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Results of the quantitative and qualitative analyses are presented below. Because this is a mixed methods study in which quantitative results informed the subsequent qualitative analyses, the cross-cutting themes that emerged are elucidated in the Discussion section of this report. Quantitative Results We address below the results of analyses related to IET measures for SUD treatment and OUD treatment. Tables referenced below are at the end of the text describing the quantitative results for SUD treatment. IET Measures for SUD treatment and engagement in SUD treatment, with a mean beneficiary count of 50,585 (Table 10). The majority (62.3 percent) of the plans were PPOs. Thirty percent of the plans covered residential services provided per beneficiary was 0.005, and the mean number of SUD outpatient services was 0.008. Mean median provider reimbursement for outpatient SUD services was \$54.01, and costs per user for inpatient services was \$6529.62 per user for outpatient services was \$54.01, and costs per user for outpatient services was \$6529.62 per user for inpatient services was \$6529.62 per user for outpatient ser beneficiaries in these employer health plans had an identified SUD (Table 10). Approximately 55 percent of beneficiaries were between the ages of 18 and 44 years, and nearly 52 percent were female. Among those with an identified SUD, most (53.85 percent) did not use the emergency department, while 22.36 percent used it once, and 23.79 percent used it two times or more during the study period. State-level market and environmental characteristics. Mean total state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state spending on the single state agency (SSA) for substance abuse services and state mental health per 1,000 members of the state services and state agency (SSA) for substance abuse services agency (SSA) for substance abuse services and state agency (SSA) for substance abuse services agency (SSA) for substance abus by the plans identified as non-Hispanic White. Just under 20 percent lived below the poverty line and, on average, 66 percent of subs was slightly greater than 8 percent, with 7 percent aged 18 years and older receiving SUD treatment per 1,000 individuals in the state population. Just over 40 percent of beneficiaries lived in states where all MAT medications for alcohol and OUDs were covered by Medicaid. Sixty-four percent lived in states that require prescribers or dispensers to access the state PDMP in certain circumstances. TABLE 10. Characteristics of Employer Health Plans Included in the Analysis of NCQA IET Measures for SUD Treatment (N=321) Health Plan Characteristics N % Mean Number of beneficiaries --- -- 50584.60 Plan type PPO 200.00 62.30 --- HIGh deductible 61.00 19.00 --- Reimbursement OP-OOPa --- -- 54.01 IP-OOPb --- -- 980.20 OP reimbursement a --- -- 186.25 IP reimbursement b --- --- 6529.62 Benefit design Residential 95.00 29.60 --- IOP/PH services --- -- 0.0047 OP services --- -- 0.0075 Beneficiaries --- -- 8.38 SUD beneficiaries --- -- 51.81 ED use 0 times --- -- 53.85 1 time --- -- 22.36 2 or more times --- 23.79 Market characteristics SUD prevalence --- 8.38 SUD capacity --- 7.34 6 MAT medications --- 40.30 Non-Hispanic White --- 66.79 Poverty --- 19.87 Private insurance --- 66.01 PDMP --- 63.90 SSA spending --- 63.90 SSA spending --- 63.90 SSA spending --- 16358.80 SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services include IOP services and partial hospitalization services in addition to other outpatient services. Inpatient services include inpatient and residential services. Initiation variable kurtosis = 0.27721992. Engagement variable kurtosis = 0.67542441. Mean NCQA IET measures by health plan characteristics. The mean SUD treatment initiation rate for the health plans studied was 0.53, and the mean engagement rate was 0.14 (Table 11). Initiation and engagement rates did not differ greatly between plan types, although they tended to be somewhat lower in HMO or capitated plans than in either PPOs or high-deductible plans. Plans covering residential services had a marginally higher rate of initiation but not engagement. Plans that were equal to or above the mean in terms of numbers of IOP or partial hospitalization SUD services (initiation 0.57 vs. 0.51; engagement 0.18 vs. 0.12) had higher initiation and engagement rates than plans that were below the mean in the provision of those services. Similarly, those with higher median out-of-pocket costs for SUD outpatient SUD services (initiation 0.57 vs. 0.51; engagement 0.18 vs. 0.12) had higher initiation and engagement rates compared with those below the mean in out-of-pocket costs and provider reimbursement for outpatient SUD services. These findings on out-of-pocket cost (initiation 0.52 vs. 0.53; engagement 0.14 vs. 0.15) and reimbursement (initiation 0.52 vs. 0.53; engagement 0.14 vs. 0.15) were reversed for inpatient services. Mean NCQA IET measures by plan beneficiary characteristics. In health plans with a mean or above mean percentage of beneficiaries with an identified SUD, the mean SUD treatment initiation rate (0.16 vs. 0.13), compared with plans that had fewer of these beneficiaries (Table 11). There were few or no differences in rates related to emergency department use or age, although engagement rates were higher in plans where the percentage of female beneficiaries was equal to or above the mean, rates of both initiation and engagement were lower (initiation 0.51 vs. 0.13). Where the percentage of female beneficiaries was equal to or above the mean, rates of both initiation and engagement were lower (initiation 0.51 vs. 0.13). 0.54; engagement 0.12 vs. 0.16). TABLE 11. Mean NCQA IET Measures for SUD Treatment by Employer Health Plan Characteristics (N=321) Health Plan Characteristics (N=321) Health Plan Characteristics Initiation Rate Mean Rate Plans equal to or above mean 0.55 0.15 Plans below mean 0.51 0.14 IP-OOPb Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.57 0.18 Plans below mean 0.51 0.12 IP reimbursementb Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.57 0.18 Plans below mean 0.51 0.12 IP reimbursementb Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementb Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementb Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.51 0.12 IP reimbursementa Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.15 OP reimbursementa Plans equal to or above mean 0.52 0.14 Plans equal to or above mean 0.52 0.14 Plans equal to or above mean 0.53 0.1 0.15 Benefit design Residential 0.54 0.14 IOP/PH services Plans equal to or above mean 0.58 0.21 Plans below mean 0.50 0.11 OP services Plans below mean 0.57 0.18 Plans below mean 0.51 0.12 Beneficiary characteristics SUD beneficiaries Plans equal to or above mean 0.56 0.16 Plans below mean 0.51 0.13 Age 18-44 Plans equal to or above mean 0.53 0.15 Plans below mean 0.53 0.13 Female Plans equal to or above mean 0.51 0.12 Plans below mean 0.53 0.14 Plans below mean 0.52 0.14 Market characteristics SUD prevalence Plans equal to or above mean 0.51 0.12 Plans below mean 0.51 0.14 Plans below mean 0.55 0.14 SUD capacity Plans equal to or above mean 0.52 0.14 Plans below mean 0.53 0.14 Six MAT medications Plans equal to or above mean 0.54 0.16 Plans below mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.54 0.14 Plans below mean 0.52 0.14 Non-Hispanic White Plans equal to or above mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.52 0.14 Non-Hispanic White Plans below mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.54 0.16 Plans below mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.54 0.16 Plans below mean 0.54 0.16 Plans below mean 0.51 0.13 Poverty Plans equal to or above mean 0.52 0.14 Plans below mean 0.14 Plans below mean 0.53 0.15 Private insurance Plans equal to or above mean 0.53 0.16 Plans below mean 0.53 0.13 SSA spending Plans equal to or above mean 0.53 0.15 SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services include IOP services and partial hospitalization services in addition to other outpatient services. Mean NCQA IET measures by state-level market and environmental characteristics. Differences in initiation and engagement rates between plans equal to or above versus below the mean were minimal related to total state spending on the SSA, percentage of the population below the poverty line, and number of beneficiaries 18 years or older receiving SUD treatment relative to the state population (Table 11). However, when the state past-year prevalence of SUDs was equal to or above the mean, initiation rates were lower (0.51 vs. 0.52). In contrast, initiation rates were higher if a plan was in a state where all MAT medications for alcohol and OUDs were covered by Medicaid (0.54 vs. 0.52), a mean or above mean percentage of the population had private insurance (0.55 vs. 0.50). Engagement rates were higher if a plan was in a state where a mean or above mean percentage of the population had private insurance (0.16 vs. 0.13), or where prescribers or dispensers were required to access the PDMP in certain circumstances (0.15 vs. 0.13). Characteristics by performance on the basis of performance on the initiation measure, with mean rates for the lowest tertile 0.53, and for the highest tertile 0.64 (Table 12). Compared with low performers, middle and high performers tended to be PPOs. Low performers were less apt to cover residential services and provided far fewer SUD IOP, partial hospitalization, or outpatient SUD services than did middle and high performers. The mean number of IOP or partial hospitalization services per beneficiary ranged from 0.0026 for low performers to 0.0075 for high performers, with the mean number of outpatient services ranging from 0.0051 for low performers to 0.0114 for high performers. Similarly, out-of-pocket