

State Strategies to Support Access to Substance Use Disorder Treatment Services through the COVID-19 Pandemic

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New Challenges

Prior to the COVID-19 pandemic, many governors were looking for ways to strengthen substance use disorder (SUD) provider capacity as part of their comprehensive response to the opioid epidemic. However, the imperative is now greater than ever as providers and states face unprecedented fiscal challenges and there are increasing reports that the country is seeing an increase in need for SUD treatment as a result of the stress, social isolation, and job loss associated with the pandemic ([Box 1](#)). While comprehensive national data are not yet available, initial reports suggest that many states are experiencing a resurgence of overdose deaths, potentially erasing some of the progress made in recent years in combatting the opioid epidemic.¹ At the same time, SUD providers, many of whom are Medicaid providers, are facing financial hardship as they lose revenue due to lower utilization, face new costs for personal protective equipment (PPE), and are required to reconfigure their work spaces and approach to providing care to reduce the risk of spreading COVID-19 ([Box 2](#) below).²

This issue brief describes strategies that governors are using to address these challenges even as they face the most severe fiscal crisis seen in decades. With expected revenue shortfalls of 25 percent or more for the upcoming fiscal year, governors are looking for and pursuing strategies that are high-impact and cost-effective. Many governors are significantly leveraging federal funding opportunities; taking advantage of new emergency flexibility granted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) to support access to medication-assisted treatment (MAT); working with SUD providers to develop and disseminate information; and integrating SUD treatment providers and patients into their state's broader response to COVID-19. States also continue to invest some of their shrinking general revenue funds into SUD interventions, reflecting the urgent need to bolster an already strained behavioral health system and invest in SUD treatment that can save money by averting even more costly medical care, as well as criminal justice and child welfare expenses.^{3, 4, 5, 6}

Box 1: COVID-19 is Complicating Access to Treatment for People with SUD*

A survey of nearly 1,100 patients, families, and individuals in recovery from SUD conducted by the Addiction Policy Forum from April 27 to May 8, 2020 revealed that COVID-19 has disrupted their routines:

- 20 percent of respondents increased their substance use since the start of the pandemic;
- 34 percent of respondents experienced changes in treatment or recovery support services due to the COVID-19 pandemic; and
- 14 percent of respondents were unable to access needed services due to COVID-19.

Even after the pandemic eases its grip on the country, the resulting economic disruption may have long-term consequences for those already living with an SUD or at risk for one in the future. The Meadows Mental Health Policy Institute modeled the impacts of the COVID-related economic recession and found that increases in the unemployment rate are likely to be tied to increases in suicide and overdose deaths.

*Hulsey, J., Mellis, A., & B. K. (June 8, 2020). "COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD." Addiction Policy Forum. Retrieved from <https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-from-substance-use-disorder> & Meadows Mental Health Policy Institute. (April 28, 2020). COVID-19 Response Briefing: MHSUD Impacts v.1: Effects of COVID Recession. <https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf>

Factors Driving Fiscal Pressure on SUD Providers

Like other providers, SUD providers have been hit hard by COVID-19 as people avoided medical care to comply with social distancing requirements or out of fear of contracting COVID-19. On average, outpatient providers (including SUD providers) reported a 33-percent drop in visits as of May 2020.⁷ In the weeks and months ahead, they may face new pressures as states are required to respond to their budget shortfalls, responses which could include reducing reimbursement rates in Medicaid and state investments in SUD interventions and treatment.

At the same time, COVID-19 has introduced new costs such as:

