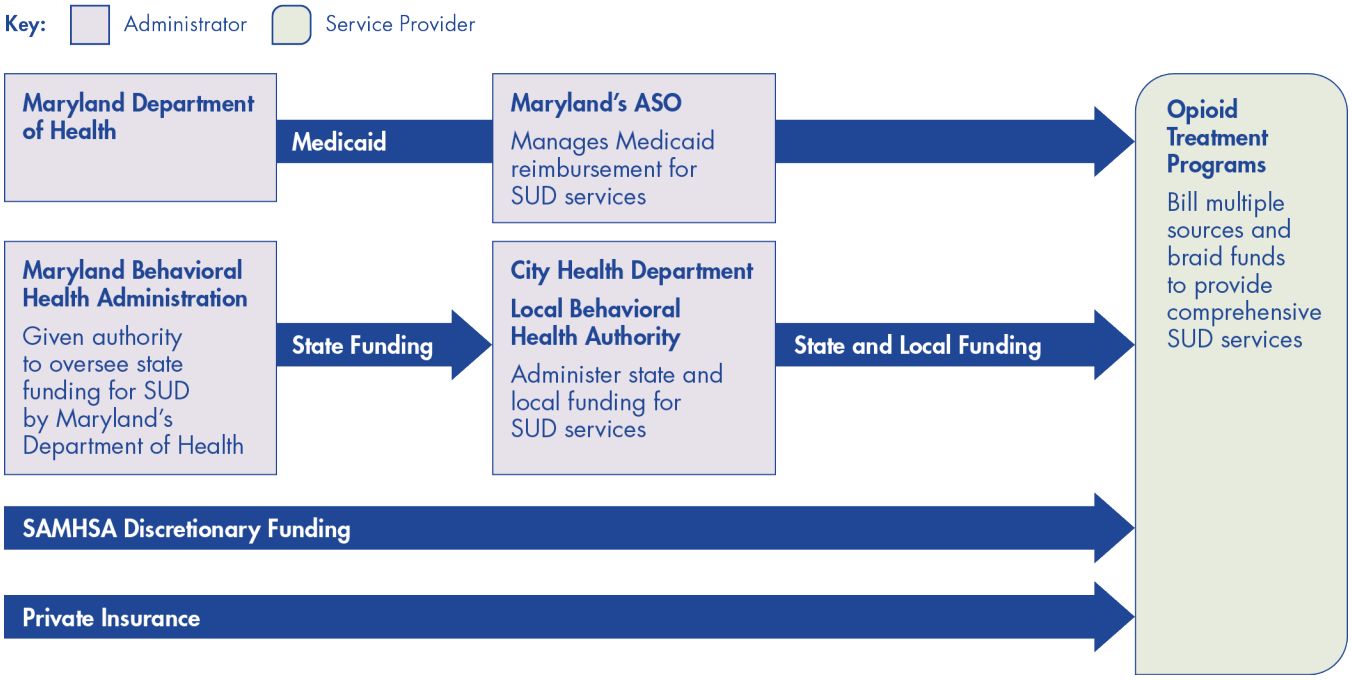
$ SAMHSA Funds

$ State and Local Funds

* Grant available from National Institute for Health (NIH), John Hopkins Team holds the grant and REACH is a subcontractor.

† Medicaid offers an optional State Plan benefit to establish Health Homes to coordinate care for Medicaid clients who have chronic conditions. Providers are expected to operate under a "whole person" philosophy, coordinating all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Flow of Funding: Maryland Case Study



can be billed to the ASO as an "uninsured status" for up to 3 months. Almost all uninsured individuals can eventually qualify for Medicaid. The ASO's provider manual contains a detailed flow chart of the financing mechanism for behavioral health care in Maryland (see page 4 of the provider manual).

While REACH provides comprehensive services to individuals with SUD, not all services are covered by Medicaid or private insurance. Grant funding is braided into the funding model to support staff and pay for the additional services.

For example, if an individual with an OUD seeks treatment but lacks funds for a private insurance copay or does not have transportation, REACH's grant funding comes into play, arranging transportation services or providing a sliding copay scale based on the patient's financial situation. Meanwhile, the private insurance continues to cover the costs of the treatment services itself.

REACH also uses a grant from their local behavioral health authority to pay for physicians and nurses to deliver MOUD to patients who arrive at a hospital in need of sub-acute rehabilitation. They may be started on buprenorphine for example, and when their condition improves, they can be referred to one of the community primary care clinics where opioid treatment is offered. REACH is the hub and clinics are spokes in the hub-and-spoke model implemented in Baltimore.[41]

State Structure and Policy Landscape

In March 2023, the Opioid Operational Command Center of Maryland, responsible for supervising the distribution of opioid settlement funds, established a competitive grant program. This program is designed to provide funding opportunities to state agencies and local governments, as well as private and nonprofit community-based organizations, with the aim of supporting initiatives combating the opioid crisis. The total grant amount allocated for these initiatives amounts to a substantial $6 million.[42] REACH anticipates that a portion of these funds

will be allocated to the treatment centers, as they play a pivotal role in directly fulfilling one of the key objectives outlined in the Inter-Agency Opioid Coordination Plan: expanding access to evidence-based treatment for OUD.

According to administrative staff at REACH, the transition in Maryland from a general medical and surgical benefit structure managed by multiple MCOs to a behavioral health carve-out managed by a single ASO has streamlined the process of obtaining prior authorization. However, the ASO that assumed responsibility in 2020 has encountered challenges in ensuring prompt reimbursement and effective dispute resolution mechanisms.[43]

Braiding Advantages

REACH has effectively braided its grant funding with both public and private insurance, ensuring coverage for coordinated and comprehensive treatment services. Additionally, REACH has forged valuable partnerships with local organizations that offer in-kind services, including nursing students and doctoral fellows. This collaborative program not only contributes to educating the upcoming generation of substance use specialists but also augments the staffing capacity of their clinics.

REACH is one of the few programs in Maryland that offers Medicaid Health Home Services.* Although other centers are eligible to provide these services, a significant number of them choose not to do so. REACH's ability to provide Health Home services can be attributed, in part, to its dedicated staff who adhere to a comprehensive model of care. Furthermore, REACH has successfully leveraged grant funding to support their work and fill any gaps in funding for those who receive Medicaid Health Home Services.

Braiding Challenges

When providers have multiple funders, the administrative burden tends to increase significantly. **The reporting requirements, approvals, and audits associated with each funder consume valuable staff time.**

Effective January 2020, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act allowed Medicare to reimburse OUD services, based on a bundled rate, furnished by an opioid treatment plan (OTP).[44,45] The additional funding brought significant benefits to providers like REACH, but it also entailed increased federal oversight. Recently, REACH underwent a Medicare audit that necessitated the provision of initial assessment documents for all 100 of its existing patients, including assessments that were conducted as far back as 25 years ago. Undertaking such a colossal task posed a considerable challenge for the organization.

The most prominent hurdle in braiding funding for REACH lies in the regulatory and administrative limitations imposed on public and private insurance funds. The process of braiding is typically more straightforward when it involves grant funding, as grants offer greater flexibility in terms of their utilization.

Data Collection

Maryland's ASO requires providers to collect and submit the data deliverables required for each funding source. Claims data, including demographic information, type and duration of service, location of service, and diagnoses, provide the ASO and the state with information that is used to manage the overall system of care as well as to plan for future service needs.

* Medicaid Health Home Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services.

Lessons Learned

REACH staff report that there has been a slight decrease in the demand for their services in recent years compared to the pre-COVID years. This decline can be attributed to the emergence of additional treatment centers. REACH actively collaborates with local hospitals and correctional facilities to obtain referrals for individuals who require assistance and support in their journey toward recovery.

Linking REACH's OTP program with the Medicaid Health Home optional benefit, in which braided funding is used to coordinate services between OTP and general health care, has allowed OTPs to offer patients a broader scope of services and made their program more attractive to their clientele. The OTP provides medical case management, transportation, and coordination with primary care, all braided from a variety of funds, while Medicaid allows for direct provision of SUD treatment, MOUD, and other health care services.

Reengaging patients in counseling and other recovery services has proven to be a significant challenge following the temporary suspension of these services during the pandemic. Additionally, REACH has made concerted efforts to provide support to staff members who continued working in the office throughout the pandemic and Medicaid reimbursement has allowed for this. In a positive development, Maryland's Medicaid program recently increased reimbursement rates by 7.5 percent, and REACH has therefore been able to increase staff salaries. This is especially helpful given the ongoing importance of addressing post-COVID burnout and fatigue.