costs (\$856.24 vs. \$1055.87) and reimbursement to providers (\$6248.28 vs. \$7167.33) were far lower for plans that performing plans, plans that were highest performing on initiation had more beneficiaries identified with SUDs (0.52 percent vs. 0.39). percent) (Table 12). They also had lower percentages of beneficiaries aged 18-44 years (53.33 percent vs. 55.25 percent). The most pronounced market or environmental characteristics that differed between the lowest and highest tertile plans were: (1) mean total state spending on the SSA (higher for low performing plans); (2) mean percentage of individuals in the state who were non-Hispanic White (lower for low performing plans); and (3) mean percentage of individuals in the state with private insurance (lower for low performing plans). TABLE 12. Employer Health Plan Characteristics by Performance on the NCQA Initiation Measure for SUD Treatment (N=107) Health Plan Characteristic Lowest Tertile Performers N/Mean Lowest Tertile Performers % Middle Tertile Performers N/Mean Middle Tertile Performers % Highest Te 62.60 HMO or capitated 26.00 24.30 12.00 11.20 22.00 20.60 High deductible 22.00 20.60 21.00 19.60 18.00 16.80 Reimbursement OP-OOPa 45.64 --- 57.56 --- 58.82 --- IP-OOPb 1055.87 --- 1028.50 --- 856.24 --- OP reimbursementa 161.79 --- 152.10 --- 244.87 --- IP reimbursement of 7167.33 --- 6173.26 --- 6248.28 --- Benefit design Residential 27.00 25.20 37.00 34.60 31.00 29.00 IOP/PH services 0.0026 --- 0.0039 --- 0.0075 --- OP services 0.0051 --- 0.0061 --- 0.0114 --- Beneficiaries 0.39 --- 0.38 --- 0.52 --- Age 18-44 years 55.25 --- 56.61 --- 53.33 --- Female 52.02 --- 51.81 --- 51.59 --- ED use 0 times 54.91 --- 53.33 --- 53.32 --- 1 time 21.85 --- 22.86 --- 22.36 -- 2 or more times 23.25 --- 23.81 --- 24.32 --- Market characteristics SUD prevalence 8.42 --- 8.37 --- 8.34 --- SUD capacity 7.46 --- 7.10 --- 6 MAT medications 43.15 --- 33.92 --- 43.83 --- Non-Hispanic White 62.90 --- 66.89 --- 70.57 --- Poverty 19.71 --- 20.06 --- 19.83 --- Private insurance 65.22 --- 65.58 --- 67.24 --- PDMP 61.39 --- 67.94 --- 62.36 ---- SSA spending 17307.40 --- 15781.50 --- 15987.50 --- SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services in addition to other outpatient services. Inpatient services in clude inpatient and residential services. Characteristics by performance on the NCQA engagement measure. Health plans also were divided into tertiles on the engagement measure for SUD services, with mean rates for the lowest tertile at 0.25 (Table 13). The lowest performing plans had the highest mean number of beneficiaries. Middle and high tertile plans were PPOs to a greater extent than were low performing plans. There were no substantial differences in initiation rates depending on the provision of residential SUD services per beneficiary ranged from 0.0021 for low performers, with the mean number of outpatient services ranging from 0.0051 for low performers to 0.0117 for high performers. Differences in reimbursement characteristics were greatest for median provider reimbursement for outpatient SUD services per user (low performing \$137.50 vs. high \$271.19), for median provider reimbursement for inpatient SUD services per user (low performing \$7239.56 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$137.50 vs. high \$271.19), for median provider reimbursement for inpatient SUD services per user (low performing \$1239.56 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$1239.56 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$271.19), for median provider reimbursement for outpatient SUD services per user (low performing \$127.50 vs. high \$127.50 high \$6268.03), and for median out-of-pocket costs for inpatient SUD services per user (low performing \$996.45 vs. high \$965.03). TABLE 13. Employer Health Plan Characteristics by Performance on the NCQA Engagement Measure for SUD Treatment (N=107) Health Plan Characteristic Lowest Tertile Performers N/Mean Lowest Tertile Performers 18.70 High deductible 21.00 19.60 19.00 17.80 21.00 19.60 Reimbursement OP-OOPa 50.72 --- 55.73 --- IP-OOPb 996.45 --- 979.12 --- 965.03 --- 0P reimbursementb 7239.56 --- 6081.28 --- 6268.03 --- Benefit design Residential 31.00 29.00 32.00 29.90 32.00 29.90 IOP/PH services 0.0021 ---0.0034 --- 0.0083 --- OP services 0.0051 --- 0.0058 --- 0.0117 --- Beneficiary characteristics SUD beneficiaries 0.41 --- 0.47 --- Age 18-44 years 54.98 --- 54.38 --- 55.83 --- Female 52.11 --- 52.70 --- 50.61 --- ED use 0 times 53.84 --- 53.77 --- 53.94 --- 1 time 22.45 --- 22.66 --- 21.96 --- 2 or more times 23.71 --- 23.57 --- 24.10 --- Market SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services and partial hospitalization services include inpatient services. Inpatient services in addition to other outpatient services include inpatient services include inpatient services. Major differences in beneficiary characteristics were not seen between plans at different levels of performance (Table 13). Compared with middle performing plans, market and environmental characteristics often were more similar between low and high performers also had higher percentages of beneficiaries living in states requiring prescribers or dispensers to access the PDMP (low performing 60.94 percent vs. high 66.36 percent) and higher percentages of individuals living in states with a higher percentage of non-Hispanic White population (high performing 69.94 percent vs. 62.76 percent). TABLE 14. Multivariate Regression Results Examining the Effect of Health Plan and Environmental Characteristics on Employer Health Plan Performance on the NCQA IET Measures for SUD Treatment (N=321) Health Plan Characteristics Initiation Measure Beta Initiation Measure p-value Engagement Measure p-value Engagement Measure p-value Number of beneficiaries 6.21E-08 0.4523 -4.1E-09 0.9528 Plan type PPO Reference Reference Reference HMO or capitated -0.01858 0.2345 -0.00948 0.4723 High deductible -0.00244 0.8674 -0.00386 0.7541 Reimbursement OP-OOPa 0.000517 0.0007 9.13E-05 0.4774 IP-OOPb -9.8E-06 0.1948 -4.5E-06 0.2331 3.42E-07 0.8014 Benefit design Residential 0.0101 0.409 0.000302 0.9766 IOP/PH services 2.06408 0.0103 3.82326 14 days 41.00 --- 48.00 --- Residential 13.00 31.70 17.00 41.50 IOP/PH services 0.0031 --- 0.0120 --- Beneficiary characteristics OUD beneficiaries 0.27 --- 0.31 --- Age 18-44 years 52.29 --- 55.52 --- Female 53.28 --- 50.53 --- ED use 0 times 56.87 --- 54.36 --- 1 time 20.22 --- 21.08 --- 2 or more times 22.92 --- 24.57 --- Market characteristics Opioid prescriptions 93.29 --- 93.63 --- SUD capacity 7.88 --- 6.54 --- OTP capacity 151.28 --- 3 MAT 52.41 --- 51.59 --- Non-Hispanic White 65.71 --- 70.84 --- Poverty 20.75 --- 19.90 --- Private insurance 65.21 --- 67.02 --- PDMP 69.36 --- 66.54 --- SSA spending 16110.90 --- 16540.90 --- 16540.90 --- SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services include inpatient services include inpatient services include inpatient services include inpatient services and partial hospitalization services include inpatient servi at different levels of performance, although high performing plans had higher percentages of beneficiaries with an identified OUD, had more beneficiaries between the ages of 18-44 years, and fewer beneficiaries who were female. Examination of market and environmental characteristics revealed that the factors most strongly differentiating low from high performing plans on the engagement measure for OUD treatment were that high performing plans were most often in states that spent more on the SSA per state population (low performing \$16,110.90 vs. high \$16,540.90), were less likely to be in states where prescribers or dispensers are required to access the PDMP (low performing 69.36 percent vs. high 135.99 per 100,000 population), had higher numbers of non-Hispanic White individuals in the population (low performing 65.71 percent vs. high 70.84 percent), and had higher numbers of individuals in the state with private insurance (low performing 65.21 percent vs. high 67.02 percent). Results of multivariate analysis on characteristics influencing initiation and engagement. Characteristics significantly associated with higher rates of initiation of OUD treatment among employer health plans included providing higher numbers of IOP and partial hospitalization services per beneficiary ($\beta = 4.47344$, p = 0.0409) and being in a state with above mean prevalence of opioid prescriptions per 100 people in the state ($\beta = 0.00228$, p = 0.024) (Table 19). Negative associations also were seen, including higher rates of initiation of OUD treatment negatively associated with being in a state where prescribers or dispensers are required to access the PDMP under certain circumstances (β = -0.0864, p = 0.0362). TABLE 19. Multivariate Regression Results Examining the Effect of Health Plan and Environmental Characteristics on Employer Health Plan Performance on the NCQA IET Measures, Limited to OUDs (N=82) Health Plan Characteristics Initiation Measure Beta Initiation Measure p-value Engagement Measure p-value Reference Referen 0.0022 0.922 -0.01354 0.2006 Reimbursement MAT OOP -1.5E-06 0.98 1.16E-05 0.6735 OP-OOPa 0.000139 0.2494 IP-OOPb -1.1E-05 0.4726 -5E-06 0.4841 MAT reimbursementa 0.000129 0.1579 8.18E-05 0.057 IP reimbursement -7.7E-06 0.6506 1.53E-06 0.4841 MAT reimbursement -7.7E-06 0.4841 MAT reimbursement -7 None Reference Reference Reference Reference Reference - 14 days or less 0.52499 0.1406 0.22302 0.179 > 14 days 0.05631 0.5172 0.03338 0.4114 Residential 0.00705 0.6487 0.00124 0.8637 IOP/PH services 4.47344 0.0409 4.07017 0.0001 OP services -1.0704 0.5242 -0.57529 0.4635 Beneficiary characteristics OUD beneficiaries 0.34887 MAT use 0 times Reference Reference Reference Reference 1 time 0.12579 0.5519 0.01033 0.9165 2 or more times -0.03954 0.7857 -0.0384 0.572 Market characteristics