- **Personal Protective Equipment** for staff and, depending on the setting, patients as well. The cost of PPE varies, but can include the cost of nitrile gloves, surgical and N95 masks, as well as gowns, all of which have increased exponentially in price throughout the pandemic as supply has not kept up with demand.^{8,9}
- **Testing.** States increasingly are encouraging behavioral health providers to test patients before they enter residential treatment, as well as to conduct testing of staff and patients in group or congregate settings, particularly if they display any COVID-19 symptoms. For example, Alaska recommends that residential treatment and other congregate care facilities test newly admitted clients within 48 hours of admission.¹⁰ Each test costs between \$75 and \$100, a cost that can quickly add up across staff and patients. Providers may be able to get the testing costs covered for individual patients who are enrolled in Medicaid and meet medical necessity criteria, but Medicaid generally does not currently cover the cost of routinely testing staff unless this cost is built into reimbursement rates, as some states have done for nursing homes.
- **Reconfiguring space** to create more distance between patients and, in residential and other congregate settings, allowing for the isolation of any patient who becomes ill or has been exposed to someone with COVID-19. In residential facilities, this can require providers to move from double or multiple room occupancy down to single room occupancy.¹¹
- **Expanding operating hours** at opioid treatment programs (OTPs) or other outpatient clinics in order to reduce the flow of patients seeking treatment at the same time.
- **Hazard pay and backup staffing** may need to be offered to encourage staff to work despite the risk of contracting COVID-19, and preparation should be made for the possibility that regular staff will be out due to childcare obligations, a sick family member, or their own illness.¹²

Along with the issues faced by specialized SUD providers, states also are monitoring how primary care providers that prescribe medications for people with opioid use disorder (OUD) are faring. An increasingly important part of responding to the opioid epidemic, office-based opioid use disorder treatment (OBOU) providers face many of the same issues outlined above, including lost revenue from lower utilization, need for PPE, and an imperative to change the way that they provide care by reconfiguring their workspace and using telehealth.

Box 2: Impact of COVID-19 on Financial Stability of Behavioral Health Providers†

According to the National Council for Behavioral Health, many behavioral health providers are at risk of closing as a result of the COVID-19 pandemic. In early April, the Council [surveyed](#) 880 member behavioral health organizations (including mental health and SUD providers) to understand COVID-19's financial impact and found:

- Nearly all of them (91 percent) reduced their operations, with close to two-thirds (62.9 percent) closing at least one of their programs;
- Close to half of them have had to lay off employees;
- A significant majority of them did not have enough PPE for two months of operations; and
- More than 60 percent reported that they can only survive financially for three months or less under the COVID-19 conditions.

As parts of the country started to further reopen in May, SUD providers have started to see more people using services again, but demand is expected to remain below historic levels for some time.

† Warren et al. (April 29, 2020). "Letter to Congressional leadership regarding Mental Health Emergency Funding." Congress of the United States. <https://www.warren.senate.gov/imo/media/doc/2020.04.29%20Letter%20to%20Congressional%20leadership%20re%20mental%20health%20emergency%20ofunding.pdf> & National Council for Behavioral Health. (April 6, 2020). "COVID-19 Economic Impact on Behavioral Health Organizations". National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56.

Strategies for Supporting SUD Providers

Before COVID-19, governors were working effectively to strengthen SUD provider capacity as part of responding to the opioid epidemic and broader challenges in the SUD treatment system. Now, however, they are developing and evaluating additional strategies to reflect the unique issues generated by COVID-19 and the new budget reality confronting their states.

1. Systematically gather data on SUD providers.

In order to better understand the scope and severity of the financial and operational challenges confronting SUD providers during COVID-19, states are looking to systematically assess how their providers are faring through strategies such as:

- **Analyzing Medicaid claims** and Medicaid managed care organization (MCO) encounter data to understand changes in utilization of SUD treatment services. In the short term, states may want to examine prescription drug claims, typically available more quickly than other medical claims, to assess treatment trends. For example, West Virginia is reviewing its prescription drug claims to explore how greater flexibility on telehealth and prescribing MAT without mandatory counseling has impacted access to MAT during COVID-19.
- **Conducting a survey of SUD providers** on a regular basis to gather data on how they are faring, including volume of visits; cash on hand; recent or planned closure of treatment sites or facilities; changes in number of treatment slots; and updates on any grants, payments, or other revenue from federal COVID-19 resources that they have received. Governors can work with state agency leaders to undertake such a survey themselves or encourage a provider association within the state to gather the data.
- **Establishing a provider dashboard** to track which providers are closing and if they have plans to reopen. Virginia, for example, uses a dashboard for internal planning purposes that tracks by region and provider type the number and share of fee-for-serve Medicaid providers — including behavioral health providers — that have closed and if they plan to reopen.

2. Provide information on high-priority federal funding opportunities and support SUD providers in accessing federal funding.