CASE STUDY

Michigan: Prepaid Inpatient Health Plans

The Michigan Department of Health and Human Services (DHHS) delegates management of SUD funding to 10 regional **Prepaid Inpatient Health Plans (PIHPs)**. PIHPs are a type of managed care plan responsible for overseeing and managing a limited benefit package, such as behavioral health and SUD treatment services.* The PIHPs serve all 83 counties and work with 46 Mental Health Service Programs and other providers.

The State utilizes the PIHPs to provide behavioral health coverage to Medicaid enrollees through a risk-based arrangement whereby the PIHPs receive a per-member per-month capitation rate. Additionally, Michigan has delegated authority to the PIHPs to manage SAMSHA mental health and substance use block grants, certain federal discretionary grants, and state funding sources - such as the state liquor tax, opioid grant, and general funds, though this effort is separate and distinct from Medicaid.†

How Braided Funding Works

Braiding of SUD funds can occur at either the PIHP level, the provider level, or both, depending on the requirements of the funder.

When utilizing braided funding, it is essential to comply with and report on the expenditure rules of each funding source individually. The PIHPs keep track of the different funds allocated to their region and are responsible for reporting requirements. The PIHPs have statements of work with providers that describe in detail what services are reimbursable and how to bill for them. Providers bill for services allowable under their contract using a claims management system.

Key Facts

In Michigan:

- ★ Funding for SUD services in 2022 totaled $48 million in general funding and $170 million in federal funding
- ★ The PIHPs manage nearly all the SUD funding, including a Medicaid carve-out for SUD and MH services

Where Braiding Occurs:

- ★ PIHPs
- ★ Providers

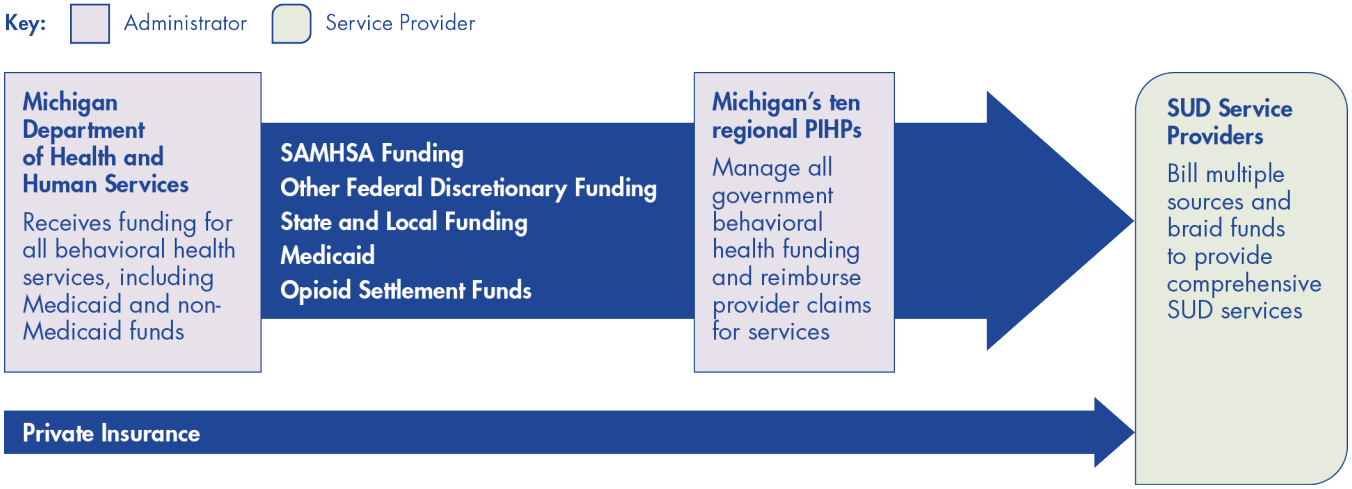
Braided SUD Funds Include:

- $ Insurance
- $ SAMHSA Funding
- $ Federal Discretionary Funding
- $ State Funding
- $ Opioid Pharmaceutical Settlement Funds

* PIHPs: the term is defined in federal regulations from the Centers for Medicare & Medicaid Services. PIHPs: 1) manage behavioral health services for enrollees under contract with the state Medicaid agency on the basis of prepaid capitation payments; 2) have responsibility for arranging inpatient hospital care; and 3) do not have a comprehensive risk contract. Effective January 1, 2014, Michigan has 10 PIHPs, responsible for managing the Medicaid resources for behavioral health and intellectual/developmental disabilities services for Medicaid and Healthy Michigan enrollees.

† Most non-Medicaid allocations to the PIHPs are determined by a formula based on population, poverty rates, insured/uninsured rates, and unemployment rates.

Flow of Funding: Michigan Case Study



This system, in conjunction with contract billing specifications and provider trainings, ensures a shared understanding and adherence to the requirements associated with each funding type. By utilizing this comprehensive framework, all parties involved can maintain compliance with specific obligations and guidelines for each type of funding.

With braided funding, treatment programs or health homes* may use several funding types to serve the needs of their patients. Medicaid can be used to reimburse providers on a fee-for-service basis for approved services like medication, counseling, and SUD treatments. More flexible block grants and general funds can be used to support things like prevention staff and recovery housing. Payment arrangements vary for non-Medicaid sources. Recovery housing programs not covered by Medicaid may receive a per diem for each eligible client they serve.

Much of the braiding is done at the PIHP level, which has the dual benefit of reducing the administrative burden on providers and giving the PIHP more flexibility to responsively address and redirect allocations. Because the state and federal grants are smaller, time limited, and often more flexible, PIHPs must work with providers to strategically spend them down. For example, after exhausting SAMHSA block grant funding for a particular service, the PIHP may begin using another funding source. The provider may not need to know about the switch in how their services are reimbursed, if there is enough detail in the billing codes to meet any reporting criteria set by the funders.

The PIHPs have the ultimate responsibility for meeting the specific requirements for the funding source, but they also require cooperation from providers. For example, SOR Grant funds can only be used for treatment of individuals with a stimulant or OUD. PIHPs must train providers about the requirements for SOR billing so that the claims substantiate the specific use disorder. Regardless of whether the funding comes through the PIHP or directly from a discretionary grant,

* Michigan's Opioid Health Homes provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder.

providers must adhere to the grant's requirements for expenditures and data reporting.*

State Structure and Policy Landscape

PIHP Evolution

The regional nature of the PIHPs allows them to have a more intimate knowledge of the needs in their communities and ability to respond to those needs. There have been some adjustments to the number and size of the PIHPs to find a good balance between efficiency and responsiveness. In 2012, the Michigan legislature voted to reduce the number of existing PIHPs from 18 to 10, making the system more efficient, and better organized under 10 regional entities located across Michigan. The reorganization was finalized in 2014.

The SUD directors of the PIHPs work closely together and meet monthly. There is a culture of collaboration and sharing best practices, including practices around braided funding. The state has benefited from the sharing of innovations occurring across the regions, and the willingness of PIHPs to help one another improve. For example, the directors are implementing a statewide monitoring reciprocity tool, to simplify monitoring of patients who live in one PIHP area but use services in another area.

Medicaid Changes

In 2014, Michigan expanded Medicaid through an 1115 Demonstration.[46] After expansion, more people had access to SUD treatment benefits through Medicaid, which freed up federal block grant funds to provide additional substance use services. As a result of the demonstration's expansion of access to Medicaid benefits, Michigan was able to increase the total number of adults receiving SUD care by 14 percent. Residential admissions for SUD treatment increased nearly 40 percent.[47] Additionally, the state entered into a SUD 1115 demonstration program in 2019 to improve access to SUD treatment across the continuum of care.

In 2022, Michigan's Department of HHS reorganized, moving the state's Medicaid Authority and behavioral health departments into the Behavioral and Physical Health and Aging Services Administration. The SUD and gambling disorder programs were moved to the Bureau of Health and Wellness under the Division of Chronic Disease within the Public Health Administration. The reorganization was designed to improve efficiency, responsiveness, and coordination between programs.[48]

Braiding Challenges

Braiding funds with Medicaid dollars can be challenging because Medicaid has a retroactive eligibility period, paying for certain services up to 6 months prior to the month of initial application. **The retroactive Medicaid payments can impact allocations from other funding sources and make it difficult to have accurate real-time accounting of spending.**

Braiding Advantages

By braiding funding, PIHPs and providers can utilize more funding streams simultaneously and fund a broader set of activities within a single program.