Opioid prescriptions 0.00228 0.024 -0.00013 0.7705 SUD 0.9667 -10.549 0.0089 Age 18-44 years -0.04029 0.5353 -0.02013 0.507 Female -0.27617 0.13 -0.1958 0.0233 ED use capacity 0.00013 0.4067 -9.1E-05 0.2132 OTP capacity 0.00567 0.3107 0.00221 0.3977 Buprenorphine prescribers -0.07678 0.0352 -0.03747 0.028 3 MAT 0.000122 0.948 0.000873 0.3197 Non-Hispanic White -0.00541 0.4227 -0.0006 0.8484 PDMP -0.0864 0.0362 0.00574 0.761 SSA spending -8.2E-07 0.8013 1.35E-06 0.3756 SOURCE: Truven Health MarketScan CCAE data, 2013-2014. Outpatient services include inpatient services include inpatient services. Initiation measure regression r2: 0.6625. Higher rates of engagement were associated with providing higher numbers of SUD IOP and partial hospitalization services per beneficiary (β = 4.07017, p = 0.0001). Negative associated with having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, p = 0.0089) or having a higher percentage of beneficiaries with an identified OUD (β = -10.549, beneficiaries who are female ($\beta = -0.1958$, p = 0.0233). Qualitative Results Plan Characteristics Six health plans participated in site visit interviews--five Medicaid plans and one commercial plan. The plans served Midwestern states, one served a Northeastern state, and one served a Southeastern state. Health plans described covering diverse populations, including urban and rural populations, including urban and rural populations. They varied substantially in the size of their membership, ranging from approximately 9,880 to 2.9 million covered lives. Group interviews with health plans included plan representatives in varying roles--from executive leadership to quality improvement strategy teams to clinicians and other staff members engaged in beneficiary outreach efforts. The research team interviewed a total of 65 health plan stakeholders, averaging 11 individuals per plan. To obtain information regarding health plan governance, organization, culture, and strategy from key systems leaders, across all site visits the researchers interviewed two health plan presidents; eight chief executive officers, or other individuals in operations leaders; two utilization management leaders; two utilizations and product management leaders and staff members; two chief medical officers; two plan medical directors; and six behavioral health medical directors. Quality improvement strategy or corporate quality directors and staff members. In addition to medical personnel employed in the positions referenced above, to obtain information on beneficiary outreach and management and implementation of quality improvement strategies, we interviewed clinical stakeholders, including nine health plan affiliated providers, four case management team members, and nine care coordinator team members. Interviews with the health plan stakeholders revealed several factors that health plans perceive as influencing their ability to initiate and engage beneficiaries in SUD treatment. Results from the qualitative research question, and brief deidentified summaries of health plan visits are included in Appendix F. Qualitative research question 1: Which types of health plan characteristics and strategies are demonstrated by plans with higher performance or greater improvement in IET in SUD and OUD treatment? Health plan structure, including leadership organization and governance over behavioral health services and SUD IET strategies Health plan representatives generally described a multilevel governance approach, including corporate and local oversight of behavioral health with local plans described varying mixtures of centralized, corporate oversight for behavioral health with local execution of procedures and policies regarding behavioral health utilization management, care management, and care coordination strategies. National insurance companies operating with centralized corporate leadership noted that their approach enabled them to streamline decision-making and ensure consistency across their business lines, which included other state Medicaid plans, Medicare, and commercial business lines. However, all of the national and regional insurance companies stressed that some level of local decision-making was critical to implementing behavioral health policies and procedures in ways that respond to local population needs. The extent of health plans' emphasis on local governance represented a spectrum--from having limited local oversight of policy implementation, to equally shared decision-making with the corporate executives viewed as consultants for guidance on specific issues (Figure 9). Regional health plans favoring local governance noted that limits on the plan's corporate decision-making were critical to achieving a managed care model that served local population needs. Representatives of these plans described the importance of ensuring local leadership, with state-specific plan presidents, medical directors, and behavioral health directors overseeing locally stationed case management and care coordination teams. FIGURE 9. Spectrum of Governance Structures and Factors Affecting Health Plan Organization Similarly, plans that serve smaller beneficiary populations or that were not nationally recognized health insurance brands also favored more local control over decision making and policy implementation efforts. Leadership from locally governed plans described the importance of a "feet-on-the-street" approach, which was supported by the interviews with care managers and others. As such, representatives from locally governed plans frequently described how their organizational structure promoted regular opportunities for communication about beneficiary needs or health services access challenges among plan presidents, medical directors, and staff members to discuss beneficiaries with complex needs or anecdotally observed trends in initiation and engagement success. The differences in philosophy and approach between the large national plans with much more local control do not manifest clearly in the plans' relative rates of initiation or engagement on IET or or other behavioral health measures. The state Medicaid plan operated by the large centralized insurer had one of the highest possible rates on initiation but had an engagement rate that was in the 80th percentile. Plans with pronounced local governance had somewhat similar mixtures or had exceptional results on both rates. Promoting care coordination models and culture. Interviewees from every health plan described their plan's care model and culture as integral to their success in initiating and engaging beneficiaries in treatment. Care models consistently were described as focused on care coordination. Interviewees emphasized the importance of promoting an understanding of patients' needs for ongoing coordination of physical, mental, behavioral, and substance use-specific services while also managing additional needs such as housing. Having plan-wide care coordination models was described their health plan cultureand thus care coordination models--as reflecting a holistic view of member needs, concerned for underserved populations, and focused on collaborative efforts between plan leadership, clinicians, and plan members. Interviewees commented that their respective health plans sustained and reinforced their care culture and values by tailoring their processes for staff hiring and provider contracting around the plan's mission statements. Most plans described some process for vetting new care coordination in SUD treatment as a continuous process, rather than an episodic service. Health plan representatives also expressed a desire to hire care managers who were willing to go beyond phone outreach and follow up with members in the community, including conducting house calls, meeting in hospitals or detox facilities, or locating them at community, including conducting house calls, meeting in hospitals or detox facilities, or locating them at community. hiring requirements for outreach staff that extended beyond clinical competency and focused on soft skills including communication and demonstrating empathy and patience with master's degrees and a few years of experience in a variety of care coordination roles. Effective care coordination roles. Effective care coordinators and outreach workers frequently were described hiring for a variety of outreach and care coordination roles. managers frequently are used to conduct face-to-face visits with members, coordinate care plans, and review entitlements. Plans use clinical community specialists and communi case managers, care coordinators, and community health workers as promoting beneficiaries' use of services included within the plan's benefit array. However, several plans also described these staff members as critical to identifying additional community-based recovery supports for members beyond the plan's benefit. Health plans expect these staff members to coordinate external recovery supports in the hope that members would maintain engagement with treatment services longer and become more stable. Health plan statement when meeting with new providers. Health plan representatives generally expressed a desire to expand their provider network, but many were concerned about including providers to reinforce the plans' commitment to continuous engagement with beneficiaries--that repeated successes and failures with SUD treatment initiation are part of the recovery process and providers must continuously engage patients in communication about the benefits of treatment. The goal is to repeatedly reinforce this message so that, if the patient is hearing this on a day when he or she is receptive, the provider will be able to initiate a treatment plan with the patient. Plan representatives described hiring or contracting with providers and staff members who would promote a culture of acceptance among staff and members. Benefit