

IAP Medicaid Innovation Accelerator Program (IAP) Assessing SUD Provider and Service Capacity May 2, 2017

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John O'Brien (JO): moderator

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Hanna Dorr (HD): Good afternoon, everyone. I'm Hannah Dorr from NASHP and welcome to today's Seventh National Dissemination webinar Assessing SUD Provider and Service Capacity. Before we get started I'd like to go over a few logistics. We ask that you please mute your line and do not put your line on hold otherwise we'll hear your hold music. If you'd like to ask a question or leave a comment please use the chat box on the lower left-hand side of your screen. The chat box will not be seen if you are in full screen mode, so make sure you exit out of full screen mode if you'd like to ask a question or leave a comment. You will also need to exit out of full screen mode to participate in polling questions. There will be additional opportunities to ask questions and provide feedback periodically throughout the webinar. After the meeting's over, please complete the evaluation that will pop up after you exit the webinar. This will allow us to continue to improve your experience. And with that I will hand it over to Tyler Sadwith from CMS.

Tyler Sadwith (TS): Thanks, Hannah and welcome to everyone joining us today. My name's Tyler Sadwith and I'm the project lead for the Substance Use Disorder Track of the Medicaid Innovation Accelerator Program (IAP). We're glad you could join us for this national webinar entitled, "Assessing Substance Use Disorder Provider and Service Capacity." Today's webinar is part of our effort to highlight what we've learned from working with states on Substance Use Disorder (SUD) Delivery System Reforms under the IAP. We know as states design and implement their delivery systems for SUD, there's a lot of interest in aligning those systems with recovery-oriented models of care and key benchmarks from the field. To that end, the IAP is offering several webinars focusing on some of the approaches that are out there at the state level for administering SUD systems in line with the continuum of care and with the national criteria that are out there.

Two weeks ago we had a webinar where states and presenters discussed how nationally developed treatment guidelines are supporting states to develop benefits and program standards and provider networks that comprise the full continuum of care and are consistent with national standards for addiction treatment. Today's webinar continues that dialogue.

Today our speakers will discuss various strategies for understanding and developing provider and service capacity for SUD treatment. The purpose and goal for today is really just to highlight different methods states are using to assess their provider networks and how they're using those assessments to form strategies and to develop the networks to provide the full continuum. Those are some of our key learning objectives.

Moving to the agenda, a key step to understanding the provider network is to develop an inventory. Today our state speakers will discuss how they're approaching that work. A team from Michigan will discuss

different sources of data that the state leveraged and pulled together to develop a comprehensive picture of their SUD system. To follow that thread, we have speakers from Virginia who will discuss their strategies for filling out the service gaps and developing their network based on their initial assessment. We're pleased to have officials from the Substance Abuse and Mental Health Service Administration (SAMHSA) join us as well to help connect some of the dots on using provider inventories to develop strategies for addressing gaps in capacity.

We hope today's discussion is helpful to states that are interested in learning different approaches to conducting service capacity assessments as part of the larger provider network planning effort. With that I'd like to introduce our speakers and then we can get started.

John O'Brien will serve as our moderator for this webinar. John brings more than 30 years of experience in behavioral health systems design, financing, and implementation. He has worked with Medicaid, mental health, and substance abuse authorities in many states to develop federal Medicaid waivers, state plan amendments, and federal grant applications. John directs tax work on SUDs with an emphasis on helping states increase access, integrate with primary care, and reduce unnecessary costs by using Medicaid and other sources to support effective systems.

Dr. Kimberly Johnson is the Director of the Center for Substance Abuse Treatment at SAMHSA. In this role she leads the center's activities to improve access, reduce barriers, and promote high quality, effective treatment and recovery services. Previously, Dr. Johnson was Deputy Director for Operations of CHES NIATx, a research center at the University of Wisconsin, Madison that focuses on systems improvement in behavioral health. She was also co-director of the National Coordinating Office of the Addiction Technology Transfer Center.

Phil Chvojka is a departmental specialist for the Michigan Department of Health and Human Services (DHHS) who has been collecting and analyzing SUD data for over 18 years. He's participated in hundreds of site visits at SUD treatment providers in Michigan and he's the lead manager of the Treatment Episode Data Set (TEDS) for the state to track who receives services, what the service settings are, and when and where they're delivered. His current mission is building a better inventory of the facilities that deliver SUD services rather than relying on disparate sources of information.

Also from Michigan we have Angela Smith-Butterwick who's been working with families in the state for over 20 years within the addiction and mental health field for 12 years. She's the Women's Treatment Specialist for Michigan since 2006, providing oversight and technical assistance for women, youth, and family treatment programs. Miss Smith-Butterwick has implemented standards for women's SUD programming in collaboration with the child welfare agency. She's also contributed to the state technical advisory on trauma informed care and services. She holds a Masters of Social Work (MSW) from Michigan State University and gives back to the program through field supervision of Social Work interns.

We have two speakers from the State of Virginia. Dr. Kate Neuhausen is a board certified family physician and chief medical officer with the Virginia Department of Medical Assistance Services or DMAS. She's responsible for developing and implementing clinical and pharmacy guidelines, procedures, and policies for the Virginia Medicaid program, which serves over one million low income Virginians. Dr. Neuhausen is leading innovative initiatives including developing and implementing the Medicaid Addiction and Treatment Services benefit, which expands coverage of the full continuum of evidence-based treatment and transforms Virginia's SUD delivery system under Section 1115 demonstration.

Last, but not least, Melanie Boynton is a senior policy and research data analyst at the Virginia DMAS program. She is responsible for leading the agency's data governance program, which sets all data policy and standards for Virginia Medicaid. She's been with Virginia Medicaid since 2014 and is honored to support its mission to provide health care to Medicaid enrolled residents of the Commonwealth. With 17 years of experience, Miss Boynton has dedicated her career to public service, especially in the fields of healthcare and higher education, and she holds a Masters of Public Administration from Virginia Commonwealth University and a Bachelors of Public Affairs from Indiana University.

The IAP is pleased to have so many stellar speakers from these states and from SAMHSA. With that, I will turn it over to John O'Brien to get us started.

John O'Brien (JO): Thanks, Tyler and good afternoon everyone. Knowing your current provider capacity to deliver SUD services is really a critical step in your development or your changes in your SUD system. In conversations with managed care organizations (MCO) in late 2013, many of the MCOs that were preparing for additional enrollees were very concerned about the treatment capacity that existed in the SUD field. They, in fact, were more concerned or as concerned about the lack of SUD capacities there were then they were about their primary care practitioner capacity; doing an inventory can really help you understand where the gaps are in your current SUD system. However, completing the inventory is dependant, as we will hear today, on your data, your resources, and the time needed for completing such an inventory.