With state revenue falling, many governors are making it a priority to support their SUD providers (and others) in taking advantage of federal funding opportunities. We describe below some of the most important sources of funding (in terms of the dollar amount available and the breadth of eligible providers) for which SUD providers are still potentially eligible, as well as how governors are working to assist providers in taking advantage of such funding opportunities. [Appendix B](#) provides a comprehensive list of federal funding opportunities being used to support SUD providers, several of which have already closed.

► **Tax and Loan Opportunities for SUD Providers as Employers**

✓ **Paycheck Protection Program (PPP):**

In early May, Congress allocated an additional \$310 billion to PPP, first established by the CARES Act, to disburse loans through the end of June to small businesses to maintain operations and retain staff. Small businesses with up to 500 employees are eligible to apply to a participating bank for a loan equal to ten weeks of a company's payroll, up to \$10 million, that can be used to cover rent, payroll, mortgage payments, and utilities. Borrowers that maintain their workforce for the duration of the 10-week period are eligible for loan forgiveness for 8 weeks of their loan. As of June 2020, PPP applications remained open.¹³

✓ **Main Street Lending Program:**

The Federal Reserve created a \$600 billion loan program for small and medium-sized businesses that is expected to begin accepting applications in the near future.¹⁴ Businesses in operation prior to March 13, 2020 with up to 15,000 employees or annual revenues in 2019 of up to \$5 billion can apply for a loan of at least \$250,000.¹⁵ Businesses that have received a PPP loan can apply for a loan through this lending program. Currently, nonprofit organizations are not eligible for the program, which may preclude it as a source of loan dollars for many SUD providers. The Federal Reserve, however, announced on April 30, 2020 that it is exploring how to

remedy this gap.¹⁶ On June 15, the program opened for lender registration and expects to begin accepting loan applications in the near term.¹⁷

✓ **Employee Retention Tax Credit:**

Qualified employers that have experienced a slowdown of operations and revenue due to COVID-19, including eligible nonprofit organizations, can claim a tax credit equal to 50 percent of wages up to \$5,000 per employee for wages paid to employees between March 13, 2020 and December 31, 2020.

▶ **Provider Relief Fund:**

The [Provider Relief Fund](#) consists of \$175 billion that the Department of Health and Human Services (HHS) is distributing to Medicare, Medicaid, and other providers to help defray the impact of new costs and lost revenue attributable to COVID-19. It includes multiple tranches of money, many of which already have been distributed to providers, including \$50 billion set aside for Medicare providers. On June 11, HHS announced that \$15 billion of the \$175 billion will be distributed to Medicaid providers that had not received funding from the \$50 billion. To qualify for a portion of the \$15 billion, providers must submit data on their fiscal situation and profitability to a Health Resources and Services Administration (HRSA)-run portal by July 20, 2020. Many behavioral health providers that treat Medicaid beneficiaries are expected to qualify. However, those that received any funding from the \$50 billion are explicitly barred from receiving any of the \$15 billion even if they only received a de minimis amount. Those Medicaid providers that qualify for the \$15 billion will receive at least two percent of their gross revenues for 2017, 2018, or 2019, and may receive more depending on the number of providers that opt to participate.

Assist SUD Providers in Accessing Federal Funding. For many SUD providers, especially smaller organizations with limited administrative staff, it can be daunting to sort through the available federal funding options and processes to apply for support. In response, some states are assisting SUD providers in securing federal funding, using the following approaches:

✓ **Provide direct technical assistance and resources.**

States can provide direct technical assistance to SUD providers on the opportunities for which they are eligible, the application process, and the terms of the opportunity. Montana, for example, sent its providers a simplified chart that summarizes when and how they can apply for support out of the \$175 billion Provider Relief Fund.

✓ **Coordinate with state associations for SUD providers.**

States can partner with their state SUD provider association to provide technical assistance to member SUD provider orga-

Employers that have obtained a PPP loan are ineligible for this credit.¹⁸

✓ **Payroll Tax Delay:**

Employers that have not received a PPP loan may defer paying the employer share of payroll taxes otherwise due for 2020 wages, with the first half of the deferred payment obligation due on December 31, 2021 and the second half due on December 31, 2022.¹⁹

nizations. An association is often able to identify issues that are plaguing a number of providers and may be able to work with the state and federal government to get these problems resolved more quickly than an individual provider could.