arrays. Health plan representatives described significant differences in their benefit arrays. and inpatient services, but some stated that they do not reimburse for certain of the intermediate services such as partial hospitalization, and only one reimbursed for limited residential care. Half of the Medicaid plan representatives also described the need for prior authorization before members could engage in several types of SUD treatment services. However, none of the Medicaid plans required beneficiaries to pay for any services out-of-pocket. The representative of the commercial plan interviewed for this study described the plan's benefit array as an "all-you-can-eat buffet" of services for beneficiaries, free of prior authorization or utilization management review. Although the plan covers an expansive continuum of SUD treatment services, members are required to meet their plan deductible prior to having all service costs reimbursed by the plan. Deductibles vary on the basis of individual plans offered through the commercial insurer. in their benefit arrays. Representatives of only two plans described having implemented universal early intervention activities such as SBIRT. One Medicaid plan implemented universal SBIRT to screen for all alcohol and other substance misuse for all beneficiaries aged 12 years and older. hesitation to conduct SBIRT because of uncertainty about how to talk about substance use and competing priorities during the visit. The plan representative noted that SBIRT adoption into practice ultimately was driven by a statewide performance measure that put the plan financially at risk for uptake. SBIRT-like model to screen for risk of alcohol use disorder but does not conduct screening for illicit substances. With the support of its research department, the plan staff developed an alcohol screening form in-house. Initially the commercial plan requested that clinicians conduct brief interventions using evidence-based motivational interviewing techniques. However, clinicians expressed discomfort with the process, and the plan shifted its SBIRT model to require that clinicians provide members with harm reduction advice prior to making a referral to a follow-up visit. To aid in this process, the commercial plan developed a loose script for clinicians to reference when giving advice. The script mirrors the way in which clinicians talk about diabetes care management and being above or below target levels. Clinicians inform plan member's drinking behavior is above or below those guidelines. Harm reduction strategies such as reducing the number of daily drinks or binge drinking episodes are discussed with plan members exceeding safe drinking guidelines. All six plans cover some medically monitored and medical plan members are admitted to these services. One plan in a non-expansion state covers only detox services, including intensive inpatient services, including intensive inpatient and partial hospitalization services, frequently were described as requiring prior authorization from health plans. Representatives from plans requiring some level of notification for any of these services indicated that the condition was not meant to limit or delay access to care but rather was a method of tracking members and follow-up. Medicaic plan representatives described limitations on their ability to reimburse for residential treatment services because of state Medicaid policy. Four of the five Medicaid agency did not include residential treatment in Medicaid benefits for non-pregnant beneficiaries. The representative from one Medicaid plan with a residential treatment benefit described being able to approve their members' residential services, most plan representatives described having their case managers and care coordinators outreach to community-based programs and grants to help members idential treatment. In contrast, the commercial plan representatives from only 1 Medicaid plan and the commercial plan indicated that they include naltrexone in injection form on their formularies. High cost was cited as a barrier for inclusion. All health plans provide members with coverage of at least two MAT medications as well as methadone. However, multiple plans described a preference for referring members to buprenorphine prescribers over methadone clinics because of plans' ability to coordinate member services with external methadone clinics. The representative from one Medicaid plan also described a state policy that required beneficiaries to access methadone as a carved-out benefit through another state plan that specifically handled methadone treatment. Although the state recently had allowed its Medicaid managed care plans to coordinate benefits for methadone treatment. the plan from promoting methadone. Representatives from only one Medicaid plan and the commercial plan indicated that they include naltrexone as a barrier to including it on their preferred drug lists. Most plan representatives noted that they did not require prior authorization for MAT. They said that removing prior authorizations was important to ensuring access to necessary SUD treatment. However, one described maintaining prior authorization for all types of MAT. Although the state Medicaid benefit did not require prior authorization, the plan representative noted that it was beneficial to ensuring that the plan was knowledgeable about which beneficiaries initiating MAT also were participating in some other SUD treatment service such as one-on-one or group counseling. The plan representatives described their MAT service authorization similarly to how other plan representatives expressed a need for prior authorization on detoxification services. The approval was not meant to serve as an access restraint but to keep the plan informed about which beneficiaries were engaging in SUD treatment services and might require additional care coordination. Naloxone formulations are included on all the interviewed plan drug formularies. None of the plan representatives described having specific coprescribing practices in place to direct providers to prescribe naloxone to members at risk for overdose. family member could carry the overdose reversal medication in case of emergency. Leadership at three of the interviewed plans said that this topic had been discussed previously in meetings about improving SUD treatment outcomes. Representatives from the commercial plan were more familiar with providing naloxone to family members of beneficiaries at risk for overdose. Plan leadership described a state law that required plans to make the medication. Coverage of recovery and the plan's ability to promote access to the life-saving medication. support services was sparse among Medicaid plans. In some cases, peer supports are not a covered state benefit and, in at least one instance, the plan did not use peer supports as part of their service buffet offered at all SUD treatment clinics affiliated with the plan. Their plan members have access to individual and group counseling as well as to educational groups focused on relationship building, anger management, depression, mindfulness, and other holistic recovery supports at the plan-affiliated clinics. Although most Medicaid plans do not operate their own educational and recovery supports at the plan-affiliated clinics. support groups, they do rely on outreach workers and case managers to identify community-based supports for their beneficiaries. Representatives from all but one Medicaid plan described sending outreach staff into the community in provement activities. Health plans engage in SUD treatment-related quality improvement in a variety of ways (Figure 10). Representatives from nationally branded plans and those with greater membership populations report employing large quality improvement teams that include statisticians and leadership to continuously monitor data trends in diagnostics and service use. Representatives from plans with limited resources or those without fully integrated EHRs described focusing on enhancing communication channels between base management teams and plan representatives also spoke about the importance of engaging with their provider population to promote uptake of evidence-based practices relevant to imitation and engagement in SUD treatment. FIGURE 10. Quality Improvement Activities Used by Health Plans struggle overall to achieve full integration of their electronic medical records. However, multiple plan leadership groups reported investing significant resources in developing fully integrated physical and behavioral health records. Integrated records were described as a cutting-edge way for plans to measure the frequency of acute care services or diagnostic risk factors for SUDs in their population. Plan representatives generally noted confidence in their ability to identify members with the most severe health risks and proactively outreach these individuals with additional supports. For example, one plan is conducting a monthly analysis of its pharmacy data to identify any members who billed for three or more prescriptions, dispensed by three or more pharmacies, with prescriptions written by three or more pharmacies. long list of beneficiaries, including a significant portion who do not have any SUD or mental health diagnosis in their medical record. The plan then shares their monthly report with its care coordination team to identify next steps for member outreach. Plan interviewees also described using integrated EHRs to track members' progression from a positive identification for substance use risk through treatment initiation and engagement over time. The commercial plan integrated a universal alcohol use are flagged for follow-up. The plan generates a daily report of all members who are identified as having risky alcohol use and monitors those individuals for receipt of treatment referral and completion of follow-up