The results of the inventory will give you a better understanding of a number of things. First of all, it will help you understand your existing service capacity for those providers that are currently participating in your Medicaid network, whether that is part of an MCO network or part of a fee-for-service (FFS) network. It will also help you understand the service capacity for potential Medicaid services, whether those are additional providers that can offer existing services or give you a sense, if you're thinking about adding benefits, the extent to which there are existing providers out there that offer those benefits that could, in fact, be purchased by the Medicaid agencies.

Understanding the service capacity will also be part of the drivers to determine whether or not you might need to change to the authority. Changing the provider specifications are important to the 19L58 authority and other authorities where you have to identify what changes or what are the definitions of the providers. It may affect changes to your provider contracts as well as your MCO contracts.

Last, but not least, are changes to the network inventory that may have budget implications about incapacity. It might expand current providers' efforts or, if you're adding new providers, you'll have to keep an eye towards potential word-working implications as you move forward with your network development.

There are a number of key questions that are helpful when you think about designing a network inventory. The first question, clearly, is who needs to be involved in designing the network inventory and, as you will hear today, it is certainly more than just the data analytics staff although they play a very important role. It is certainly leadership within the various agencies, both Medicaid as well as the behavioral health agency that contracts for a significant portion of SUD services. It's program staff who understand the service that you're seeking to contract for or develop and it's the staff that's going to be responsible, whether that's in the state agency or in the MCO organization, for doing network development.

Another key question is who will be responsible for collecting data and you have, certainly, many choices, but it's primarily relying on your own state agency staff or some delegation to your MCO or, if you have

regional entities that are part of the network development process of the data collection process, it may be delegated to them, or a combination of any of those three.

The format for delivering the inventory can vary. Some states, as you will hear, do this by level of care and/or maybe by individual service taxonomies within level of care. It may be a format that identifies agencies that are delivering services versus individual practitioners that are delivering the services as you might have for medication-assisted treatment (MAT).

And then there are geographic considerations. You may choose to do an inventory that looks at some availability statewide, depending on the size of your state, or, more likely, you'll be looking at geographic considerations or more sub-state regional areas in terms of doing your particular analysis.

Let me turn it over to Kim Johnson on how you can use this information that you get from the network inventory.

Kim Johnson (KJ): My clicker's not working; can you just click to the next slide? There we go.

One thing to think about is, for those of you who are Medicaid directors, we, SAMHSA, have just given a bunch of grant money to your colleagues in the SUD agency and one of the things that we asked them to do was something very similar to what you're thinking about here, so they may have done the bulk of this work for you. That would be one thing to consider is having the conversation with them about what they've already done.

In terms of how gaps will be identified, we've actually created maps, and I think they will be available on the SAMHSA website sometime before the end of this week, that look at just one service level: the need for MAT for opioid disorders. We're developing those maps for other services as well. Just thinking about where are the deserts; where treatment deserts are is probably the simplest place to start in terms of looking at the gaps that you have in your service array. Thinking about where there's no service at all and are there gaps for certain kinds of services like medication, for example.

In terms of the strategy for addressing gaps, but before I get to that I actually want to talk about if you don't have the data yourself we probably have it at the federal level, either SAMHSA or elsewhere, so just let me quickly run through some sources of data that might be useful for you. We have a database of treatment programs in our NSSATS database that you can search for and you can download that by state. We also have data on physicians, NPs, and PAs who have been waived to prescribe medication for opioid use disorder so if you don't have that data you can get that from us.

On the needs side the data that is probably the most useful is the National Survey on Drug Use and Health and we have state and sub-state level estimates; the sub-state level estimates are usually a couple of years behind, so you can get 2014 now. That's useful information to have. I know you're going to hear about TEDS and other data later on so I won't talk about that.

In terms of the strategy for addressing those gaps there are a couple of things. One is to think about how you can add capacity to existing providers? One of the things I've asked the SSAs to think about is, since we've given these grants, is what can they do immediately within a very short period of time to increase capacity in the OTPs. For example, can they do small grants or contracts to the OTPs so the OTPs could do intra-methadone while they staff up to be able to do the counseling part of those services? A thing for you to think about is, are there ways to quickly add capacity to existing providers? That's a short-term solution.

Thinking about the longer term, adding new providers, either programs or individual practitioners, sometimes it's asking an existing program to expand their services to another area or asking an existing program to add new services. Depending on the state you are in there are lots of programs, for example, that don't offer medication now that could add medication to their array of services if it were something that were reimbursed or had some kind of start-up funds to help them do that. Those are the kinds of things to think about in terms of how you can address the gaps and work with your partners at the state level, particularly the SSA because we just gave them a pile of new money, so they are thinking about the same things; about how they address those gaps, particularly for opioids. That will also help states think about what the gaps are and how they address those gaps for some of these conditions.

What are your plans to address longer term gaps or plan for new issues? For example, we're seeing increases in cocaine use. We have a lot of energy right now on opioids, but if you're in parts of the country now you might be seeing increases in cocaine use and the treatments for cocaine or methamphetamine are different from the treatments that are effective for opioids, so think about how you can plan for those changes in drugs of choice and, therefore, the changes in the services that are necessary.

I think that's all I will say and I'll pass it on to Phil and Angie, who are next.

Phil Chvojka (PC): Oh, thanks. Of course, we do use some of those. We're going to talk about the TEDS and, obviously, some of the things with the resources we use at your end and they're invaluable. One of the things I do is work with the treatment technology work group. We have a regional system in Michigan and in June I showed them how they could get on to the WebBGAS system and how they could log in as a citizen and take a look at our block grant application. Anyone can do it; you can all do it. Basically, you don't have to have the fancy logins; it looks kind of scary with all the warnings, but if you log in as a citizen with a two digit abbreviation of your state, such as for Michigan, MI, and then put citizen down, you get read only access.

You talk about who needs to be involved in putting together the inventories; the day I was doing that with that group I was showing them how to navigate through all of the different things and we came upon what is called "Table 7," the statewide entity inventory. I thought I'd done a really good job piecing it together and they looked at the address of one of the providers and said, "Hey, Phil. That's not the right address." We paged through it some more and they said, "Hey, Phil. That's not the right address." What I found is that when I put it together at the statewide level because we have sub-state regions called the PIHPs that there's going to be flaws. They recognized instantly how it needed to be fixed. In our situation they have to become partners in terms of putting these together. I think I've sometimes taken credit for putting together inventories or putting together our TEDS data collection system and putting them out on the web and doing whatever we do, but in our system we do have these regions. The next slide we'll get to is our sub-state regions.

I describe our system as this: we have regional networks, but we can have a statewide inventory. In Michigan we have 10 pre-paid inpatient health plans and all 10 of them create their own networks. They are the ones who put out the RFPs, they are the ones who contract with them, and they monitor them if they do site visits, they have the corrective action plans, and they are their networks. What we do is to contract with these PIHPs, and you can see in the third bullet point I have down there where I say with MDHHS, and that's who both Angie and I work for, when we contract with them we essentially pay them; we pay them to provide services for Medicaid and for the block grant and for all the services we monitor. The PIHPs contract with those 340 plus providers. However, we have stipulations, we have contractual obligations that need to be passed and Angie you can talk a little bit about what those are.