✓ **Seek clarification from federal agencies on behalf of providers.**

States tend to have more direct and frequent communication with federal partners that may allow them to advocate for and intercede on behalf of SUD providers that need help with application procedures or getting answers to questions.

3. Leverage Medicaid as a tool to support providers.

A number of governors are using Medicaid flexibilities to help prevent SUD providers (and other providers) from going out of business as a result of the pandemic. Since Medicaid requires a non-federal share, states typically turn to it only if federal COVID-19 dollars are not available or would take too long to reach financially fragile providers. In the Families First Act, Congress temporarily increased the federal Medicaid matching rate by 6.2 percentage points for nearly all Medicaid beneficiaries except for low-income adults covered as a result of Medicaid expansion, increasing its viability as a tool for supporting providers. The specific ways in which Medicaid can be used include:

▶ **Direct Payments to SUD Providers.**

A state that provides Medicaid SUD services through a managed care delivery system can require plans to use a portion of its capitation dollars to support SUD providers through the pandemic.²⁰ Given state budget challenges, the option has attracted attention because it essentially allows states to “re-use” already dedicated capitation dollars not currently being used by MCOs for direct care to help keep providers afloat. New Hampshire, for example, redirected approximately 1.5 percent of its capitation payments for a nine-month period into a payment pool that supports six classes of essential Medicaid providers, including SUD residential treatment centers.²¹ CMS must approve directed payments — as it already has done for New Hampshire — before they are implemented, including both a description of the directed payment strategy and materials on the continued soundness of the rates.²² The agency, however, has said it will review such requests quickly and has provided states with templates and resources to facilitate the process.²³ In a similar vein, North Carolina has allowed its behavioral health MCOs to use up to 15 percent of its risk reserves to support providers.²⁴

▶ **Increase Fee-For-Service Payments to Reflect Lower Utilization and COVID-19 Costs.**

In fee-for-service systems, states can directly increase their payments to SUD (and other) providers to help compensate for uti-

lization declines and new COVID-19 costs. For example, a state could enhance its daily reimbursement rate for residential providers to reflect the higher costs associated with PPE and testing obligations. West Virginia recently increased reimbursement rates for a range of behavioral health services by 20 percent, retroactively establishing an effective period of February 1, 2020 through June 30, 2020.²⁵ California temporarily has increased reimbursement for OTPs and intends to conduct a cost settlement to reconcile the payment increases with the service delivered.²⁶ Connecticut is disbursing supplemental payments of up to 10 percent for behavioral health providers and 20 percent for residential treatment providers to account for COVID-19-related expenses.²⁷ Unlike with directed payments, states do not need CMS approval to modify their fee-for-service rates.

▶ **Financially Reward SUD Providers for Meeting Performance Metrics.**

To ensure greater accountability for payments designed to keep providers afloat, states can link payment to a provider’s performance on COVID-19-related metrics. For example, Massachusetts’ Mental Health Center Transformation Incentive Payments support mental health centers that transition from delivering in-person services to telehealth in response to COVID-19 and meet certain related metrics (e.g., training for staff and updated clinical procedures). The amount of funding a provider is eligible to receive depends on its performance on these metrics.²⁸

4. Reduce barriers to care for people with SUD during COVID-19.

In addition to payment strategies to ensure that providers are fiscally sound, states have adopted a number of additional regulatory and policy strategies to support broader access to treatment for people with SUD. The pandemic has spurred changes in when and how people with SUD can gain access to MAT and other services. For MAT specifically, states generally must “take up” these options after they are made available by SAMHSA and the DEA. They can also play a role in alerting providers about the changes and providing them with guidance and support in taking advantage of them.

▶ **Allow Initiation of Buprenorphine Without an In-Person Visit.**

In response to COVID-19, DEA and SAMHSA are temporarily allowing providers to prescribe the first doses of buprenorphine via telehealth (including telephone), spurring a burst of creative

educational materials for providers and consumers on how to do so.^{29,30} Since buprenorphine is a highly regulated medication, this change marks a significant departure from pre-COVID-19 practice when patients had to be seen in person before they

could start buprenorphine. Numerous states have allowed providers to initiate buprenorphine without an in-person visit, in accordance with the federal guidance.³¹ Although states have this flexibility for initiation of buprenorphine, SAMHSA continues to require an in-person visit to initiate methadone.³²