The infrastructure in Michigan may also allow them to easily braid additional funding sources as they become available. Michigan recently received its opioid settlement funds and has set statewide priorities for spending that include improvements in treatment capacity.[49] Local governments may apply for additional funding to address specific challenges or special circumstances that are not captured by the formula used to calculate

* Michigan's health department allocates certain funds, such as targeted discretionary grant funding, to specific regions based on the focus and requirements of the funding. For example, department staff may write an application for a grant that is specific to needs assessments and gaps in services in an identified region. When awarded, the funding would be specifically allocated to the identified region and managed according to the rules of the grant.

allocations.[50] PIHP directors are reaching out to their municipalities to see if they have received additional funding and want help managing the funds.

Data Collection

All providers and prevention programs must submit outcomes and service data to the PIHPs. PIHPs use this data to monitor program activities, outcomes, and ongoing funding decisions.

States with Medicaid managed care delivery systems are required to assess their managed care entities' performance annually and PIHPs must also submit data to the state authorities on their performance. All PIHPs are evaluated on quality, timeliness, and accessibility of the care and services they provide to Medicaid recipients.[51]

Lessons Learned

PIHP directors are generally pleased with Michigan's system, especially the support they get from other PIHPs and from their state behavioral health agency. Directors note that braiding funding would be a simpler process if funding sources had fewer restrictions and funding levels were more predictable from year to year.

CASE STUDY

Nevada: Sober Moms and Healthy Babies

Nevada's Sober Moms and Healthy Babies program is a collaborative effort between the Bureau of Child, Family, and Community Wellness and the Bureau of Health, Wellness and Prevention, which are both within the Division of Public and Behavioral Health under the Nevada Department of Health and Social Services. The program was initiated in response to the 2014 National Governors Association meeting on Para-natal Health Initiatives, which prompted the formation of a collaborative perinatal substance use workgroup, which evolved into the Nevada Perinatal Health Initiative, a multidisciplinary workgroup aimed at improving health outcomes for pregnant individuals impacted by substance use.

The workgroup took a public health approach and created a website in 2015 presenting substance use prevention and treatment information. In 2019, the workgroup made significant improvements to the website by adding a feature that enables users to search for local providers and treatment centers directly on the website. In 2019, the workgroup developed a Screening, Brief Intervention, and Referral to Treatment (SBIRT)[52] reference guide for providers specifically aimed at pregnant individuals with substance use issues. In 2022, the state required annual SBIRT training for osteopaths, physician assistants, and nurse practitioners.

The Maternal Opioid Treatment, Health, and Recovery (MOTHER) program was initiated in 2022 at the High-Risk Pregnancy Center in Las Vegas. The program combines MOUD with specialized maternal-fetal medicine (MFM) to offer a range of services, including:

- Psychiatry
- Buprenorphine and Naltrexone
- Counseling
- Peer support
- Advanced MFM care

To ensure that all mothers can access these services, SUPTRS Block Grant funds ($320,000) are used for uninsured mothers and to provide services not covered by Medicaid or private insurance. The MOTHER Project served 15 patients in the initial start-up year of 2022.

How Braided Funding Works

Funding is derived from two braided sources: the Title V Maternal and Child Health Block Grant and the SUPTRS Block Grant. These funds are allocated to project activities in the following manner:

- Initial website creation ($120,000)
- Provider referral website enhancement ($15,000)

Key Facts

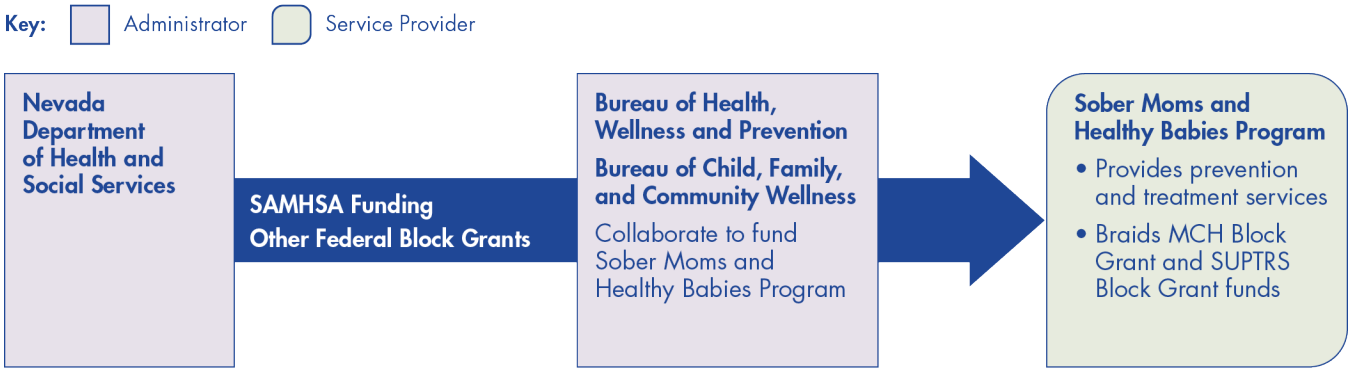
Nevada's Sober Moms and Healthy Babies Program used braided funds for website expansion, public service announcements (PSAs), SBIRT training, and substance use treatment services at a Las Vegas health center.

Braided SUD Funds Include:

$ SAMHSA Funds

$ Other Federal Block Grant Funds

Flow of Funding: Nevada Case Study



- Bilingual radio and television advertisements ($60,000)
- Special messaging and print materials ($30,000)
- Website hosting and maintenance ($3,600)

In 2022, there were 13,429 television and radio spots promoting the Sober Moms and Healthy Babies website. That year, the website had 3,109 total sessions with 2,577 users. Of these users, 2,492 were new or first-time users. Just 28 percent of the website sessions were initiated by individuals living in Nevada. The remainder were initiated from California, Oregon, and Virginia.

Braiding Challenges

Braiding funding requires providers and staff to have a basic level of knowledge about funding and client eligibility. **Keeping all staff informed of the program objectives and operations is a challenge because there is high staff turnover across both participating bureaus within the Department.**

Another challenge is the development of the necessary infrastructure to accurately track services, funding, and individuals served for each funding source. Each funding source has its reporting requirements, and ensuring accuracy in reporting, particularly regarding Government Performance and Results Act (GPRA) data for the SUPTRS Block Grant, can prove difficult.

Braided Advantages

Braiding funds to support shared public health and substance use prevention and treatment goals led to several organizational benefits and **stronger collaboration** between two distinct areas of the Department of Health and Social Services. The partnership resulted in new activities such as the launch of the MOTHER Project. The joint efforts of the Sober Moms and Healthy Babies programs enhanced communication and participation among various providers of substance use treatment, child welfare, and maternal medicine.

Lessons Learned

Significant staff turnover throughout the lifecycle of the program was a challenge to sustaining the level of collaboration required to braid funding. Overcoming staffing issues takes time and patience from the collaborating sections of the Nevada Division of Public and Behavioral Health.

Braiding funds to support the Sober Moms and Healthy Babies initiative enabled the program to evolve beyond the original scope. Braided funds now support the prevention of opioid use and the MOTHER Project.

Finally, establishing distinct reporting methods up-front is critical to adhering to the different funding and tracking requirements across funding sources.

CASE STUDY

New Mexico: Behavioral Health Collaborative

New Mexico's Behavioral Health Collaborative is a state-sponsored entity composed of representatives from 17 agencies and the Governor's office for the purpose of managing nearly all the state's non-Medicaid behavioral health funding (from SAMHSA, other federal block grants, state funds, and any other local or county funding that comes through the agencies). New Mexico's Behavioral Health Collaborative (Collaborative) develops expenditure rules to help braid funding and maximize federal grant dollars before spending state general funds.[53]

How Braided Funding Works

The Collaborative agencies individually apply for and receive behavioral health funds from state or federal sources for a specific behavioral health program, intervention, population, or support service. The agencies then pool their funds and collectively create spending priorities, keeping in mind the individual requirements of each funding source. Considerable planning is needed to braid the funds so that there is little overlap and maximum coverage for services and prevention activities.