Angela Smith-Butterwick (AB): Our contracts with our PIHPs identify what we expect to see in their contracts with providers and what we expect to see take place in the actual service delivery so it will outline what we want to see in assessments; what we'll look for as far as treatment services; progress notes; any kind of service delivery component. We also talk about different things in our contracts that include outreach, expansion of services, monitoring of services to make sure that waitlists are being managed appropriately and that providers have a resource to come back to our PIHPs if, for whatever reason, they have somebody that they're not going to be able to place in a timely fashion so they can reach out to other providers and get that person into treatment faster and not have them languishing on a waitlist forever. That helps us maintain both our priority populations and our other populations that wouldn't qualify under our regular outline.

PC: These regional networks that they create have some overlap and there are some major providers that have contracts with multiple PIHPs. The providers typically deal with the PIHPs; they're the ones that build them and set the rates and so forth, but on occasion some of these major ones do an end run to us and you cannot understand why, but basically one PIHP is necessarily nicer or pays better rates or does these sorts of things. Essentially the way we've done it since 1978, and sometimes you'll hear me slip and say CAs, coordinating agencies; there were coordinating agencies that did this until 2014, but this model has been in place and the relationship, obviously the important level is at the provider level, but some of the stronger relationships occur between the provider and these PIHPs and we cannot ever... the mistake I was getting at the first time, whether I said it well or not, is that if when I think I can be a lone wolf and put these things together sitting here in Lansing, I really can't and they tend to suffer.

What we have to do then to build these networks is we need to rely on multiple data sets. If you look wide-eyed at this slide you'll see that all these are attributes of providers that we could put in our provider inventory. What I would have to do with this is probably those first two - the name, location, contact information, and the license number/license status - those types of things would come from my TEDS system and our licensing system. We are working on an ASAM level database that Angie will talk about, something that is exciting to me because it's a functionality and a level that I've never been able to do; we've always collected it at the service category level, but we're going to have another data set, another database. Right now it's an Excel spreadsheet that I reference, but in order to look at ASAM levels, which is exciting as far as that goes, for things like the accreditation, population served, and the funding, a lot of times we use the treatment locator for that. Sometimes N-SSATS were noted with that and, certainly, the accreditation. We do require that all providers be licensed and that's why the licensing database is important for that and accredited, and sometimes we actually go to the accreditation sites.

Where we start in Michigan is what you see on the second line: the license number. We know that a provider has now come into our system and is new to it because, again, the PIHPs would put them on. When a license numbers shows up on a TEDS admission and we don't have a label for it we know we have somebody new here. That starts the process of us having to then go to the licensing database that we use and start to kick through and figure out all the things we need to figure out so that we know what their capacities are, what they can deliver, what their bedside is; all the things that you start to look at are in place with that. All these types of things we have in these data sets basically boil down to these common core resources that we use.

As was mentioned, people will talk about TEDS; I've been collecting TEDS myself since 1999 with over 1.2 million admissions that have come in place. For me it is the lifeblood of what I understand: the who, the what, the where; a TEDS record, obviously, even allows you to look at changes over time with the admission discharge model. You'll see behavioral top health in there; we in Michigan are transforming

what was just an SUD TEDS record to all of mental health. They've piggybacked off of what we're doing to create that T1, that admission, that T2, that discharge, and to look at that. I can create, basically, an inventory from TEDS where it's at least a listing; it's a table that shows the providers and the service categories they provide and characteristics of other persons that are providing them services. That becomes a home-based inventory.

The second is the 837 encounter and procedures. We have a system called CHAMPS that processes all the encounters that come in so any person that is admitted and starts receiving services through those codes then we can identify what they're getting. It is another thing that informs us what is being provided. Obviously, with increases in MAT services we've been tracking things like the 80020 methadone dosages as they've been increasing and it's through these 837 encounters that we're able to describe what it is that people deliver.

The important third bullet point is LARA, as I would refer to it; it's the Licensing and Regulatory Administration website. They house the All Health License health license database for all of health care in Michigan, but now they have the SUD licensing. Prior to 2010 it was in-house and when it was in-house we had a nice interactive where you could put down the states; I like what we had. When it got moved to LARA we lost some of the functionality. I would really like to see this become more of a one source where we don't have to jump to five sources where some of the things that are part of the treatment locator information on the ancillary services and those types of things could be placed in there. Right now it's not, but because all providers who receive our services must be licensed it becomes our central repository of who they are and what they're licensed to deliver and we will double check; even with the TEDS record if they say it's a detox that they have licenses for.

Beyond that we will still get the N-SSATS, there's some information in that and the provider surveys. As the business coordinator I actually encourage people to fill out the survey as that information is useful. I put the IBHS log in. Again, I am responsible for making sure the Inventory of Behavioral Health Services (IBHS), it used to be I-SSATS, is also in LARA by comparing the two on dual screens to make sure they are in sync. We always get reminders from Synectics to make sure things can or cannot be in the locator; it's a tie-bar where I'm making sure that what we're reporting on what they have in place is in place. It's also a good place for those addresses that we found were wrong to be fixed.

If need be we go directly to the PIHPs; they are the ones that have the networks. If we want to know what the credential of what one of the clinical supervisors might be, they're the one who have it and we don't hesitate to ask for their documentation.

I mentioned in the intro that I did a bunch of site visits in the past. We have discontinued those. As an editorial comment I am not pleased that we have done that, but in those instances we could get documentation directly from them about the providers and I've still saved some of that.

The second-to-last bullet point, different provider surveys that have been done over the past that we can tie that to, but most importantly is the ASAM database that Angie has been working on, so I'll let her tell you a little about what that is.

AB: As part of our 1115 waiver application we indicated that we would have all of our providers apply for the level of care that they're going to provide to our citizens. The important piece that this is going to give us is actually the level of care for each provider because the LARA database for all of the licensed programs does not include anything beyond: this is a residential, this is an outpatient, this provides MAT, this one does early intervention. We're very interested in being able to have all of that information at our fingertips

and we're interested to be able to offer that to our access management system so as people in need of assistance call in, they're able to pull up much more information and assign them to the appropriate level of care with the appropriate provider that's in their region and get them what they need.

Of course, as with any state system, we are a little bit farther down the list than I would like to be as far as getting our database developed, so we're currently doing everything by paper as Phil mentioned and we just started maintaining an Excel spreadsheet that has everybody's information on it while we're waiting for our turn to develop our database and put in all the fun features that we want to have in there.

PC: I was responding to someone asking what the LARA web address is. We are looking forward to that. It will allow us to do it at a level that I have not been able to do before; we were stuck with the service category.