► **Promote Alternate Dispensing of Methadone.**

Methadone is an even more highly regulated medication than buprenorphine, and can be dispensed only by specially licensed OTPs except when used for pain. Prior to the pandemic, most people on methadone were required to visit an OTP daily to receive their dose. During the pandemic, SAMHSA has given states unprecedented discretion to allow OTPs to provide a 28-day take-home supply of methadone to stable patients, and a 14-day supply to those who are less stable but still able to safely handle take-home doses. States must alert SAMHSA if they want to take advantage of the option, which can be done via a simple email.³³ Rhode Island has worked with clients and law enforcement to determine that increased take-home dosing has not resulted in higher rates of adverse events such as diversion and opioid-related deaths. Indiana is providing funding for OTPs to provide lockboxes and naloxone to patients to support increased rates of take-home dosing.³⁴ For those who are not good candidates for extended take-home doses, states can encourage OTPs to stagger dosing days so that half of the clients appear on alternate days for dosing, as Washington and Ohio have done.^{35, 36} Critically, OTPs retain clinical discretion to decide whether an individual is appropriate for take-home dosing. In accordance with DEA and SAMHSA guidance, states such as New Jersey are encouraging OTPs to arrange for delivery of methadone to a patient's home when necessary to contain COVID-19.³⁷

► **Eliminate or Suspend Counseling Requirements.**

Although most experts continue to strongly encourage people with OUD to participate in counseling, there is a growing trend against penalizing those who fail to do so by denying them buprenorphine. Especially since it is harder to participate in counseling during a pandemic, states such as West Virginia are suspending their detailed requirements that people participate in counseling as a condition of receiving MAT.³⁸ As long as they meet basic federal standards, states have significant discretion to decide the conditions under which they want to authorize MAT and do not need to secure approval for any changes in their own counseling requirements.

Use Longstanding Options to Eliminate Prior Authorization and Other Barriers to Treatment.

States can opt to revisit any prior authorization or step-therapy requirements that create unnecessary barriers to MAT. The American Medical Association and others long have recommended such changes as a basic step toward increasing access to proven treatments.³⁹ However, the need to reduce unnecessary visits to the pharmacy and simplify the process of securing medical care during the pandemic may encourage further consideration of the options in states that have not already taken them up. For example, Pennsylvania has recently lifted prior authorization requirements for Sublocade in response to the pandemic since it is a long-acting form of buprenorphine.⁴⁰ As Virginia, Massachusetts, and California have done, states also can extend the length of prescriptions and authorize automatic refills for medications for the duration of the pandemic.^{41, 42, 43}

► **Use Medicaid to Support Virtual Counseling and Peer Support Through Telehealth and Telephone.**

Like the federal government in Medicaid, many states are entirely revamping their telehealth policy to expand access to critical care during the pandemic, including for behavioral health services. Most are adopting temporary policies linked to the duration of the pandemic, while simultaneously considering which flexibilities they might want to retain once the pandemic subsides. Notably, at least 48 states have amended, or are in the process of amending, Medicaid telehealth policies.⁴⁴ These states are extending Medicaid reimbursement to providers for providing services via telehealth, and are often applying the same terms for these modalities as for in-person visits, including payment parity. States are also providing flexibility in Medicaid for use of telephone-based visits. For individuals with SUD, some states are sweeping in a far broader array of providers than usually benefit from telehealth. In North Carolina, for example, the state has extended its telehealth policies (including payment parity) to licensed clinical addiction specialists and peer counselors.⁴⁵ States have also encouraged providers to conduct recovery groups through video-conferencing platforms.

Looking Ahead

States have a number of options for supporting continued access to SUD treatment through the COVID-19 pandemic, and many have already taken significant action to do so. Some states acted quickly to support providers in keeping their doors open, and nearly all updated their policies to take advantage of new opportunities to promote access to MAT and expand telehealth. As it becomes increasingly apparent that the medical, economic, and fiscal fallout from the pandemic may be felt for an extended period of time, ***the question arises of how states will support continued access in the longer term.*** With the notable exception of federal funding opportunities that are closing, the state strategies described in this brief can work to support provider networks and maintain access to critical SUD services in both the short and longer terms. Many strategies, such as those that ease access to MAT, may turn out to be important tools to reduce barriers to care which the federal government and states may want to evaluate and adopt on a permanent basis.