The Collaborative partners with an ASO to distribute funds to substance use treatment programs. Providers utilize scope of work contracts with the Collaborative or an agency of the Collaborative, but the ASO manages all provider contracts and handles billing services.

The ASO reduces administrative inefficiencies and reimbursement wait time for contractors and provides technical assistance to help in the submission and adjudication of claims.

Key Facts

The New Mexico Behavioral Health Collaborative:

- ★ Pools agency funding for behavioral health (including SUD services) and establishes spending priorities and expenditure rules
- ★ Has a single statewide ASO that manages service provider contracts and billing

Where Braiding Occurs:

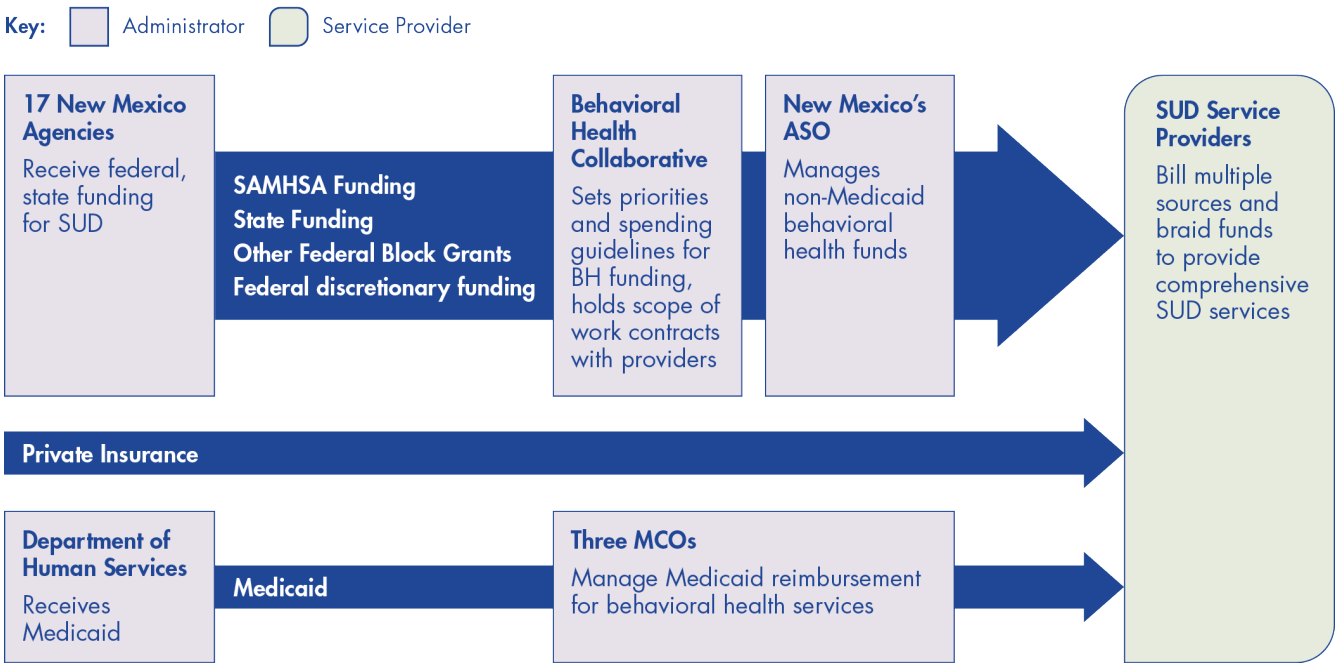
- ★ Collaborative
- ★ ASO

Braided SUD Funds Include:

- $ SAMHSA Funding
- $ Other Federal Block Grants Funds
- $ Federal one-time discretionary funding
- $ State Funding
- $ Any other agency funding for SUD

Providers treat patients with mental health or SUD needs, and they bill the ASO for services allowed in their agreement with the Collaborative member. For some services, providers can submit a bill to the ASO without needing to know which funding source is being used to pay them. They only need to provide the level of billing detail that the agency requires the ASO to collect. For other services, providers may need a more thorough knowledge of the funding source to decide which service a patient is eligible for.

Flow of Funding: New Mexico Case Study



State Structure and Policy Landscape

Medicaid

New Mexico is a Medicaid expansion state, and over one-third of New Mexico's population received Medicaid in 2021.[54] That could soon change as eligibility redeterminations for all Medicaid recipients resumed on May 11, 2023, with the end of the COVID-19 public health emergency. State health officials estimate 85,000 people will be deemed ineligible because of the reevaluations, but they estimate most of those will move to employer-sponsored medical plans or plans offered through the health exchange. About 5,000 pandemic enrollees will qualify for reduced Medicaid coverage.[55]

There are three Medicaid MCOs in the state. Medicaid policies have a large impact on the spending priorities and strategies of the Collaborative.

While the State Medicaid Agency is not a member of the Collaborative, New Mexico Medicaid and its Department of Human Services Behavioral Health Services Division work closely to ensure that Medicaid reimbursement is maximized prior to the use of other funds.

Collaborative Authority

The Collaborative voting members meet quarterly and have the authority to make decisions about policy and legislative recommendations. Agencies that participate with the ASO meet once a month to receive updates and review logistical issues.

Data Collection and Evaluation

The ASO is responsible for providing the Collaborative and state government with outcome and spending data. The Collaborative uses the data to review the status of funds throughout the year, see where they are being spent, who are the recipients of services, and where additional funds may be needed.

The ASO creates a variety of data dashboards for funders and administrative entities (SAMHSA, Centers for Disease Control and Prevention, and

the state legislature). This allows for the Collaborative to continually fine tune its spending plans. For example, if funds for a particular purpose are significantly underspent, the responsible Collaborative agency may redirect funds to another purpose.

The ASO can also implement, collect, and report on a variety of non-financial data, such as quality measures. When a specific funding source has data requirements, these are written into the provider agreements and the ASO is instructed to collect and report on these. This cumulative data set collected by the ASO provides extremely useful data to the Collaborative to manage its system of behavioral health care at the ASO, the provider, and the client level.

Braiding Advantages

Collaborative agencies braid their funds to reduce waste and increase informed decision-making and oversight of the State's behavioral health system. **When they work together, there are more opportunities to have an impact using limited resources.**

The Collaborative also partners with seven local behavioral health collaboratives, three of which are run by tribes. The Indian Affairs Department in New Mexico is a voting Collaborative member, and as such they help bring tribal needs to the attention of the Collaborative members.

Braiding Challenges

Program managers and providers that receive more than one public funding source have additional rules governing how the funds may be used.

For example, if a SUD treatment program braids two funding sources to pay for housing vouchers, its providers must understand two different sets of eligibility and reporting requirements. They may use the MHBG for individuals with a significant mental illness, while using Housing and Urban Development (HUD) funds for those who meet certain financial criteria.

New Mexico's ASO provides ongoing technical assistance to the providers to help them understand how to correctly use the resources available and bill for services.

Lessons Learned

New Mexico's Collaborative has used braided funding to build a more integrated and efficient behavioral health system. They have partnered with their ASO to manage all behavioral health billing claims, provider contractual issues, and technical assistance regarding billing. The ASO effectively gathers data so that all Collaborative agencies meet their reporting requirements for their individual funders.

CASE STUDY

New York: Medicaid Reimbursement for Drug User Health Hubs

New York's Drug User Health Hubs provide harm reduction services for individuals who inject drugs. The goal of these services is to lessen the possibility of harms from substance use such as the transmission of infectious diseases like HIV, and deaths from overdose.

The Drug User Health Hubs (referred to here as "Health Hubs") are operated by 12 (of 26) syringe exchange programs (SEPs). Health Hubs make accessible appropriate health, mental health, and medication assisted treatment services to people who use drugs. New York has been funding SEPs since 1992 in response to the HIV epidemic.

New York's 26 SEPs provide services in over 90 locations. In addition to needle exchange, SEPs provide a range of services from engagement and education on risk reduction practices to distribution of harm reduction supplies. Services also include community level interventions to promote and provide opioid overdose prevention training and anti-stigma campaigns.[56] The services offered, and funding streams received, differ by SEP.

Since 2017, the AIDS Institute* has provided funding support to SEPs to become Health Hubs. Services provided by the Health Hubs include

Key Facts

Drug User Health Hubs are a part of New York State's harm reduction services.