The final thing I would leave with is some of the comments made earlier about tracking capacity with your inventories and what your provider panels and networks are. In Michigan, with the advent of Health Michigan plan, which is Medicaid expansion, we've seen a 30% increase in admissions for detox, residential, and short-term residential. We've gone from 20,000 combined admissions to 30,000 combined admissions. We've also seen methadone MAT increase and so far it has been done without incident, without showing signs of strain on capacity, but it's something we definitely have to track because maybe we weren't at capacity then, but we might be now. These types of inventories help us track that.

AB: Our providers have been very good about keeping us informed of their process and most of them are doing handsprings to be able to provide the services that need to be provided and meet the capacity needs we have. They're capacity is only really limited by the number of people they can assess each week. They're doing whatever they need to do to get contractual therapists in and make sure everybody's being seen, but they can only assess so many people each week so that's slowing down our process a little bit, but for the most part everybody's needs are being met as efficiently as we possibly can right now.

PC: That moves us to discussions and questions.

JO: Phil and Angie, thank you. There were a few questions about the waived physicians list and, Kim, thank you for setting up the link. Do you want to do a two-second overview of what that link is and who's included and who's not?

KJ: I posted the link to the page on the SAMHSA website where you can look up physicians. It is only physicians that have given permission to be on that site so there are more waived physicians than are on that site. It does vary by state of what percentage is on; some states it's a very high percentage, some states it's a relatively low percentage. The other thing, I didn't put the link, but you can get to it from that page is the provider database. We have a page where you can find a provider organization and that is populated by the N-SSAT survey that I mentioned and Phil mentioned, so that's another resource.

What I would say about those is that the physician resource that probably is the best one that there is, but in terms of the provider, the organization data, if your state licenses organizations you should probably start with state level data if that is available. Phil and Angie might want to chime in; it is probably more current and up-to-date than the federal level data.

AB: I think primarily ours is because our programs are reviewed every year; our licensing person is extremely busy and he licenses both our prevention and our treatment programs, so he's licensing a vast

quantity of programs every year. That includes all of our programs that offer DUI classes as well; that's how we certify that they're appropriate. We do have a fairly robust number of programs in the LARA system at any given time. You can also see the ones who have lapsed; their system is massive. It allows you to do some fairly good searches and I think for providers as well as people who are looking to open up their own provider, especially with MAT and the Office-Based Opioid Treatment (OBOT) and some of our outpatients will use that tool to see what areas are saturated.

KJ: Some states don't license programs and some might not have good databases, but if you are a state that does, that would be where I would start first if I still worked in a state. The provider locator on the SAMHSA website, which comes out of the N-SSATs data, would be an alternative if you didn't have good state-level data. For physician data that is probably the best thing we have available at this point in time, though not necessarily complete as someone mentioned in the comments. Again, depending on where you are, because in some states it's more complete than others, it's the physicians that are willing to take new patients and put their name out there; it's probably the ones you would be interested in contacting anyway.

JO: That's a very good point. Phil and Angie a couple of questions for you: one is about resources. Phil or Angie, what's your best guess as you look back over the last few years, what would be the resources that you would need to do what you did and even some ballpark around staffing?

PC: One of the resources we were able to pull upon is DTMB who was able to build us a data repository and a data collection system for TEDS and was able to build us a data warehouse for the encounters that come in. It's fairly involved and ties in with other parts of MDHHS, but they allow us to have the tools to dig into the data. What's nice for our TEDS record is that it's an automated system where there are 350 automated edits that have to be passed and if it's incomplete or missing or useless data it gets kicked to the curb and comes back in. Getting that data collection system built, which started around 2003 and we have it Java Script enabled and it's now a web-based system that was, for me, the thing that moved me away from doing a lot of... we used to even mail in diskettes years ago, where my job became trying to get data in to having it built and automated where people can do that so now you use it; you're not just constantly hoping to get enough in so we get paid our Synectics money.

AB: We use our data quite effectively in most instances. We've used it all across the board and have helped other departments across the state use our data to show they have needs in different areas, especially Children's Services Agency, drug courts, our local family courts, and pretty much anybody who needs it.

PC: In one particular region, Southeast Michigan, there was not any youth; the penetration rates for youth were non-existent so they were able to use it. Sometimes I would take this data back to providers at provider meetings and they would be shocked and surprised that we knew what we knew about them. Even though they realized they filled out these records, we did these TEDS records, when I talked about continuation rates or national outcome measures they were surprised the data was being used, so even using it tends to be a useful thing.

AB: Very much so.

JO: We have two more questions: one for Kim and one for Michigan. Kim is there a link or data on waived nurse practitioners and physician assistants and, if so, can you send that out?

KJ: There is data; it changes every day. We are working on getting that so on the web page there is something on the physicians, but the nurses aren't in there yet. We're working on that. If people have my email address you can send an email about your particular state and who the NPs are that are waived, I can get that responded to. That's probably the best way for me to do it, John, as opposed to trying to send something that is a file with everything.

JO: Okay. We'll make sure folks have your email address. And for the folks in Michigan, Phil, in particular, you mentioned about the uptick in MAT; are there settings that you're generally seeing an increase in that utilization?

PC: Yes. The outpatient setting has about a 45% increase in the number of persons. Last year there were 12,145 persons who received a dose in an outpatient setting; we never broke 10,000 and for years it was 6,000 and 7,000. We also see it in a detox setting. We have places that now are getting some oxone into the mix and we have them in our TEDS records note that even though it's not a maintenance program, it was involved in the treatment. Some of that is we didn't collect the data the same way as we're doing now so we have a new baseline, but we are seeing it in detox. What I was talking about before is in the outpatient setting.

AB: We are seeing an increase in the number of pregnant women who are coming in and are opiate involved; we are in the 60-70% now. The amount of money we are spending on residential treatment for adolescents is about half of what we're spending for treatment for all adolescents and it's because of a rule we have in place where they have to attempt a drug-free twice before they can get MAT so we know there are some issues we need to address as far as making sure everybody's getting the right treatment, but there's a lot of changes.

JO: Really interesting presentation. Kim, Phil, Angie, thank you. Let us turn to Virginia and Kate Neuhausen and Melanie Boynton.

Dr. Kate Neuhausen (KN): This is Dr. Neuhausen from Virginia Medicaid. Today we were hoping to share the transformation that Virginia has launched under the 1115 delivery system reform waiver opportunity. In the past our system had been siloed where all of our community-based addiction services were covered by a behavioral health services administrator and all of our traditional physical and mental health and addiction services were covered by our MCOs. About 70% of our Medicaid members are in managed care and that will be close to 90% by the end of this year.

The major transformation Virginia embarked on under our 1115 waiver that went live April first was carving in all of the community-based addiction services so they'll be covered by the managed care plans.