appointments. A monthly report is generated for each plan-affiliated provider practice to identify members with a positive alcohol screen, the date of their positive screen, whether a follow-up appointments. appointment and assessment were scheduled and completed, whether the member's PCP. The plan implemented provider change leaders in each affiliated practice group and are responsible for reviewing the monthly reports with all physicians in their group. Change leaders are helping this plan bridge its advanced data analytic capabilities with more traditional quality improvement focused communication strategies. All interviewed health plan representatives described open communication within the plan and between the plan and its membership as key to achieving improvements in SUD treatment. Communication strategies included using secure electronic messaging services to maintain real-time communication with providers that identify members in need of follow-up services, plans are using secure messaging systems to send providers reminders to conduct follow-up calls and send outreach letters. Interviewees also described these systems as critical ways for providers to reach out to the plan directly, indicating whether the provider thinks that a plan member could benefit from care coordination or outreach efforts orchestrated by the plan. Providers can essentially "refer" a plan member to discuss his or her care needs. Outreach teams are trained on effective communication techniques to encourage members to engage in treatment. CO-LOCATING SERVICES Representatives from only 1 Medicaid plan and the commercial plan indicated that, prior to co-locating its SUD treatment counselors ir primary care settings, only approximately 25% of the members they identified as in need of treatment actually initiated services. Ensuring regular opportunities for open communication between care coordinators, outreach workers, case managers, and plan leadership including behavioral health medical directors were cited frequently as essential to improving treatment initiation and engagement. Every interviewed plan described some form of regularly scheduled in-person or conference call meeting for health plan staff members to discuss general treatment initiation challenges or to focus on strategies to improve outcomes for individual members with complex needs. As previously noted, many interviewees considered these regular meetings a critical way to keep plan governance leadership needs. Interviewees from multiple plans described several occasions in which meetings between case managers and plan leadership resulted in the plan providing additional support to meet specific member needs. For example interviewees described using plan funds to cover non-reimbursable costs for transportation or authorizing additional hospitalization days for members who otherwise would be discharged into unsafe living arrangements. Overall, health and behavioral health providers. Primary care provider visits are seen as plans' first opportunity to identify the unmet behavioral health needs of their membership population. Several plans described co-locating behavioral health counselors in primary care practices as critical to treatment initiation for patients who otherwise would not attend services provided in a behavioral health facility. One plan anecdotally described that, prior to co-locating its SUD treatment counselors in primary care settings, only approximately 25 percent of the members they identified as in need of treatment actually initiated services. Interviewees also use co-location as a strategy to overcome patient stigma around attending SUD counselors in primary care practices also was seen as improving communication between different specialty providers, which facilitated outreach efforts to plan members. If a member has disengaged from SUD treatment but attends a primary care or other medical appointment, the embedded SUD counselor can do a quick face-to-face visit to motivate that member to re-engage in services. Many of the health plan representatives described plans to continue expanding efforts to co-locate services as a way to facilitate initiation in SUD treatment. For example, members with mental health needs frequently attend group sessions, which gives them little time to attend one-on-one or group SUD sessions. occurring group sessions for mental health and SUD issues would help more members initiate treatment for their SUD diagnosis. Plan providers described providers described providers as an essential piece of their quality improvement strategies One health plan, however, expressed concern about burdening providers who must work with multiple insurers and indicated a disinclination to target education or initiatives directly at providers, but this plan did not hesitate to engage in quality improvement targeted at beneficiaries. providers with too much information but aimed to carefully disseminate information about targeted best practices in SUD treatment. Interviewees described these efforts as a way to motivate providers while encouraging their accountability for quality health outcomes in the membership population. Health plans reported investing significant resources in their quality improvement activities, and establishing secure communications with beneficiaries and providers. Representatives from two of the Medicaid plans reported focusing their time and financially at risk under the state Medicaid plan. These plans are motivated to maximize their returns on those metrics. Although many of the Medicaid plans are part of value-based purchasing at the state level, at the time of interview the majority of plans included in this study were not engaging in value-based payment arrangements with providers related to substance use metrics. At least two changes that are anticipated in the near future would involve providers in shared savings arrangements. However, all plans expressed an interest in closely managing their SUD population in an effort to manage overall costs. Generally, plan representatives expressed a concern that poorly managed SUDs would result in higher overall costs incurred at the emergency department or other ambulatory care service providers. Qualitative Research Question 2: What other factors (e.g., patient, setting, provider, state, and local market characteristics) do health plans identify as affecting rates of initiation and engagement in SUD and OUD treatment? Health plans identify as affecting rates of initiation and engagement in SUD and OUD treatment? blans' effectiveness at initiating and engaging members in SUD treatment services: Federal and state policies--specifically federal privacy and Medicaid-specific policies--specifically federal privacy and members in SUD treatment services is specifically federal privacy and members in SUD and mental health treatment was cited repeatedly as a major barrier to treatment initiatives. Plan member attitudes toward treatment and receiving support from their health plan vere cited a general concern over network adequacy for SUD treatment and receiving support from their health plan vere cited as substantially affecting treatment and receiving support from their health plan vere cited as substantially affecting treatment uptake. barrier to future access to treatment. Policy factors. Health plans described federal confidentiality requirements of the 42 Code of Federal Regulations (CFR) Part 2 as specifically challenging to coordinating care for members admitted to detox and other inpatient facilities. 42 CFR Part 2 was established to restrict the disclosure of medical records describing an individual's diagnosis with an SUD or receipt of SUD treatment. The regulation requires individuals to provide consent to share any records pertaining to services received for SUD treatment. Several health plan representatives described detox facilities' understanding of the release of information requirements for 42 CFR Part 2 as overly burdensome to their ability to outreach to members prior to discharge and not reflective of the actual regulation and indicated that the amendments did not effectively address the needs of health plans to be able to coordinate care for their members. One interviewee characterized the recent amendment to the regulation as having "wasted an opportunity." Multiple health plan stakeholders described learning of beneficiary had been discharged from the facility. Case managers expressed frustration about being unable to engage in predischarge planning or identify new contact information on the plan members prior to their discharge. Case managers at one of the health plans described spending a significant amount of time working to improve their relationships with the detox facilities. The case managers are hoping that their positive relationships with the detox facilities will encourage facility staff to reach out to them, within the confines of 42 CFR Part 2, when their plan beneficiaries are admitted for detox services. SHORTAGES OF RESIDENTIAL PLACEMENTS One barrier to obtaining residential treatment for Medicaid health plan members is the prohibition against Medicaid reimbursement in so-called IMDs with more than 15 beds. This means that many Medicaid health plans do not reimburse for residential services. States, however, are increasingly seeking Section 1115 waivers to allow such reimbursement under their state Medicaid plans. Some health plans also seek residential placements with fewer than 16 beds so that reimbursement can be obtained. Despite these efforts, significant shortages of residential beds are reported, sometimes resulting in health plan members leaving detoxification and re-entering the community prematurely. Each of the five Medicaid agency as factors limiting their ability to initiate and engage members in SUD treatment. Most of the Medicaid plans viewed restrictions on the types