In 2017, a Medicaid State Plan Amendment allowed Medicaid coverage and payment of harm reduction services in New York that include a plan of care, individual and/or group counseling, psycho–educational support groups and medication management and treatment adherence counseling.

Where Braiding Occurs:

★ Health Hubs

Braided SUD Funds Include:

$ SAMHSA
$ Other Federal Block Grant
$ One-time Federal Discretionary Funds
$ State Funds
$ Opioid Pharmaceutical Settlement Funds
$ Local Funds or private foundation funds
$ Insurance (Medicaid)

* In New York, harm reduction services are administered through the AIDS Institute within the New York Department of Health. The State's Single State Agency (SSA) is the Office of Addiction Services and Supports (OASAS), which operates independently of the Department of Health and provides some funding to the AIDS Institute for harm reduction services, but whose primary focus is treatment, prevention, and recovery services.

The AIDS Institute's Office of Drug User Health oversees Drug User Health Hubs.

accessible (or low threshold) buprenorphine,* opioid overdose prevention, supportive services and counseling for individuals who have experienced an overdose, referrals from the community including law enforcement, and anti-stigma activities.

How Braided Funding Works

The provision of harm reduction services through the AIDS Institute has largely been grant-funded. The AIDS Institute started service provision with HIV-prevention funds from the Centers for Disease Control and Prevention (CDC) in 1992. Other sources of funding received to support AIDS Institute programs include various state funds, opioid litigation funds, federal COVID-19 funding, and SAMHSA State Targeted Response to the Opioid Crisis (STR) and SOR funds received through OASAS.†

Because of the federal ban on funding needle exchange, SEPs may only use state funding for the purchase of syringes. For programs designated as SEPs, the AIDS Institute determines an equitable distribution of funding across the programs through an internal review process. Programs do not need to apply for funds annually.

Braiding of funds happens at the provider level. Providers have contracts that support their services. For example, one SEP provider interviewed for this case study noted having about 20 different contracts that support their work. They have contracts with the Department of Health, the AIDS Institute Office of Drug User Health, OASAS, local governments, and private foundations. In this braiding funding process, providers must strictly adhere to funding source-specific rules in three areas:

- **The services a fund covers**: providers cannot use OASAS funds from federal agencies for syringes or certain harm reduction supplies.
- **The reporting required for each funding source:** providers use a variety of methods to complete reporting requirements. The provider interviewed for this case study noted that each person on their leadership team is responsible for reporting for 3-4 contracts. Most reporting is done monthly. Some reporting is done through systems operated by the funding source (e.g., the AIDS Institute Reporting System [AIRS]) while other sources have data tracked using spreadsheets.
- **Hiring requirements related to background checks**: some agencies (although not all) have contracts requiring that staff hired by the agency pass a background check, something that is often difficult when hiring people with lived experience who may have a criminal history. Providers must be careful to determine which sources of funds can pay for particular program staff.

State Structure and Policy Landscape

In 2018, New York received approval of a Medicaid State Plan Amendment (SPA) that allowed for Medicaid reimbursement for selected harm reduction services.[57] This added another possible funding source Health Hubs and SEPs can braid to provide services. The scope of coverage includes the following services:‡

- Development of a care plan through either an initial assessment or reassessment of client needs.

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* Accessible buprenorphine is promoted both as a means to begin a path to recovery and to prevent deaths due to a drug overdose; it is harder to overdose with buprenorphine in someone's system. It lowers barriers to receive and maintain buprenorphine access. See Lowering the Barriers to Medication Treatment for People with Opioid User Disorder for a description of the low-threshold approach.

† See 2018 AIDS Institute Funding Matrix (the latest data available on their website) for an idea of the variety of funding sources that support AIDS Institute programs.

‡ See this Guidance Document for a description of each service.

Flow of Funding: New York Case Study

- Individual and group supportive counseling.
- Medication management and treatment adherence counseling.
- Psychoeducation—support groups facilitated by a direct service provider, a case worker, or the director of harm reduction services or co-facilitated by a peer.
- Health system navigation and linkages to care.

Braiding Challenges

Braiding funding with Medicaid reimbursement for harm reduction services provides both challenges and opportunities for SEPs and Health Hubs. SEPs and Health Hubs have not rushed to take advantage of Medicaid reimbursement. In 2022, 6 of the 12 Health Hubs billed Medicaid for harm reduction services. All received reimbursement, but one agency submitted multiple claims that were denied because the claims were for services that overlapped with another funding source. Reimbursement was denied due to duplicate billing.*

Medicaid reimbursement that supplements activities of grant-funded programs in New York has presented some challenges:

- The original SPA included many educational requirements for staff who provide reimbursable services. The Office of Drug User Health submitted an amendment to the SPA, approved in April 2023that modified or lowered the provider qualifications for harm reduction services.
- Many of the services provided by harm reduction programs are provided anonymously. To bill for services, programs need information such as birth dates and Medicaid numbers. Programs that did not collect this type of information in the past may have felt that asking for information would deter their clients from receiving services.

* The Department of Health is responsible for monitoring the Medicaid program in New York. Auditing policies are included in the Medicaid programs General Policy Manual.

- Programs lacked needed infrastructure and staff for documenting services and submitting claims.
- Initially, to be reimbursed, services had to be provided on site. This was a barrier for programs that delivered services off-site in mobile vans.
- Providers find the Medicaid payment rates lower than what is optimal for them to provide services. January 2022 billing guidance shows payment rates as low as $2.52 for each 15-minute unit of group supportive counseling.[58]
- Programs were fearful that mistakes in billing would cause them to have to repay funds if they were audited.
- Programs struggled with the documentation needed to bill. For services like the development of a plan of care, programs were being asked to do something with which they were unfamiliar and needed more guidance.
- Clients did not always engage consistently with the program, so budgeting in a fee-for-service environment was problematic.

Braiding Advantages

Braiding Medicaid reimbursement has presented some advantages as well:

- Medicaid reimbursement provides an opportunity for SEPs to broaden the scope of the program services they offer to clients.
- Grant funding is often not stable and not sufficient to provide all the services needed. Medicaid reimbursement opens the door to a more stable funding source.

For providers, Medicaid reimbursement is a funding source that does not need to be applied for annually and is not associated with the anxiety and administrative burden of grant funding.

Lessons Learned

The ongoing implementation of Medicaid payment for harm reduction services in New York has yielded valuable insights, despite its limited success thus far. A significant takeaway is that the desired outcome measures requested by funders such as Medicaid do not easily align with the nature of services offered by harm reduction programs. Funders often have binary expectations regarding their funding, focusing on whether a life was saved, or an HIV infection was prevented. But harm reduction services are much more complex than that. When a person with SUD walks into a stigma-free space provided by a harm reduction program, the experience can be life changing for them, but it is simply documented as a visit. Harm reduction is not a medical service and expecting to use the same kinds of outcome measures to evaluate service provision shortchanges providers and recipients.

Helping harm reduction service providers understand the Medicaid billing model takes time. Providers who have relied on grant funding for an extended period may encounter challenges in striking the appropriate balance between grant-funded and Medicaid-reimbursable services. In cases where certain services can be covered under both funding sources, providers must make clear determinations regarding which staff members or services will be reimbursed under each, based on the funding source's requirements. The knowledge of the potential for audits and the subsequent obligation to repay funds instills a sense of caution among providers, impeding their full acceptance of Medicaid as a source of funds for the services they provide.

Medicaid-reimbursable services are a dependable source of income for providers and can alleviate some of the anxiety and heavy administrative burden associated with grant funding. Lack of experience with billing for services, however, means that they will need clearer guidance from the state on how to bill.

It is essential that Medicaid programs offer, if eligible, payment rates that adequately cover not only the cost of services, but the cost of the infrastructure and staffing needed to submit claims. Without sufficient payment rates, programs cannot take advantage of Medicaid reimbursement.

CASE STUDY

Ohio: Pearl House's Family-Based Recovery Housing and Supportive Services

Ohio's Pearl House is a family-centered recovery housing program, providing 21 two-bedroom apartments, located in downtown Lancaster, Ohio, which is about 30 minutes southeast of the state's capital, Columbus. The program is operated by Fairfield Homes, a property management company and developer for the multifamily housing industry in the State of Ohio and throughout the Midwest. The Recovery Center (TRC) provides alcohol, drug and mental health prevention, intervention, and treatment services to residents. In response to a TRC assessment, which revealed that 30 client families could benefit from family-based recovery housing, Pearl House was built in 2014.