Previously inpatient detox wasn't covered and we added the full array of services and the full evidence-based continuum that included residential treatment, partial hospitalization, intensive outpatient programs, and opioid treatment programs; we also created a new payment model for office-based opioid treatment, case management, and added peer recovery supports for both addiction and mental health, which will go live July first.

Our goal in carving these into managed care plans was to create a fully integrated physical and behavioral health continuum of care. Members in FFS SUD treatment services will be covered by our behavioral health services administrator.

The other major transformation of our system was to align all of our services with the ASAM level of care. The first thing we did was cross-walked ASAM with all of our licensing by our Department of Behavioral Health (DBH) and with our services. Before, we had home grown services and based on the guidance of the state Medicaid director letter and help from the IAP team, we worked on developing a full continuum of services. It was pretty clear from the letter that we needed inpatient, residential, partial hospitalization, long-term recovery support, experts, and rigorous and robust MAT.

This shows our continuum in our new delivery system where we have everything from the intensive inpatient, acute care, general hospitals, to all the different ASAM levels of residential care from the 3.7 highest intensity inpatient psych units, the 3.5 and 3.3 community-based facilities, and the 3.1 group homes. We had to set a whole new standard for residential, which had only been covered for pregnant women in the past and just at the group home level. For partial intensive outpatient we have changed the definition and raised all of the provider qualifications and services along with ASAM where we brought in our coverage of experts into early intervention. We also developed new payment models for opioid treatment programs and office-based opioid treatment.

I'm giving you this background because, essentially, our health plans had to build entirely new networks for the OBOT, OTT, level 2.1 intensive outpatient, 2.5 partial authorization, our residential, and then our inpatient. This is the framework to understand we had to actually get them to submit and build these networks and then had to verify and validate their networks.

We've been asked specifically to talk about OBOT. This was the biggest gap in our system. Before, our addiction recovery treatment services (ARTS) it was a 6-12 month wait in major urban areas, like Richmond, for a Medicaid member to obtain outpatient methone or suboxone. So, we created the new model OBOT; these are our gold card clinics, they can be our public mental health providers, CSBs, federally qualified health centers, outpatient psychiatry practices, and primary care clinics. We were trying to promote the evidence-based MAT with the medications combined with counseling and behavioral therapies because we know it results in successful recovery rates of 40-60%. The specific payment model supports the integrated behavioral health.

The on-site credentialed addiction treatment professionals, who can be psychologists, social workers, and counselors, are co-located and practicing with the department-waivered practitioner.

For the payment incentive we talked to many physicians and asked what it would take for them to offer suboxone and MAT as part of their practice. They said Medicaid would need to pay for the psychosocial support, which would mean the behavioral health professionals in our office. To incentivise best practices, we're allowing providers to bill the OBOTs only; they can bill much higher rates for individual and group opioid counseling and, for the first time, Medicaid is paying at the provider level substance abuse care coordination \$243 per member per month (PMPM) for members with moderate to severe opioid use disorder and that are actually receiving the MAT. That is to support the co-located behavioral professionals and a professional team of the RN, the waived MD, and the behavioral health clinician working together to address social service needs as well as behavioral health and primary medical needs in a professional team approach.

The OBOTs, on July first, will also be able to bill for Peer Recovery Support Specialists (PRSS).

A key component to our waiver and what we worked really hard with the IAP on both its OBOT model, but to think through the provider recruitment so we did a comprehensive approach where we went to the methadone clinic, the opioid treatment provider programs and we brought in experts from the highest

quality OTPs to advise us on our payment model. Once we developed the payment model to incentivise the OTPs to participate in Medicaid because only two were billing Medicaid in our old world, we brought in all of the OTPs with our single state agency for behavioral health and presented the new opportunity in Medicaid provider in the ARTS payment model.

We presented to the Virginia Association of MAT Professionals and then did a huge amount of outreach. Our team spent the fall on the road and provided an ARTS 101 to over 1,000 different providers. They then did a whole other round of provider outreach in March where they presented to 1,000 providers on the ARTS provider manual. We did targeted outreach around the OBOTs and went to the conferences for our public mental health providers, for the Federally Qualified Health Centers (FQHC); we pitched this model to them. We met with the CEO leadership and the board at our largest health system as well as our largest FQHCs and community service boards (CSB).

We had to walk people through what the benefits are of this model and hold their hand. This was part of the larger training; our other state agencies for health in the Virginia Department of Health (VDOH) led addiction abuse management courses with the Buprenorphine Waiver training and they trained over 700 physicians, nurse practitioners, behavioral health clinicians and clinic administrators. They really focused on the inter-professional approach to MAT. A lot of these people who attended the training have formed OBOTs and this will result in about 150 new waived physicians.

Our DOH also obtained a Project Echo grant from NGA that will provide ongoing support to new waived physicians via telemedicine. We are forming OBOT quality collaboratives that will meet quarterly to share measures and best practices across our OBOT; that's really driven by Medicaid. We are also continuing to meet with our opioid treatment programs and are focusing in on our first quality collaborative meeting to teach them about care coordination and ensure they know how to provide high quality MAT and also how to bill our new codes.

I'm going to let Mel from our office of data analytics (ODA), who are wonderful partners, talk about how we built the network.

Melanie Boynton (MB): When people in the operations side of the agency start working on launching programs like this, they want to understand what actually has happened as a result of their efforts. Dr. Neuhausen talked at length about all of the effort they went through to educate and recruit providers who would be willing to offer this different kind of care to our members. The overall question that her team came to the ODA with was, "Do our members have access to the services they need? What do they need?"

We already understood from a critical standpoint what kind of services would help to drive recovery, but we wanted to understand, in the state, where was the greatest need and how could that be met by the providers available. Let me break that down into the sub-questions of the main question.

Questions that we need to consider from the member side are:

How do we define each level of care?

What kinds of services are needed?

Who can provide those services?

This slide is reversed, but when we look at the member information we want to understand:

Who's facing addiction issues?

Where do those people live?

Then we had to look at the provider network to understand:
What kind of level of care can each provider offer?
What are they licensed to do?

Finally, we wanted to take a look at what is the actual distance between the member and those kinds of providers and how many members have true access to the kind of providers they need.

Digging a little more deeply into this issue, in order to understand the members or who has addiction, we had to look at eligibility data so we could figure out where people are living. We were able to drill down to the street level, but in general we tend to focus on zip codes because what we have found from an analysis standpoint is that analyzing the zip code is small enough to give you meaningful information, but aggregated enough that you're not trying to figure out individual houses and streets, which can become burdensome.

We use claims and encounter data in order to identify who among these people actually have addiction issues and need SUD services.

Next we looked at our provider network in order to understand which providers could actually deliver services to our members. This is one of the toughest parts of the analysis because it's difficult to determine from our existing data information as detailed as who is licensed to give a particular level of care. I will talk at length about how we got at that issue.