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Appendix A:

New Hampshire Directed Payments

On April 30, CMS approved New Hampshire's request to require its managed care organizations (MCOs) to make directed payments to six types of Medicaid providers. The intent of this request was to help providers stay afloat during the COVID-19 pandemic. New Hampshire will redistribute approximately 1.5% of capitation payments from September 1 through June 30, 2020, requiring plans to distribute them to the following provider types as an increased payment for specified procedures:

- Critical access hospitals,
- Residential substance use disorder providers,
- Home health care providers,
- Private duty nursing providers,
- Personal care providers,
- Federally qualified health centers and rural health centers.¹

Appendix B:

COVID-19 Federal Funding Opportunities² for SUD Providers (listed by Administering Agency): [HHS/SAMHSA](#) | [FCC](#) | [SBA](#) | [IRS](#)

Administered by the U.S. Department of Health and Human Services (HHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA)

Statutory & Regulatory Sources	Purpose	Eligible Recipients	Total Funding Available	Application Deadline	Implications for SUD Providers
DIRECT FUNDING FOR HEALTH CARE PROVIDERS (PROVIDER RELIEF FUND)³ / (HHS only)					
<p>Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136)⁴</p> <p>Paycheck Protection Program and Health Care Enhancement Act (CARES Act 3.5, P.L. 116-139)⁵</p>	<p>Reimburse health care providers for expenses or lost revenues due to COVID-19 and not reimbursable by other sources. Eligible uses include building or construction of temporary structures, leasing of properties, medical supplies and equipment (including personal protective equipment and testing supplies), increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity</p>	<p>Public entities, Medicare or Medicaid enrolled suppliers and providers, and for-profit and not-for-profit entities that provide diagnosis, treatment, and care for possible or expected cases of COVID-19</p>	<p>\$175 billion (\$100 billion authorized by the CARES Act and \$75 billion authorized by the CARES Act 3.5)</p> <ul style="list-style-type: none"> ▪ \$50 billion general distribution ▪ \$15 billion for Medicaid/ CHIP providers that did not receive funds through the general distribution ▪ \$10 billion to safety net hospitals that meet requirements⁶ ▪ \$22 billion for hot spot hospitals ▪ \$10 billion for rural providers ▪ \$500 million for Indian Health Service and tribal hospitals, clinics and urban health centers⁷ 	<p>General Distribution: <i>CLOSED</i> – June 3; There may be another opportunity to qualify for future provider relief funding</p> <p>High Impact Distribution (second round): <i>CLOSED</i> - June 15</p> <p>Medicaid Targeted Distribution: July 20</p>	<p>SUD providers who bill Medicare for services may have received disbursements from the general fund during the two previous rounds. Those SUD providers who have not received funding from the previous two rounds of disbursements are eligible to apply for relief through the Medicaid Targeted Distribution⁸</p>
ALLOCATION FOR TRIBAL SERVICES (TBH COVID)⁹					
CARES Act	<p>Prevent suicide and substance misuse, reduce impact of trauma and promote mental health among American Indian/ Alaska Native (AI/AN) youth. Program aims to reduce impact of mental and substance use disorders, foster culturally responsive trauma reduction, and enable communities to collaborate across agencies to support youth</p>	<p>Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations, or consortia of tribes or tribal organizations</p>	\$15 million	<p><i>No application process</i> – supplemental funding will go to 154 current TBH recipients to meet increased need caused by COVID-19</p>	<p>Tribal SUD providers are eligible to receive funding through the tribal organizations</p>

Administered by HHS/SAMHSA (cont.)