Pearl House offers a unique housing opportunity for parents who are currently experiencing or at risk of homelessness and who have either actively participated in or successfully completed treatment for SUD.

The initial construction for Pearl House was funded by tax credits; the Ohio Housing Development Assistance Programs, which provide grants and loans for the development and preservation of affordable housing; a Federal Home Loan Bank Grant; and a HUD Project-Based Subsidy.

In addition to the core eligibility requirements of homelessness or risk of homelessness and participating in SUD treatment, eligibility is extended to parents with SUD who have custody of their children or have a reunification plan established with Child Protective Services. While there is no age restriction for children entering Pearl House, the program restricts the total number of family members to a maximum of five individuals.

Key Facts

Ohio's Pearl House Provides housing and wraparound services for parents and children.

Where Braiding Occurs:

★ Pearl House

Braided SUD Funds Include:

$ Insurance (Medicaid)

$ SAMHSA Funding

$ Other Federal Block Grants

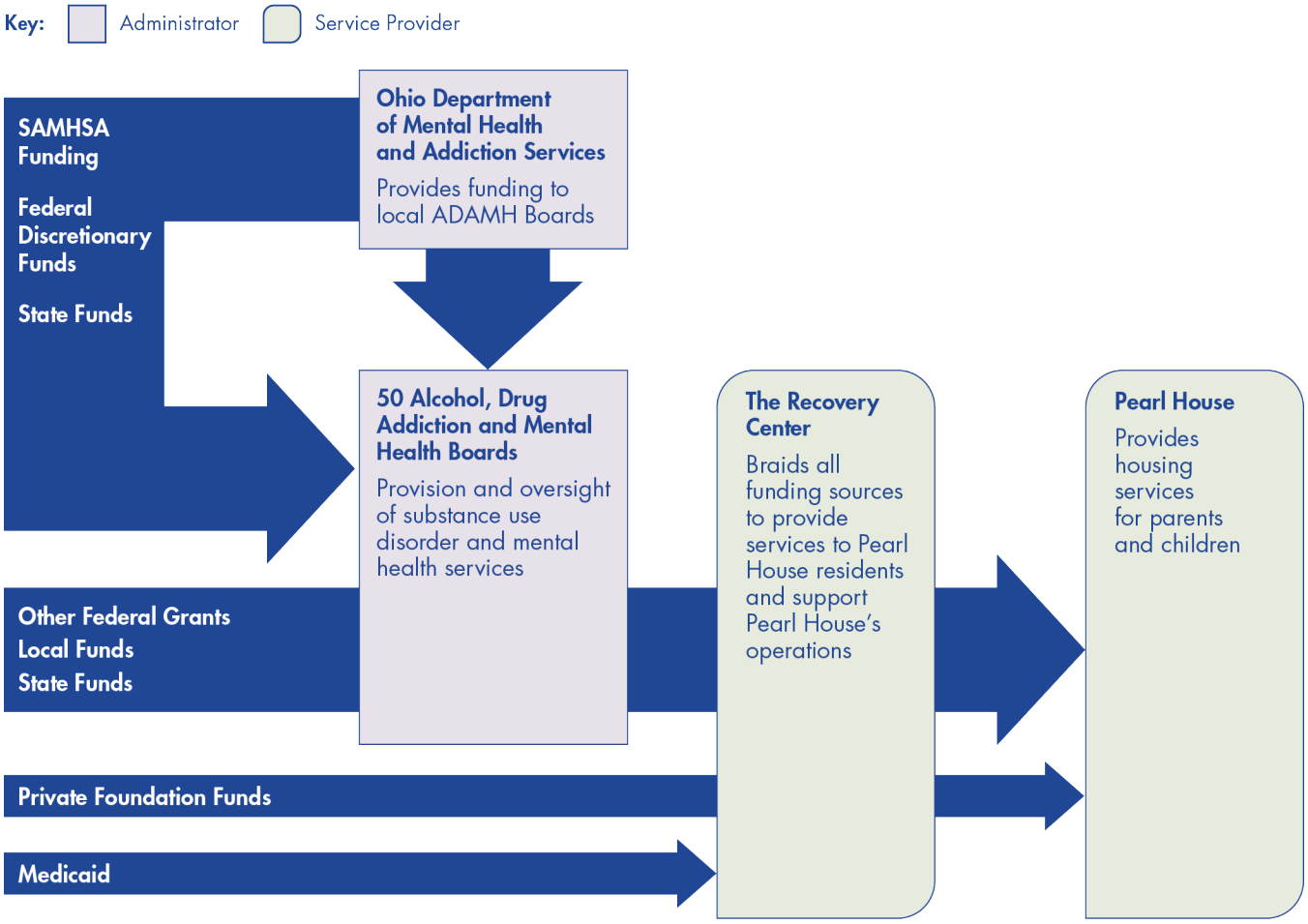
$ State Funding

$ Local Funds or private foundation funds

Pearl House and TRC are located next door to one another, reducing transportation barriers for residents commuting between these locations. Pearl House is an abstinence-based program.

Pearl House residents receive a comprehensive range of SUD and mental health services spanning the entire continuum of prevention, treatment, and recovery support. Services include individual therapy, access to MOUD (buprenorphine, buprenorphine/naloxone, and naltrexone), and group therapy. TRC also offers prevention programming for children living at Pearl House, including *Early Head Start, Head Start,* and *Reconnecting Youth,* the latter being a prevention

Flow of Funding: Ohio Case Study



program for teens that focuses on developing life skills. TRC offers extensive wraparound services for Pearl House residents, such as financial literacy education and case management. Case management services assist residents with gaining employment, initiating and completing education, accessing community resources (e.g., food, clothing, childcare, medical care), obtaining a driver's license, and securing housing after leaving Pearl House. As part of the treatment process, Pearl House residents are encouraged to gain employment, education, and training to improve their self-sufficiency.

Pearl House has several partnerships that assist with advancing its mission of providing a place for families experiencing the impacts of addiction to heal and rebuild healthy and productive lives together. These partners include Fairfield Homes, Lancaster-Fairfield Community Action Agency, Fairfield Metropolitan Housing Authority, TRC, Fairfield County Job and Family Services, and other local businesses and agencies. Daily to weekly contact is maintained with these partners to ensure prospective and current residents' needs are met. Through these partnerships, Pearl House can provide comprehensive treatment and recovery support services.

How Braided Funding Works

In Ohio, the provision and oversight of SUD and mental health services is administered by 50 local Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards, collectively responsible for all 88 counties within the state. These ADAMH Boards receive funding from the Ohio Department of Mental Health and Addiction Services (Ohio MHAS), which allocates both state and federal funds to facilitate the delivery of these vital services. Additionally, these services are often supported by a diverse array of supplementary funding sources, including local and private funding, further ensuring the availability and accessibility of comprehensive care throughout the state.

Many of the residents of Pearl House are Medicaid recipients. Recognizing the challenges of relying primarily on Medicaid reimbursement to sustain staff positions at Pearl House, TRC took proactive steps to address this issue. In 2015, TRC approached their designated board, the Fairfield County ADAMH Board, and sought financial support to bridge the gap. By braiding funding from multiple sources, TRC ensured the continued provision of essential services at Pearl House, enabling them to effectively fulfill their mission of supporting families on their journey to recovery and wellness.

Currently, Pearl House braids the following funding sources:

- Medicaid
- Local tax levy dollars
- HUD funds
- SAMHSA SOR Grant/State Opioid and Stimulant Response Grant
- State general revenue funds
- Fairfield County Overdose Response Team grants
- Private donations through Pearls of Hope (Pearl House's donation vehicle)

The Fairfield ADAMH Board provides funding for a full-time Housing Coordinator for Pearl House and assists with funding services for any residents who are not Medicaid-eligible. Rental assistance is provided through HUD project-based vouchers, which require families to contribute 30 percent of their gross income for rent and utilities. TRC's contract with the Fairfield ADAMH Board, in addition to HUD funds, and private donations support treatment and supportive services for Pearl House residents. TRC primarily utilizes a fee-for-service payment system to reimburse Pearl House's providers.

Data Collection and Evaluation

To adhere to funding requirements, Pearl House reports performance data, such as GPRA measures. Additionally, starting on July 1, 2023, Ohio agencies are required to use the Ohio Recovery Housing's outcomes tool and hold a certification.