Finally, we brought in something new that we'd never tried before, which is we actually purchased an external service. For the first go-around we used Google services, but we've actually moved to another vendor since then. That vendor essentially provided us with driving distance calculations between every zip code in Virginia and we used that to understand the true driving time between both the provider and the member.

When talking about the providers and what services they are eligible to deliver, we quickly found that the information we received from health plans was not necessarily accurate and this is because neither their system nor ours had been designed to track that particular information. We know a lot about providers, we know their taxonomy codes, we know what services they can bill for; we know a lot of information, but getting to that level of care detail was something we weren't designed to do and the health plans weren't designed to track. What we had to do was get licensing information from the DBH and build validation data sets that we could then compare to the health plan data in order to see where there data was accurate or inaccurate.

One thing that helped with this process was that for our residential providers we hired an outside contractor who certified each residential provider and specific locations for a particular level of care. This would prevent a situation where one provider was considered qualified for a 3.7 level of care, but then a different health plan said they were qualified for a 3.5. We did not want members showing up and under one health plan they could get one set of services and under a different health plan they couldn't get that same level of care. We used a contractor to create an apples-to-apples scenario where once a provider was certified for a particular level of care then that was the level of care they were qualified to provide under any of our health plans.

We also had to find ways in our data in order to define who could actually deliver other levels of care, for example, intake and detox facilities. Initially there was some discussion about what kind of hospital can offer that level of care and we had to work collaboratively with the health plans to narrow down that definition and have a clear understanding of what that meant so when they submitted data we were able to say, "Yes, that kind of hospital is qualified to do that level of care."

We spent a tremendous amount of time building this validation data, but it was well worth the investment because it allowed us to objectively compare what the health plans were telling us against what we believed was accurate and give the health plans feedback about which provider records were considered accurate or not.

We had to bring all this together so a lot of things were required to make it happen. First we needed the proper technology to handle that amount of data and do the calculations. When there are 1,200 zip codes in Virginia you can quickly do the math between how many zip codes you have to calculate the distance; every single zip code you have to calculate, the driving time and distance, between all the other 1,200 zip codes in Virginia. We discovered some interesting things such as there are zip codes in Virginia that you can't drive to: mostly government land, national parks, etc. Therefore there were some complexities in analysis we had to take into account.

We had recently set up an analytics platform that was well situated to handle this amount of data calculation. In order to visualize the results we have on the slide here an example of one of the many maps that we made that shows where access is considered adequate and not. We used the tool of Tableau. We are in the process of launching visual analytics as well here at the agency, but Tableau happened to be the tool we used for this particular project.

We also are lucky enough to have an entire team of people here at Virginia Medicaid called the ODA. This 10-person division is specially designed to handle the complexities of data analysis as well as all of the nuances around proper data storage, interpretation, and manipulation.

Finally, one thing that can't be extolled on or discussed enough is the importance of a collaborative and healthy partnership between the operations, those people who are actually trying to deliver the care that is needed to our members, and the people who are in the position to analyze the data to understand how that is being achieved. That was a business partnership between the team that was launching the new addiction and treatment recovery program and the ODA. This will show you, very briefly, just a few of the people who are involved in this collaboration. You can see it truly takes a village in order to bring all of this together and make sure that we have actually used the right data to answer questions in a meaningful and accurate way that our people who are running these programs can rely upon and be confident that the results are actually answering the questions that they are trying to ask.

Next we're going to talk about one of the issues I discussed, which is, "Where is the greatest need in the state? Which Medicaid members are facing SUD issues?" I'm going to let Dr. Neuhausen talk a little bit about that information as well as the results of our findings and what those results meant to her and her team.

KN: This map shows the Medicaid members with SUD diagnoses; we've identified over 200,000 of our 1.1 million members have an SUD diagnosis based on a physician submitting a claim in any setting - emergency room, inpatient, or outpatient. Now ODA wanted to drill down and see, just because you have the highest number that's really proportional in our highest death rates from the opioid crisis are in the far southwest. This map shows a denominator of total people living in zip codes, which can be covered by commercial, Medicaid, Medicare, or the uninsured; just total people regardless of payer. The numerator is people covered by Medicaid who have an SUD diagnosis.

You can see in the far southwest where we border West Virginia, Kentucky, Tennessee, and North Carolina, down in that region of Appalachia, there are zip codes where 30% of the people living in that community are covered by Medicaid and have an SUD diagnosis, which is pretty stunning when you consider that Virginia is not a Medicaid expansion state.

These maps have been enormously useful to share with our stakeholders, present to the health plans, and providers. We decided to compare what our networks under our Behavioral Health Administrator looked like before ARTS versus after the implementation of ARTS. This map shows that the opioid treatment program, which I mentioned was one of our huge gaps, had six providers before, out of 35 in the state participating in Medicaid, and only two actually billing Medicaid. The blue regions show we met network adequacy in the northeastern coast and Tidewater; all of the orange areas we did not meet adequacy.

This map shows that after ARTS nearly all of our 35 opioid treatment programs participating and we have network adequacy in much larger regions of the state. Our plans are still contracting and there are regions where we just don't have two licensed opioid treatment programs so we don't meet network adequacy. We've been sharing this data with stakeholders to encourage them to expand programs in the southwest and fill these network gaps.

I mentioned it before ARTS we only covered residential; this map shows beforehand we had four residential providers, group homes, for pregnant women. We only had network adequacy in our Tidewater region, which is blue and the rest of the state did not have network adequacy. In our new world under ARTS, after April first, we now have 71 ASAM certified providers by our contractor web set and we meet network adequacy virtually everywhere in the Commonwealth except for the far southwest; we have one provider, but not two within 60 miles. Again, we've taken this map and shared with our health plans that they need to focus on the orange areas to continue recruiting providers and we shared with DBH that the orange areas are where we need to fast track licensing. The state has been very helpful.

Finally, our new service, office-based opioid treatment, now has 31 of these brand new clinics with the co-located behavioral health clinicians and waived practitioners. Again, this was a service that didn't exist and now we have network adequacy in large portions of our state, particularly in the far southwest where the crisis is greatest and the death rates are the highest.

I think these maps have been enormously beneficial in demonstrating the success. We've shared these with the general assembly, key legislators, our governor's office, and our secretary, as well as providers and health plans, so it has been very helpful in demonstrating the success of the ARTS benefit and expanding networks.

We anticipate access, of course, but we've shown that higher number of providers in Medicaid. Again, many never participated in Medicaid, but there have also been providers who developed new programs specifically for ARTS and there is an ongoing identification of continuing gaps. I'm taking these to our learning collaborative next week in our Tidewater region to offer the maps by ASAM levels for the

community so they can see where the gaps are and then, as a state, with ARTS __01:05:16? work to address those gaps.