of services included in the state Medicaid benefit array as a substantial barrier. These included consistent restrictions on reimbursement for residential care given the federal prohibition on reimbursement for residential care given the federal prohibition on reimbursement for IMDs. providing the full continuum of SUD treatment services, but with restricted ability to reimbursable by the state but ultimately noted that doing so was beyond their financial capability. Medicaid plan representatives described operating under a tight budget without sufficient funds to provide recovery supports outside of the state benefit. State Medicaid policies that allow beneficiaries to frequently switch plans also were identified as negatively affecting health plans' ability to coordinate services. Many of the Medicaid policies that allow beneficiaries to place beneficiaries in pharmacy or prescriber lock-in programs. Plan representatives described using these programs when beneficiaries in lockin programs to monitor their prescription use while conducting outreach and case management efforts, only to have the beneficiaries across state plans throughout a single enrollment year. One plan noted that the state Medicaid agency had further restricted movement between plans to control "plan shopping" to evade pharmacy and provider lock-ins. BATTLING STIGMA Health plans reported investing time in supporting community education about SUDs and the positive impact of treatment as ways to reduce stigma both in the community at large and in the minds of individuals who might need treatment. Stigma. Health plan representatives commented on the ways in which stigma around SUDs and treatment hindered their ability to effectively initiate and engage members in treatment services. Health plans are cognizant of how community stigma toward SUD issues prevents individuals from identifying a personal need for care and reaching out for support. One interviewee who is actively working to cultivate working relationships between her health plan and local community organizations described the isolating effect of stigma. Although families experiencing a cancer diagnosis are supported by the community organizations described the isolating effect of stigma. in the same way. Other interviewees echoed this sentiment and described how neighborhood stigma can prevent their plan members from wanting to participate in recovery supports that do exist in their community. Health plans reported investing time in supporting community education about SUDs and the positive impact of treatment as ways to reduce stigma both in the community at large and in the minds of individuals who might need treatment. One plan also invested in remodeling its SUD treatment clinics to make them blend into the local neighborhood. The clinics do not include any signage identifying them as treatment facilities for SUDs or mental health conditions--rather their facades and waiting rooms are designed as non-specific medical practices. Health plan representatives also described investing resources in reducing provider stigma around SUDs. Interviewees noted that providers often hesitated to conduct substance use risk screenings because they had not received adequate addictions training in medical school and were uncertain about how to talk to their patients about such issues. One of the interviewed health plans is hoping to improve provider-members in self-advocacy. The plan sponsored an education class for members to learn about such issues by training their members in self-advocacy. difficult topics including substance use and unmet care needs. Health plan representatives also said that, although providers still were hesitant to take on new patients, especially those with Medicaid benefits. Plan representatives described conversations with providers still were hesitant to take on new patients, especially those with Medicaid benefits. expressing concern about Medicaid beneficiaries being disruptive in waiting rooms and burglarizing their practices for prescription drugs. Members' competing priorities including housing, child care, and accessing treatment for comorbid physical and behavioral health conditions as factors affecting successful initiation or continued engagement in substance use treatment services. Beneficiaries who are homeless or phone numbers, which would facilitate outreach efforts. Most of the health plan representatives reported employing case managers and outreach workers based in the local community as a way to engage with community as a way providing bus passes, reimbursing taxi costs, and providing gas cards to help individuals with limited finances overcome transportation barriers. Despite being able to offer these supports, case managers indicated that beneficiaries' attendance at follow-up appointments still was impeded by competing demands. For example, one plan representative explained that although members were provided a transportation benefit to get to their appointments, the state restricted children from accompanying members in the vehicle with transportation and child care needs face the challenge of securing alternative transportation or a babysitter. Interviewed plan case managers said that most beneficiaries in this predicament simply do not attend treatment. Health plan interviewees acknowledged that many of their beneficiaries with an SUD also have co-occurring medical and/or other health conditions that minder their ability to attend SUD appointments or achieve medication adherence. Health plans responded by encouraging their care managers and outreach workers to meet members where they are and to prioritize member to member immediately engage in those services. Health plans focusing on this patient-centered approach noted that it was a strategy for keeping the door open to future SUD treatment. Interviews also revealed that health plans are deeply concerned about being seen as a trustworthy resource to their members. Several health plans described member attitudes toward SUD treatment and health systems in general as a significant factor affecting their decision to initiate treatment. Health plan representatives noted that members often viewed the plan as an extension of untrustworthy state or other health care systems that they had encountered in the past. As a result, members were reluctant to respond to health plan outreach efforts. In response, these health plans are invested in developing positive relationships with community-based organizations that their members attend. Over time, the outreach workers became more familiar to both the community organizations and the plan members to begin trusting the outreach workers and the health plan. Plan members now are more responsive to outreach efforts and care coordination from the health plan. Requirements for access beyond network adequacy. All of the health plans described specific network adequacy requirements including limits on the mileage and travel time for beneficiaries to access treatment providers. Although each of the health plans are meeting these requirements set out by the state Medicaid agency and their governance boards, interviewees repeatedly described having additional network needs. Interviewees expressed concern over the growing need for treatment coinciding with decreases in the number of medical doctors specializing in SUD treatment. Health plan representatives focused most frequently, however, on how limited access to Drug Addiction Treatment Act of 2000 (DATA 2000)-waivered buprenorphine prescribers and residential treatment beds serve as barriers to meeting the treatment coincides with: Decreases in the number of providers specializing in SUD treatment. Limited access to buprenorphine prescribers. Providers who do not accept Medicaid beneficiaries. Lack of residential beds. Low reimbursement rates that limit plans' abilities to expand networks. One health plan representative reported having its provider relations team conduct monthly outreach to assess which buprenorphine prescribers are accepting new patients. Representatives from this plan indicated that their efforts have not been successful in expanding their network adequacy for MAT. They consistently hear that providers do not have openings for their members; however, they are continuing to conduct monthly updates in case prescribers expand their practices. Other Medicaid plan representatives echoed this experience, noting that they find it hard to identify DATA 2000-waivered physicians willing to treat Medicaid beneficiaries. Interviewees said that prescribers would not to take on Medicaid beneficiaries because of preconceived notions about treating that population or because they were accepting cash only for office visit services. Interviewees from each of the health plans were quick to identify specific challenges in contracting with sufficient buprenorphine prescribers to expand their treatment capacity. The amount of time spent on documenting buprenorphine treatment to meet DEA requirements was identified as a significant barrier for prescribers. One of the health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of the local health plans is using grant funding to hire a Certified Alcohol and Drug Abuse Counselor to support a few of thealt meeting DEA documentation requirements. The counselor conducts educational consultations with the plan members about buprenorphine induction. All patient follow-up appointments take place with the counselor and the prescribing physician. Other health plan representatives described a desire to support prescribers in this way but reported lacking funds to pay for this support. Additionally, health plans are concerned about the lack of residential treatment facilities. Interviewees at the plan leadership and member outreach levels expressed concern over the lack of residential treatment facilities to which they could send