Currently, Pearl House strives to maintain two program goals: 1) to house 85 percent of individuals with SUD who are homeless or at a high risk of homelessness in the local area, and 2) to maintain housing through the completion of the funding year for 70 percent of individuals who obtain housing. Progress toward these goals is tracked and submitted to the Fairfield ADAMH Board quarterly.

Braiding Advantages

Without multiple braided funding streams to support Pearl House's mission, residential services for families would not be possible. **Braided funding has supported several critical aspects of Pearl House's programming, including early learning and development for children, therapy for parents, basic needs for families, and tools to help families create a better life.**

Braiding Challenges

While Pearl House has achieved remarkable success through the practice of braiding funding, it has encountered notable challenges, particularly in recruiting and retaining the program's staff. **The short duration and fluctuating amounts of grants that support staff positions have made it difficult to ensure job security and offer competitive compensation.** As a result, the organization has experienced considerable turnover among various staff members, including peers, counselors, and property managers, during the past 8 years. Addressing these challenges and promoting stability of staffing levels remains an ongoing priority for Pearl House.

TRC's utilization of multiple funding sources for services provided by Pearl House also has presented notable administrative challenges. **The process of reapplying for grants, along with the need to navigate distinct timelines, diverse reporting requirements, and complying with budget specifications for different funding sources, places a substantial administrative burden on the staff.** Moreover, grants typically do not sufficiently cover the costs associated with administrative duties, such as paperwork completion and compliance with reporting obligations. Consequently, while braiding funding has enabled the continuation of Pearl House's services, it also has increased the administrative workload, further straining an already strained workforce.

Lessons Learned

The involvement of the local community and partners is key to the success of the Pearl House model. Steering committees, composed of neighbors and community business owners, work closely together with ADAMH Boards and local providers to assess community needs and plan and develop local projects.

Due to the collaborative nature of Ohio MHAS, ADAMH Boards, and local providers, steering committee members play a significant role in community planning, project funding decisions, advocacy, and political action. This collaborative model not only permits input at the local level but promotes community engagement and transparency in supporting and funding future community projects. Furthermore, these collaborative efforts can also ease the concerns of surrounding neighborhoods.

During the initial development of Pearl House and TRC, these projects faced resistance from residents and local business owners. However, following community meetings and a statement from TRC committing to improve the community, initial opponents soon saw business and community life in downtown Lancaster improve with no increase in criminal activity. With the help of a braided funding model, Pearl House has encouraged community cohesion, helped alleviate stigma, and improved community sentiment and buy-in.

Data Collection and Evaluation

- ★ 128 adults and 167 children have lived at Pearl House since it opened
- ★ 25 babies have been born with no signs of neonatal abstinence syndrome or fetal alcohol spectrum disorders
- ★ 88% of adults have been employed, enrolled in college, or other training programs while living at Pearl House
- ★ 55% of those eligible obtained a vehicle or driver's license while living at Pearl House

CHAPTER 3

Conclusion

Braided funding is a flexible approach that allows diverse funding sources to be combined strategically to initiate a more comprehensive and integrated system of care. This funding approach facilitates the collaboration and coordination of resources from multiple streams, enabling providers to offer a broader spectrum of services to individuals in need of SUD support. By coordinating the expenditure of funds from various sources, such as federal grants, state allocations, local initiatives, and private contributions, providers can enhance their capacity to address the complex needs of their clients and patients.

A wide array of braided funding models are employed in various domains of SUD services. These models include programs dedicated to SUD prevention, treatment, harm reduction, and recovery services. Braided funding can be employed at different levels, including the state, regional, local, or provider levels. **The primary objectives of braided funds are to enable providers to expand the range of services available to clients and, through effective resource allocation, to increase the number of clients and patients served.**

The efficient distribution of braided funds plays a vital role in maximizing service provision. By effectively allocating resources, providers can reach a larger number of individuals seeking assistance for SUD-related challenges. This not only expands access to crucial services but also increases the potential for positive outcomes and improved well-being among the affected population.

SUD providers who have access to a diverse range of funding sources, including grant funding in addition to insurance reimbursements, are often better equipped to provide comprehensive care and effective case management to address the complex challenges associated with SUD. These additional funding sources, such as block grant funds or state general funds, play a crucial role in bridging the gaps created by limitations in public and private insurance coverage. They serve as valuable resources to subsidize services for individuals who are underinsured or uninsured, thereby ensuring greater access to essential care.

Braiding in the Medicaid Policy Landscape

Medicaid often serves as the largest and most dependable source of funds for SUD treatment programs, making it a critical component of sustainable financing. SUD prevention, treatment, and recovery service programs navigate through an intricate network of funder requirements, with particular emphasis on the policies governing Medicaid reimbursement.

Medicaid demonstrations play a significant role in expanding coverage and influencing the landscape of funding for SUD services within states. Demonstrations allow states to fund a broader set of services to treat and prevent SUD, which paradoxically, may lower overall costs.* All demonstrations are required to be budget neutral

* Most states demonstrate budget neutrality using a per-capita method. Savings are represented as per-capita savings, rather than overall spending, which is dependent on the number of enrollees.

at a minimum, and some states are able to use savings to extend services to additional groups of people.* Although demonstrations themselves may not directly promote or impede the practice of braiding funds, they significantly influence the types of services (like residential treatment in IMDs) that are more likely to require braided funding and the amount of funding necessary.

Given the central role of Medicaid in financing SUD treatment programs, understanding and adhering to Medicaid reimbursement policies is essential for program sustainability and effective service delivery. In addition, Medicaid demonstrations provide states with an important mechanism to modify and enhance their Medicaid programs, allowing for greater flexibility in coverage and the inclusion of additional services. The specific terms and conditions of these demonstrations shape the opportunities and challenges associated with funding allocation and the implementation of braided funding approaches because the language of the specific waivers dictates how, for what and for whom the funds can be used.

Furthermore, the impact of Medicaid demonstrations extend beyond the facilitation of braided funding. They influence the overall landscape of SUD services, determining which services receive prioritization and financial support. By shaping coverage and reimbursement policies, Medicaid demonstrations play a pivotal role in the availability and accessibility of SUD treatment services.

Braiding by Payment Processors

Many states use ASOs, PIHPs, and behavioral health MCOs to braid non-Medicaid funding for SUD services. These organizations are frequently contracted to collect data and oversee reporting to the funder, which can alleviate some of the reporting burdens associated with grant funds. These organizations are overseen by a state agency, a statewide collaborative, or local behavioral health collaborative. Exactly which funds get braided and how they get used is specific to the state, based on a comprehensive assessment and prioritization of need and availability.

These intermediary organizations possess the expertise and resources to efficiently manage data collection, analysis, and reporting processes. **Payment processors play a crucial role in ensuring compliance with funder requirements, streamlining the reporting procedures, and providing valuable support to providers throughout the process.** Some of these organizations offer valuable training to providers about how to navigate billing and understand the requirements for each funding source.

Payment processing organizations that manage federal block grants or state allocations often braid funds so that provider billing is more streamlined. Relieving providers of some of the reporting tasks through these intermediary organizations not only saves valuable time and resources but also enhances the accuracy and timeliness of the reporting. By leveraging the knowledge and experience of these organizations, providers can navigate the intricacies of reporting requirements more effectively, thereby maximizing their ability to meet the expectations of funders.

Braiding for Sustainability Can Be a Continuous Challenge

Braided funding offers the potential for establishing more permanent, well-funded service provision and sustainable staffing positions—a

* According to a 2019 MACPAC report, "thirteen states used $1.4 billion in Section 1115 demonstration budget neutrality savings to expand Medicaid coverage in FY 2019. In the 1990s and early 2000s, coverage expansions were the most common use of budget neutrality savings, but after the passage of the ACA, many states began covering low-income adults under the Medicaid state plan instead. However, some states that have not expanded Medicaid under the ACA still use Section 1115 demonstrations to provide limited coverage to low-income adults who do not otherwise qualify for Medicaid."

critical need given existing workforce shortages. However, it is important to acknowledge that grant funding, although valuable, is often subject to instability and may not provide sufficient resources to meet the full range of required services. Even when braiding funds from multiple grants, this approach may not entirely resolve the issue, especially when the hiring requirements of the various funding streams differ.