MB: Dr. Neuhausen is going to turn things back over to me so I can talk a little bit about what happens after you're able to share this information. Before I do that I want to go back to one of the maps for a brief moment and bring your attention to what we call the Eastern Shore; that part of Virginia that's hanging off of Maryland out on the water. I also want to draw your attention to the counties over by the mountains on the border between us and West Virginia.

One of the things that we in the ODA of Virginia Medicaid did that's pretty different is that we actually used true driving time and distance, whereas as many states, as far as I know, have relied purely on crow flies distance; this physical distance between point A and point B. Initially when we did this analysis, the very first time, we did that crow flies distance and it was kind of great and we thought, "Wow! Is this really true? Is really representing what's going on for our members?" We decided we could do better and try to understand what actual driving time is for these people.

What we discovered is that parts of the state that previously looked accessible suddenly became inaccessible. Great examples are over here by the mountains between us and West Virginia and in these pieces of Virginia that are near the Chesapeake Bay or the Eastern Shore that when you drew a straight line between the center of one zip code and the next everything looked fine; when we actually calculated driving distance we suddenly discovered that these regions could not get access to the care they need.

That dramatically changed not only our understanding of the situation, but also the places where we felt we needed to do the most effort to recruit providers because in the mountains, and even down in the far southwest, which is another part of the state that looks totally okay when you use crow flies distance, but when you use driving distance suddenly because of the mountainous areas and winding roads, these people couldn't get to providers within a reasonable amount of time.

I do think that we were able to do a good job of understanding the questions and the need that was being proposed by our operations team when they were trying to understand whether these providers were truly available to these members.

I will mention, although we don't have time to discuss it today, other ways we're using the data in order to further explore how accessible these providers are because as you and I know, it's wonderful if you have access to a provider down the street, but if you can't get in with the provider, can't get an appointment, there can be other barriers to care access and we're going to be looking at using new data, additional data, in order to explore any of those issues, but I won't be able to talk about that today.

Finally I want to talk a little bit about some of the outcomes that we've seen happen here at Virginia Medicaid as a result of just doing this provider network adequacy.

These maps tend to fuel a very honest dialogue about the challenges and opportunities for health plans when it comes to provider recruitment. It's all well and good to bring people in the room and say, "How do you think things are going? Where do you think the need is," and everyone hypothesizing based on their take on the situation. But when you put a map up in front of everyone and you can look at it and at a glance see very quickly where the holes appear to be suddenly people are having very honest discussions about challenges that they face.

An example I'll give because the map I just went over we showed first with crow flies distance and then we showed with driving distance and suddenly the Eastern Shore became inaccessible. We had health plans explaining things about there being this and that provider out there on the Eastern Shore; there are very few providers; there are only three of them and two of them only take cash and won't allow health plans or health insurance. All of a sudden we're having a very honest conversation about the challenges that they're facing. That doesn't tend to come out of the woodwork until we're looking at results.

These visualizations spur discussions about the way the data is collected and any challenges that we have extracting the data. Again, when you look at the results you're able to, at a glance, have a gut feeling about whether or not you think those results make sense; are they accurate. Many times throughout this process we show these results to different stakeholders internally and on the health plan side and the gut check reaction from these folks was, "You know what; that number looks too high," or, "I don't think that's high enough." "Let me make sure I understood you correctly when you asked me to identify this kind of provider."

Again, it's only by looking at the results that people are able to think intelligently and in a focused way about whether or not the data below those results, the data that actually fueled that information was correct. A lot of mistakes can happen from the initial point where the person who is collecting the requirements, an actual individual who's extracting that information on the IT side, all of those steps in between can result in failures of communication where you can end up with a data extract that does not actually represent the information you're looking for and is not accurate.

These little additions have been very helpful in getting us all to discuss what an ASAM four provider looks like; who actually is a qualified hospital to give inpatient detox. I will say that Medicaid, although we are the ones who are communicating to the health plans because Virginia Medicaid is largely a managed care state, we need feedback, too, about what the health plans need for success. The health plans have been able to react to this information and share with us some of the challenges they face in contracting with service providers. We as an agency, with the ear of the Secretary of HHS, perhaps the governor, sometimes some calls can be made or connections can be facilitated so, perhaps, certain contractors or providers can reconsider whether or not they're going to contract. That has been helpful.

Again these maps show, as Dr. Neuhausen discussed, very quickly you're able to, at a glance, look at the map and understand where the gaps are; where the spaces are where we are not reaching the people who need our care. All these things together bring us closer to our goal of understanding whether or not we have provided adequate provider access to our members.

I think that's the end of the presentation from Virginia.

JO: Terrific, Kate and Melanie, that was very informative and very impressive. The use of data and the timeliness of data, I noticed in one of the footnotes of the slides it was as of Friday, April 28. Thank you so much and I think we will have more questions for you, but we are going to do a couple of polling questions.

The first polling question is: Does your state have a process in place to assess SUD service needs and treatment capacity? Yes, no, or unsure. It looks like just over half are unsure and about 25% of the individuals say they do have a process in place and the balance do not have the process in place.

This will be a little bit skewed because this will be to the folks that did indicate they have a process in place, but for those individuals, or those states, have you conducted that process in the last 24 months? Yes, no, or unsure. We are seeing some states that do these types of analysis within the past two years and others have not, and a number are not sure when the analysis was last done. Again, those may be the same folks who were unsure if one exists.

The last polling question is for those folks who did inventory, did that data, informed your MCO, contracting strategies, your provider contracting strategies, budget legislative requests, purchasing strategies across your agencies, both Medicaid, SUD, and, maybe, other public health agencies or the data informed adding benefits. Almost all of them certainly influenced the provider contracting strategies with few of the data informing cross-agency purchasing or adding benefits.

Let's open it up for discussion and questions. A few questions came across prior to the webinar that I'd like to ask any of the presenters, but we'll start off with Virginia. Kate and Melanie you did talk about your marketing or outreach strategy to your various providers and CSPs and others around SUD services. Did you have a specific marketing or outreach strategy or are your plans developing a specific marketing or outreach strategy to recruit physicians and other practitioners who might want to become a waived provider for MAT?

MB: We have one other person on the call with us on the Virginia side and that's Tom Watson who has been instrumental in launching this program and I think he has the best understanding of how to answer that question so we're going to let him speak quickly on our behalf.

Tom Watson (TW): Good afternoon. It's a combination to be honest. We do six scenarios and you can obviously get six different personalities and six different ways of treating something. DMAS was instrumental in establishing the guidelines and the guidance for the plans to follow to do the recruiting, marketing, and outreach. Everything that we've done over the last year has been of a collaborative nature; every step that DMAS has taken the plans have been right there with us to include our stakeholders as well. When we did a broadcast or we went out and did outreach we did it as one; we went out and did it as a united force. To answer your question, it was a collaborative nature and DMAS kind of led by half a pace just on establishing the guidelines, but the plans really picked it up from there and ran with it.