their beneficiaries following discharge from detox services. Interviewees felt that, without residential treatment available to their members, they were watching them get discharged from detox only to relapse in the community without the appropriate level of care to support them. Low reimbursement rates for both MAT and residential treatment were identified as significant factors limiting plans' ability to expand network adequacy for necessary services and ultimately to ensure access to care for plan beneficiaries. Medicaid plans expressed concern that providers withhold open spots from Medicaid beneficiaries to receive greater reimbursement rates from commercial plan expressed similar concern over the low rates that Medicaid plans can offer providers. Members of commercial plan leadership said that they are reluctant to reimburse residential treatment providers at rates substantially higher than those set by the state Medicaid agency. Previously the plan had set a higher reimbursement rate for residential providers, but in doing so they priced out the state Medicaid plans. Members of commercial plan leadership also reported reducing their reimbursement rates to help maintain access for Medicaid beneficiaries. LOW REIMBURSEMENT Low reimbursement was identified as a significant factor limiting plans' ability to expand network adequacy for necessary services. The Medicaid plans do contract on an ad hoc basis with out-of-network providers to fill gaps in access. Payment is negotiated, and most of the Medicaid plans pay the same rate as they do for in-network providers. One plan paid less to provide an incentive indicated that paying more than a small amount above the state-established rate was burdensome because they would be required to justify doing so to the state. Qualitative Research Question 3: What do health plan representatives believe are significant barriers and facilitators to initiating members in care differed from the challenges to continued engagement in care. Plan representatives generally noted that any barriers to encouraging members to disengage after a few visits. In response, health plan representatives described identifying and developing facilitation strategies

that applied to getting members to both initiate and continuously engage in care. Key barriers identified by plans relate to community stigma toward SUD and treatment, providers' lack of addiction training and comfort treating individuals with an SUD, plan members' readiness for behavioral change, and service limitations of health plan benefit arrays. Because many of these findings already have been summarized in response to qualitative research Questions 1 and 2, the following section highlights key barriers and their associated facilitators. Barrier: Community stigma toward SUDs and behavioral health treatment prevents members from initiating and remaining engaged in treatment Facilitator: Health plans are focusing on integrating primary care and substance use treatment. Health plan representatives described substance use related stigma as communities' rejection and alienation of individuals with an SUD. Interviewees said that communities do not regularly engage in conversations about substance use so it becomes a taboo subject when a community member has an identified need for SUD treatment. Interviewees described stigma around substance use as one of the most significant barriers to encouraging members to initiate and more isolating than stigma around mental health conditions. Although interviewees noted that alcohol use disorder was less stigmatized than illicit SUD involving heroin or opioid analgesics, they identified overcoming stigma as a challenge to bringing beneficiaries into treatment. Health plan representatives frequently described considering substance use-related stigma when developing strategies to successfully initiate beneficiaries in treatment. Most commonly, they focused efforts on co-locating SUD treatment facilities. Members did not want to be seen entering these facilities or have medical records specifically list the name of an SUD treatment facility. Interviewees noted that these concerns were particularly troubling for individuals with more severe treatment needs. Co-locating SUD treatment services within primary care and other physical health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members to attend appointments in a familiar environment without the stigma of being identified as a behavioral health practices encouraged members. knowing that they could perform a warm hand-off with the co-located counselor down the hall. Specifically, most health plan representatives identified embedding SUD treatment. Interviewees said that providers were more comfortable having conversations about substance use risk behavior and treatment initiation with members knowing that they could perform a warm hand-off with the co-located counselor down the hall. Counselors were seen as being able to step in to talk to newly diagnosed members or members with risky behavior about the benefit of initiating some type of treatment. Interviewees also described how embedding counselors improved trust and communication between physical health and SUD treatment providers. Simply having these individuals in the same facility promoted regular conversations about integration and care coordination planning to support members' holistic needs Interviewees described this integration as key to engaging in routine check-ins with members about treatment or become disengaged over time. Primary care providers are able to repeatedly advise at-risk members about treatment or become disengaged over time. to initiating treatment. Similarly, co-located substance use counselors can check on members who come in for physical health appointments and make a subsequent effort to engage them in care. Health plan interviewees described some initial pushback from providers regarding embedding SUD treatment counselors and other integration activities. Some providers told the health plan they felt that the behavioral health counselors were monitoring or infringing on their practice. Health plans responded by having plan leadership reach out to convince providers of the potential benefits of primary and substance use care integration. Barrier: Providers lack sufficient training in addictions medicine to effectively initiate members in treatment. Facilitator: Health plans are routinely engaging providers in education opportunities to promote evidence-based practices with substance use behavior in members as well as a barrier to encouraging members to initiate and engage in treatment. Interviewees described providers reported not feeling comfortable asking the screening questions or knowing how to advise individuals who screened positive Plan representatives acknowledged that early intervention activities were difficult for providers because substance use risk screening and motivational interviewees described developing a variety of educational opportunities directed at enhancing providers' knowledge of best practices for substance use screening and treatment. Health plans that require providers to conduct universal SBIRT with plan members reported developing training modules specific to using the screening tool and to conduct universal SBIRT with plan members with an identified risk. One plan representative reported holding provider training sessions on how to conduct motivational interviews with members. Providers practiced motivational interviewing techniques in person to develop confidence with the early interview of SBIRT in favor of having providers simply offer advice about reducing substance use. After providers reported feeling unsuccessful with the original motivational interviewing requirement, local plan leadership provided them with risk reduction talking points that mimic how providers counsel diabetic patients about glucose levels. Members are advised on the safe range of alcohol consumption and how much they would need to reduce consumption to be considered within safe medical guidelines. Health plans invested in creating provider portals or other electronic systems to promote effortless communication between the providers and follow-up care with a single click. When this referral is made, health plans are alerted to the request in real-time and begin conducting outreach with the plan member. Health plan representatives said that they were motivated to create these tools to partially remove the burden of treatment uptake. Half of the health plan representatives interviewed also described generating provider reports on the number of members with an identified SUD and their follow-up treatment status. Interviewees noted that plan staff meet one-on-one with providers to discuss their performance and identify next steps for engaging members in treatment. with providers to discuss best practices in SUD treatment. Plan interviewees described these in-person and webinar meetings as opportunities to inform providers about practices that close the gap between SUD diagnosis and treatment initiation. Meetings highlight the importance of referring members for care coordination and case management. Meetings also highlight best practices regarding MAT and ASAM criteria regarding level of care and care transitions. Health plans also are promoting materials developed by SAMHSA to augment provider knowledge around evidence-based practices in SUD treatment. Two of the health plans also reported partnering with local subject matter experts and university researchers to promote providers' understanding of the local populations' needs and attitudes toward SUD treatment. Overall, health plan representatives noted that their many efforts to educate providers about substance use issues and treatment. wanting to serve as a support for providers and viewed the health plans are promoting this team sentiment by