Statutory & Regulatory Sources	Purpose	Eligible Recipients	Total Funding Available	Application Deadline	Implications for SUD Providers
EMERGENCY GRANTS FOR MENTAL AND SUBSTANCE USE DISORDERS DURING COVID-19 (EMERGENCY RESPONSE COVID-19)¹⁰					
CARES Act	Provide crisis intervention services, mental health and substance use disorder treatment, and other recovery supports for children and adults impacted by the COVID-19 pandemic	States, territories, tribes	\$110 million (60 awards for up to \$2 million per state and \$500,000 for territories and tribes anticipated)	CLOSED – April 10	SUD providers may be eligible for disbursements from states, cities and territories
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC EXPANSION (CCBHC COVID)¹¹					
CARES Act	Increase access to and improve the quality of community mental and substance use disorder treatment services	Certified community behavioral health clinics or community-based behavioral health clinics	\$250 million ¹²	CLOSED – March 10	CCBHCS and community based behavioral health clinics who all provide SUD services and have already been awarded supplemental funding
COVID-19 EMERGENCY RESPONSE FOR SUICIDE PREVENTION¹³ / (SAMHSA only)					
CARES Act	Support states and communities to advance efforts to prevent suicide and attempted suicide among adults during the COVID-19 pandemic. Program focuses on victims of domestic violence	States, DC, territories, community-based primary care or behavioral healthcare	\$40 million (50 awards for up to \$800,000 anticipated) ¹⁴	CLOSED – May 22	SUD providers are eligible to receive funding directly from SAMHSA or from their states or territories

Administered by the Federal Communications Commission (FCC)

Statutory & Regulatory Sources	Purpose	Eligible Recipients	Total Funding Available	Application Deadline	Implications for SUD Providers
FCC COVID-19 TELEHEALTH PROGRAM¹⁵					
CARES Act, Sec. 5001	Purchase telecommunication, broadband connectivity, and devices to provide telehealth services	Health care providers, including: <ul style="list-style-type: none"> ▪ Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; ▪ Community health centers or health centers providing health care to migrants; ▪ Local health departments or agencies; ▪ Community mental health centers; ▪ Not-for-profit hospitals; ▪ Rural health clinics; ▪ Skilled nursing facilities; or ▪ Consortia of health care providers. 	\$200 million	<i>No deadline</i> – FCC will review applications until funding is exhausted or COVID-10 pandemic has ended	SUD providers are eligible to apply for grant funding

Administered by the Small Business Administration (SBA)

Statutory & Regulatory Sources	Purpose	Eligible Recipients	Total Funding Available	Application Deadline	Implications for SUD Providers
PAYCHECK PROTECTION PROGRAM (PPP)¹⁶ / ADMINISTERED BY SMALL BUSINESS ADMINISTRATION (SBA)					
CARES Act, Sec. 1102 CARES Act 3.5, Sec. 101	Loans to small businesses to support payroll; loans may be forgiven	Businesses with 500 employees or fewer	\$670 billion (\$349 billion appropriated by the CARES Act and \$321 billion appropriated by the CARES Act 3.5)	June 30	SUD providers can apply for loans through this program; see interim final rules for more information ¹⁷
MAIN STREET LENDING PROGRAM¹⁸ / ADMINISTERED BY SBA					
CARES Act, Sec. 4003	Loans to small and medium sized businesses	Businesses in operation prior to March 13, 2020 with up to 15,000 employees or annual revenues in 2019 of up to \$5 billion	\$600 billion	Not announced	SUD providers can apply for loans through this program ¹⁹

Administered by the Internal Revenue Service (IRS)

Statutory & Regulatory Sources	Purpose	Eligible Recipients	Total Funding Available	Application Deadline	Implications for SUD Providers
EMPLOYEE RETENTION TAX CREDIT^{20, 21}					
CARES Act, Sec. 2301	Refundable tax credit against employment taxes	<p>Employers, including tax-exempt organizations, that operate a business in 2020 and experience either:</p> <ul style="list-style-type: none"> ▪ Full or partial suspension of operation during any quarter because of governmental limits to commerce, travel or group meetings; ▪ Significant decline in gross receipts. <p>Employers who obtained a PPP loan are ineligible</p>	NA	<i>Rolling</i> – employers must report total qualified wages and health insurance costs in their quarterly employment tax returns ²²	SUD providers are eligible to claim this credit
PAYROLL TAX DELAY²³					
CARES Act, Sec. 2302	Employers may defer the deposit and payment of employer's share of Social Security taxes and self-employed individuals to defer payment of certain self-employment taxes	All employers are eligible to defer the deposit and payment of the employer's share of the Social security tax, but employers that receive a PPP loan may not defer the deposit and payment after they receive decision that their PPP loan has been forgiven	NA	Deferral applies to deposits and payments of Social Security Tax that would have been required from March 27, 2020 to December 31, 2020. Form 941 will be revised for the second quarter (April – June, 2020)	SUD providers are eligible to claim this credit

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