JO: For Kate and Melanie, how frequently did you meet internally and externally? Internally with your analytics and program people and externally with some of your MCOs as you began to develop the inventory.

MB: I assume when it came to helping the health plans understand what we needed from them so they gave us the data correctly, I believe we did two or three meetings with them and some emails explaining what our expectations were.

However, I would say, the greatest value we got out of that relationship or that interchange was once we had received a couple of files from them because each month they would send us a file and we would analyze it, I would say after the third time, once we had a grasp on what they were providing us, was it what we were looking for and we had a validation data set to balance it off of and say which records we felt were right or not right, we were then sending them back piles of what we would call rejected records that we didn't feel were correct.

They would then inform us back that 75% of those records are incorrect, we've made a mistake and we're going to correct it and they would tell us what their fix was. If there were some records they felt truly should be considered valid, we would take a look at our validation process and see if we made any mistakes. Sometimes we did find errors on our part and would then improve our validation data set as a result. It was a lot of back-and-forth, but driven from the perspective of each side sharing what they knew and the best of the day-to-day that side had and helping it to inform each other on how to get even better and closer to what we called "the truth," but basically meaningful, accurate information that represents what we're looking to understand. That was one thing.

Internally the ODA met extensively with our operations folks to really drill in and understand what it is they were trying to measure and I would say that was definitely a ramp up. We met once a week, but as we got closer to actually settling down on the process and making sure that our maps were absolutely accurately reflecting what they wanted them to show, we were talking every day or two.

TW: At least.

MB: There was constant interaction until we felt comfortable that we completely understood exactly what they were trying to get at. I will give you one small aspect of the analysis that took a while for us on the data analytics side to understand. We didn't realize initially that the certification for certain ASAM levels of care was not just about the provider, which we identify with the National Provider Identifier (NPI), but it was also about the location; the specific address and zip code. We actually initially didn't know that. We thought it was okay as long as a provider is there that's valid. Then they were seeing results that were way too high and didn't make sense.

Then we had discussions and met and talked and realized if a provider has five locations and only one is certified then the others are invalid and needed to be flagged as invalid in the data set and not included.

Those are the kinds of conversations we had to have with them in order to make sure we truly understood what they were looking for and what was consider "valid" or not.

JO: Another question, and this can be from either state, but Melanie I think you brought this up, which is: Yes it's important to be able to look at distance and certainly important to look at it from driving time versus as the crow flies, but the you were beginning to do a little bit of a deeper dive into whether other barriers to care that were going to be important to look at including wait times or some other factors. Was there a way that you collected that information...? How did you collect that information? There's a question here about a way to have a treatment locator system that gives you a delay in appointments and just curious how you looked at that or might be looking at that.

MB: The first way we got at that was we actually knew because provider network data is something we've been collecting at the Medicaid agency for a while for other purposes, so we knew from other data sets that the health plans had been giving us that they actually track in their system whether or not a provider is accepting new patients. That's a pretty good litmus test for the true accessibility of that provider to the member. We used that as a way to further drill in and see what the access really looked like.

We would show the map with all the providers on there and things were looking great and all of a sudden because it's Tableau we can use interactive drill-downs, we would flip it to just those providers who were accepting new patients and, in some cases, the network would shrink. So, even if we thought everything

was okay, now we don't think that's true so we need to understand if we need to reach out to those providers and see if they are willing to take these patients; are they already, maybe, accepting Medicaid patients and are going to continue accepting Medicaid patients, but they've just become eligible for this particular kind of service; do we need to add more providers.

Other things we're going to do are some density calculations and adjust for certain areas of the state where we think the need is going to be really high, and we talked about some initial work we've already done on that, particularly in the far southwest where we may change the standard to say two providers is considered sufficient for certain regions of the state where the need isn't as great, but for those high density parts of the state maybe four or five providers is considered the magic. We're still narrowing in on those things to try to better understand how many providers are truly needed in each part of the state. We are working collaboratively and have contracted with an outside research team to help with some of those analyses. They're very skilled with that and do a lot of best practices in that area.

Finally, another thing we're going to be exploring, and the program is live now, once we start getting encounter data or claims data from the health plans about those services that are being delivered, claims data can be a pretty good indicator of where services are actually being delivered. If you look at, for example, six months worth of claims or encounter data and you see that there are certain providers on there that never delivered a service to Medicaid members, you can pretty much reach back to the health plans and ask if this provider is really willing to offer care. We notice there is no utilization at all; let's talk about what's going on.

Again, the data is all about fueling discussions a lot of times and really understanding what's going on because the things that are going to come out of the woodwork are either the data wasn't extracted right in the first place and they put in providers that shouldn't be in there or there are barriers to care that the health plans aren't necessarily going to be the first to volunteer exist. When you have the data to show them [crosstalk] is when you show them the data they start to talk about some of the very real challenges that they may face in certain communities or with certain providers that they might need our help solving.

We are looking at a lot of different ways to get at that question. Just because a provider is contracted does not mean that access is truly available and we want to keep using data and drilling in more deeply to understand what's really happening for our members.

JO: Terrific. I'm going to check to see if Angie and Phil are still on the line because I have one last question and I believe it's for them.

AB: Sure, we're here.

JO: Terrific. I'm going to back to slide 19, your common data resources; that's a pretty healthy list of data resources. What would you say to a state that may not necessarily have access to all those resources or they might need to do an inventory in a short amount of time? Is there a subset of these data resources that they might be able to use that will get them most of the way, not all the way, to a reasonable inventory?

PC: I would assume that they do collect the TEDS records; that they've got those that can identify the provider that was involved and the person. Like I stated before I think that's a great place to start. The TEDS and the encounters are the who, what, where, and what services.

AB: I don't have anything to add to that. We've done a fair amount of provider surveying over the years to make sure we know what capacity is and that kind of thing and it's not fast, but it's the only way we can be fairly accurate. We've done what we had to do.

JO: Terrific. We only have a couple of minutes left so let me do a quick summary with some key takeaway points.

As I think you heard today there is a need for some newer approaching to assessing your provider network capacity for SUD. Some of them are related to the ASAM levels of care and the MAT capacity. We talked a little bit about it, but we didn't get into a robust conversation about looking at what the recovery services provider network capacity should look like as well. Understand while both Michigan and Virginia did some deep dives into their data, their approach was somewhat unique and my sense is that many of you that are out there in the different states have your own way to look at inventory and will your own unique way to look at inventory because it's going to be based on what data you have, the resources that you have including the staff you have to be able to do the analysis, how you leverage information from other state partners, and, then, how you really use that data to identify gaps and then remedy those gaps.

I want to thank all the presenters today. I think you did a terrific job. The slides will be available in the future and I would request that you complete the evaluation form following this presentation. Again, thank you.

[end of tape]