carefully scripting the way that they approach education with providers. Interviewees said that they were cognizant of not wanting to come off as telling physicians how to operate, but they want providers to see best practices and electronic systems as valuable tools for their patients. Barrier: Members are not ready to abstain from substance use or other related risk behaviors, which results in an unwillingness to initiate traditional SUD treatment. Facilitator: Health plans are promoting harm reduction techniques and "no wrong door" and "no wrong time" approaches to engage members in conversations about substance use as a significant factor affecting their ability to initiate or sustain engagement in treatment programs. They described treatment programs and care management as historically focused on an abstinence-only approach with sobriety as a key requirement for continued engagement. Interviewees generally agreed that promoting abstinence-only treatment environments did not facilitate initiating members in treatment. As a result, health plan interviewees reported gradually shifting their approach to promoting harm reduction as a significant facilitator for both initiating members in treatment and maintaining long-term engagement. WHEN HEALTH PLAN MEMBERS DO NOT FEEL READY FOR TREATMENT Health plans are more frequently promoting harm reduction techniques and "no wrong door" and "no wrong time" approaches to engage members in conversations about substance use. Health plan representatives reported offering a variety of harm reduction initiatives to members. One plan began sponsoring group sessions that promote conversations between members who are reducing their use but have not fully quit. The plan representative noted that these groups have been useful for bringing more people into service who did not previously self-identify as needing treatment. The harm reduction groups were described as a place for members to begin thinking about what treatment would mean for them and what healthful behaviors are helpful to them in achieving their personal goals. Health plan representatives also described harm reduction programs for members to participate in as a first step to reducing risky behavior. Plans described harm reduction strategies as an extension of their intent to promote patient-centered care coordination and a "no wrong door" approach to SUD treatment. Health plan representatives described their no wrong door approach as enabling members to engage in any kind of treatment. building a trusting relationship with the member to support initiation and engagement in SUD treatment. In developing an ongoing relationship with members, health plan interviewees noted that they can engage beneficiaries in treatment as soon as members express an interest. Thus, the no wrong door perspective also is facilitating a "no wrong time" approach to getting members into SUD treatment. Discussions around the no wrong door approach focused on asking members about their priorities and health goals. Health plan representatives acknowledged that this approach was more easily promoted through their own care management and care coordination staff than through their contracted providers. The challenge with adopting this approach, according to interviewees, is that it requires a culture change from the way SUD treatment is traditionally viewed. Health plans are using their staff to promote a patient-centered philosophy rather than a program-centric approach. cover the continuum of SUD treatment; this limits members' ability to initiate treatment or continue engaging in services that appropriately support members' access to community-based recovery needs. Facilitator: Health plans are investing in staff that support their recovery needs. engagement. One of the most significant themes identified in the health plans are focused on promoting a care coordination model that is based in mission statements about individualized and patient-centered care. This approach enables health plans to stretch beyond their stewardship of plan benefits to support beneficiaries with care management and outreach and to facilitate engagement in community-based recovery supports. Plan-employed care managers, care coordinators, community health workers, and other outreach workers were identified as critical to successfully initiating and engaging members in treatment. Health plan interviewees repeatedly acknowledged that their ability to bring members into SUD treatment was contingent on their understanding that members have needs beyond traditional health services. Health plans are staffing their care management, coordination, and outreach teams with clinicians who are experienced and licensed and have a master's degree. Health plans expect these clinicians to conduct face-to-face visits as well as telephonic outreach with members wherever they are in the community. When plans learn of member admissions to detox or other inpatient facilities, these clinicians are expected to conduct immediate outreach with the member. members to participate in discharge planning and care transitions and to coordinate community-based treatment efforts and to integrate members' physical and behavioral health care. Interviewees also reported a consistent expectation from their health plans to understand members' holistic needs across substance use, mental health, physical health, and necessities such as housing and food. Interviewees consistently described this level of member outreach as the primary facilitator of getting members to the initial SUD treatment visit and ensuring that they continued engaging long-term. Health plan interviewees noted that focusing on their members' individual needs enables their plans to identify key moments when members are receptive to treatment. COMMUNITY PARTNERSHIPS Interviewees reported establishing relationships with community-based peer support organizations. Additionally, interviewees at all five Medicaid plans identified limits on their covered services, and other tenancy support agencies, sober housing agencies, and other tenancy support agencies, sober housing agencies, and other tenancy support organizations. recovery supports. As previously discussed, health plan representatives expressed frustration about not always being able to link their beneficiaries to partial hospitalization and residential treatment. Some of the Medicaid plans also were unable to reimburse for peer support services, which their representatives unanimously felt would facilitate their members' engagement in recovery. Because of service limits within their own benefits, representatives from all five Medicaid plans reported cultivating community partnerships to expand their access to recovery supports across systems. Although they reported being unable to reimburse for these services directly, they can refer members to the services and help identify grant or donation funding for members when necessary. Interviewees reported establishing relationships with community health workers, and other plan-employed outreach workers are expected to cultivate these community relationships to increase supports available to members. Health plan leadership frequently described these non-reimbursable services as key to promoting stability in members' lives and thus promoting their continued engagement in SUD treatment. Representatives from half of the plans interviewed reported encouraging their staff members to inform leadership about the success of these community partnerships. They described efforts to track and report on member progress as a means of producing evidence that might support possible inclusion of these services in the plan benefit array in the future. Facilitators and Barriers to Measurement for HEDIS IET The primary aims of the qualitative interviews and analyses were focused on identifying characteristics, strategies, and other factors that affect the ability of successful health plans to initiate and engagement members in care. However, several health plans also wanted to discuss ways in which they view the criteria of the HEDIS IET measure as affecting their measured success in initiating or engaging members in treatment. The following themes are drawn from brief conversations with health plans around the structure or calculation of the HEDIS IET measures. which the IET measure requires them to meet the initiation and engagement phases of the measure. The initiation phase requires individuals to receive inpatient or outpatient treatment visits and achieve engagement. Health plan representatives indicated that they often did not receive claims data on their members within those time frames, and thus they were unable to ensure that members receiving an initial diagnosis completed initial and follow-up visits in time to count toward the measure. Plan representatives noted that if they failed to receive timely notice of a member's initial detox admission, they likely would fail both the initiation and engagement phases of the measure. Health plans also commented on the same day. Representatives from two of the health plans commented that they had previously encouraged diagnosing providers to walk members into follow-up appointments with different providers to conduct this warm hand-off. Health plans enjoyed the option to count same-day appointments toward the measure requirements and expressed concern over the criteria being changed to require that all visits occur on different dates. Finally, one health plan representatives described how general sociodemographic differences between commercial and Medicaid beneficiaries should alter the expectations for treatment initiation and engagement timelines. The health plan interviewees noted that the timeline for meeting the initiation and engagement phases of the measure should be extended for Medicaid populations.

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