Medicaid reimbursement represents an avenue for more stable funding, which can contribute to addressing staffing challenges. However, it is crucial to recognize that Medicaid reimbursement does not cover all services, nor does it extend to all individuals in need of services. While Medicaid plays a vital role in supporting SUD treatment programs, there are limitations in its coverage that should be considered.

The current funding structures and workforce shortages in the field of SUD treatment necessitate innovative approaches to staffing and funding services. Braided funding, along with the utilization of grant funding and Medicaid reimbursement, can help improve staffing stability, training, and availability of resources. By strategically combining funding sources, providers can enhance their ability to attract and retain qualified staff, ultimately improving the continuity and quality of care provided to individuals with SUD.

Increasing Collaboration

Braiding funds for SUD services can foster increased collaboration between systems and relevant entities. Braided funding necessitates coordination among diverse parties involved in the funding and delivery of SUD services. This collaborative planning process brings together representatives from various systems, such as healthcare, social services, law enforcement, education, and community organizations. Through joint planning efforts, agencies, organizations and programs can align their goals, identify shared priorities, and develop comprehensive strategies for addressing SUD-related challenges in the community.

Braided funding encourages the integration of services across different systems and sectors. By combining funds from multiple sources, providers can offer a more comprehensive continuum of care that addresses the multifaceted needs of individuals with SUD. **This use of funds facilitates a holistic approach to service delivery, breaking down silos and promoting collaboration among different providers, agencies, and community organizations.** It enables a more seamless flow of services, enhances care coordination, and reduces fragmentation within the system.

Braided funding creates opportunities for pooling and sharing resources among government entities, organizations, and community providers. By combining funds, organizations can leverage their collective resources to address gaps in service provision and maximize the impact of available funding. This collaborative approach promotes efficiency and effectiveness in resource allocation, enabling all parties to optimize their limited resources and reach a larger population in need of SUD services.

Braiding funds encourages the formation of partnerships between different sectors and entities involved in SUD services. This collaboration extends beyond traditional healthcare providers and includes community-based organizations, government agencies, educational institutions, faith-based organizations, and advocacy groups. These cross-sector partnerships bring together diverse expertise, perspectives, and resources, fostering innovative approaches to prevention, treatment, and recovery services. By working together, all parties can leverage their unique strengths and create a more comprehensive and effective response to the SUD epidemic.

Braided funding promotes shared accountability for achieving desired outcomes and demonstrating the effectiveness of SUD programs and interventions. Collaborative efforts in funding and service delivery necessitate shared performance measurement and evaluation processes. By collectively monitoring program outcomes, agencies and programs can assess the effectiveness of their initiatives, identify areas for improvement, and make data-informed decisions to enhance the quality and impact of SUD services.

In summary, braiding funds for SUD services encourages collaboration among systems and community organizations and providers by promoting coordinated planning, integrated service delivery, resource sharing, cross-sector partnerships, and shared accountability. These collaborative efforts facilitate a more comprehensive and effective response to SUD challenges, bringing together diverse perspectives, expertise, and resources to improve the well-being of individuals and communities affected by substance use disorders.

Unknowns of Braided Funding for SUD

Although this report provides valuable examples of how braided funding for SUD services improves outcomes, investigations into states' practices and existing literature have uncovered a lack of systematic or comprehensive evaluations of braided funding. The current body of research is limited, and there is a need for further study to determine whether organizations that utilize multiple funding sources indeed achieve better outcomes for their clients, patients, and organizations.

Despite the absence of evaluation studies, the case studies suggest that sustainability may be one notable advantage of braided funding. By combining diverse funding sources, organizations can potentially establish more stable and resilient financial structures, reducing dependence on a single funding stream and enhancing their capacity to deliver consistent and uninterrupted services over time.

However, to fully comprehend the impact and effectiveness of braided funding, rigorous evaluations are necessary. These evaluations should explore various dimensions, including client and patient outcomes, organizational performance, cost-effectiveness, and the overall efficiency and efficacy of braided funding models. Such studies can provide valuable insights into the benefits and challenges associated with braided funding and inform evidence-based practices for SUD service delivery.

Benefits and Challenges of Braided Funding for SUD

The literature and case studies have revealed several benefits and challenges related to braided funding for SUD. They are summarized here.

Benefits of Braiding

- **Maximizing Funds:** Braiding funds allows states to maximize funding and strategically layer different funding sources while meeting the requirements for each grant or funder. By reducing administrative burdens and clarifying billing expectations, more resources can go to services rather than overhead.
- **Sustainability:** Braided funding can provide more sustainable income by diversifying revenue streams and strategically aligning partnerships for long-term stability and increased efficiency. The process of braided funding requires providers, agencies, and departments to work together, creating a mutually beneficial system that is less vulnerable to disturbances. Increased coordination can result in knowledge sharing, trust building, and increased referrals for patients in need.[59]
- **Improved Outcomes:** Braided funding may play a key role in creating integrated and flexible systems of care for patients with SUD,

leading to better long-term outcomes. When clients can get most of their needs met within a program using braided funding, there is more potential for comprehensive and integrated care. Prevention services may reduce the incidence of substance misuse and use disorders, and a more integrated network of services could help reduce the need for crisis or inpatient hospitalization by addressing social determinants of health and increasing access to tailored treatment options.

- **Providing Detailed Information for Gap Analysis:** When funds are braided at the state or regional level, the system that administers these braided funds can provide detailed data for gap analyses, indicating which funds are insufficient to meet needs or where funds are totally lacking. This data can be used to encourage increased funding where it is needed most.

Challenges of Braiding

- **Reduced Fungibility:** Funds that are braided maintain their individual spending requirements, which means they are not interchangeable across categories of services. This can create a situation in which a program could have more than enough revenue for one service and too little for another and be unable to borrow from one to pay for deficiencies in the other.
- **Administrative Burden:** Because each funding stream retains specific requirements, bundling those streams can result in additional administrative complexity.[60] Administrators need strong data collection and reporting capacity to fulfill funder requirements. Providers may need additional training or support to bill correctly for each service and client type.
- **Unpredictability:** When braided funds include grants or time-limited state or local funding, a certain amount of uncertainty is introduced. When a grant cycle ends, the grant funding is depleted, or the grant is lost, programs must seek new sources of funds or be faced with lower budgets and decisions regarding which services cannot be funded.
- **Evaluation Challenges:** If more than one funding source contributes to the health and success of a program, it may be difficult to measure return on investment for each funding source. Evaluators may need to design specialized data collection systems and evaluation methodologies such as multifactor impact analysis. Comprehensive programs with proven results may be in a better position when funders direct limited funds to evidence-based models of care.[3]
- **Potential for Duplicative Billing:** With braided funds, cost allocation methods are required to assure that there is no duplicate funding of service costs and that each funding source is charged the correct share of program and administrative costs. When multiple funders can pay for the same services, there must be a clear agreement on who will pay and when.

Future Research

The existing literature on best practices for braided funding is generally limited in its specificity to SUD services. It often provides broad recommendations that may not fully address the unique considerations of SUD programs. Further research is needed to identify and establish best practices for braided funding sources specifically tailored to SUD services and the diverse populations receiving these services.

The future research should delve into the nuances of different demographic characteristics, potential disparities, and needs among the populations served by SUD programs. States with predominantly urban areas may have distinct requirements and challenges compared to those with predominantly rural areas. Similarly, states that have Medicaid demonstrations may face different needs and constraints compared to states that do not. Understanding the variations in

states with Medicaid demonstrations and states under other Medicaid authorities is essential for developing targeted and effective braided funding strategies that address the specific needs of people with SUD.

Additionally, future research could explore opportunities for aligning funding stream requirements related to staffing and reporting. The administrative burden on SUD programs that rely on multiple funders can be substantial, particularly when each funder has distinct staffing and reporting requirements. Investigating ways to harmonize these requirements across funding streams could help alleviate the administrative burden on SUD programs, enabling them to focus more resources on service delivery and client care.

Through conducting comprehensive research on best practices for braided funding in the context of SUD services, policymakers, funders, and service providers can glean valuable insights. With these insights, program administrators can enhance the efficiency, effectiveness, and sustainability of SUD programs, resulting in improved outcomes for individuals in need of these services.

APPENDIX A

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The following is a list of the SAMHSA project leads and case study contributors that participated in interviews and/or provided documentation about their states or programs. Contributors also reviewed their case studies for accuracy. This publication was developed through significant contributions from the following individuals:

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APPENDIX B

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PEP23-06-07-002 | Released 2024

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