SUD 1115 Waiver Stakeholder Advisory Committee (SAC) Meeting Minutes, Jan 31, 2020

Welcome and Introductions
- Director Corcoran welcomed the group and expressed her excitement for 2020, especially for further discussion about the SUD 1115 waiver.
- State noted that the webinar and meeting minutes will be posted to the SUD 1115 SAC webpage.

SUD 1115 Waiver Monitoring and Evaluation Plan
- State introduced the Ohio Colleges of Medicine Government Resource Center (GRC) team that will perform the independent research, evaluation, and monitoring required for Ohio’s SUD 1115 waiver.
- GRC reviewed the numerous monitoring metrics that will be evaluated during the waiver.
- GRC emphasized the evaluation will focus on the goals and milestones that were defined by CMS with approval of the waiver. GRC reviewed goals listed on slide 7 of the webinar.
- GRC walked through the driver diagram (slide 9) including the research purpose, primary/secondary drivers, research questions, and hypotheses.
  - Question: What is a PDMP?
    - Answer: Prescription Drug Monitoring System.
- Discussion Questions posed by GRC: Do these Milestones and measures seem logical, or are there things that are missing?
  - Question: Will you look at any special populations – adolescents?
    - Answer: Yes, we will break out sub populations that will be monitored.
  - Question from GRC: Are there other recommendations for specific populations to include?
    - Answer: Pregnant and post-partum women, minority populations, dually diagnosed, incarcerated re-entry.
  - Question: In certain regions, access and level of care are not optimally available, will you look at this population? Ohio has uneven application of capacity and levels of care.
    - Answer: GRC is adding a regional analysis where there are not optimal levels of care to monitor how service access may change in those areas. Also, GRC acknowledges various measures will change over the next 5 years. This a long-term project, so analysis of changes will be a systematic approach.
  - Comment: Re: Q7 in hypothesis draft document, it is important to track other deaths, not just opioid-related deaths.
    - Answer: GRC is revising and will be reviewing with ODM. Stakeholders are encouraged to send other comments/questions.
  - Question: When you’re looking at capacity, are you looking at all levels of residential?
    - Answer: Yes.
- GRC described the CMS requirement for qualitative as well as quantitative research (slide 13). Research will rely on utilization of key informant interviews with ODM, leadership, members of the Stakeholder Advisory Committee and yet to be formed focus groups of individuals who have received SUD treatment services. GRC’s proposal is to hold two rounds of focus groups – the first will be the baseline for the evaluation, and the second a follow up.
- GRC described the intent of focus groups as to gather perspectives about the treatment experiences and successes among individuals who have received services. Suggested topics include:
• access to treatment, care coordination when transitioning between levels of care, integration of primary care services, identification of gaps and obstacles faced during treatment in the community and personal life.

• GRC reviewed the proposed approach to work closely with residential treatment facilities to identify potential focus group members who were treated for OUD and/or SUD in residential treatment in the last 6 months.

• GRC asked SAC members for feedback on proposed approach. How to recruit focus group participants? How can treatment providers in this effort? How can we best partner with providers?
  o Comment: Many patients do not receive treatment in residential care including patients in Opioid treatment programs so suggest that GRC look more broadly at potential members for focus groups who have been served as other levels of care.
    ▪ Answer: Because of the waiver’s focus on SUD residential care in IMDs, we need to seek information about residential care. But we will take this back for further discussion. We want to find a range of individuals, including those who are in recovery.

Feedback provided by SAC members included the following concerns and input:
  o Suggest not limiting the consumer focus groups to just individuals who have received SUD residential treatment in the last 6 months. Broaden to individuals who have received treatment in other levels of care.
  o Don’t forget about individuals who are receiving medication assisted treatment services from Opioid Treatment Programs. Many residential providers don’t offer MAT.
  o Try to identify individuals who are “in recovery” to include in focus groups. This will be important for the second round of interviews assuming that some of the interventions in the SUD 1115 waiver have been successful in improving access to services.
  o Consider using peers as part of the process for qualitative approach to participate in the focus groups.

The discussion concluded with SAC members asking for a review of the focus group questions before they are finalized. GRC agreed to do so and invited the SAC members to share any additional thoughts to the MCD SUD 1115 email address.

Next activity was introductions of SAC members, state staff, and members of the audience.

State Staff Announcements/Updates
1. The March 27th SAC meeting will be repurposed to serve as the official (federally required) public forum for Ohio’s SUD 1115 waiver. The March 27th meeting will occur at the same location as other SAC meetings (ODM, C621, 50 W. Town Street, Columbus, OH).
   • This meeting will occur after Ohio posts its first quarterly waiver monitoring report waiver and so state staff encourage any feedback from interested parties about that report. Input is also encouraged from interested parties on any aspects of the SUD 1115 waiver.
   • Stakeholders may attend meeting in person or by webinar and may also submit comments in writing.
   • State asks SAC members and their organizations to encourage input from any interested parties in this public forum. Request that stakeholders publicize the event to their respective members.
2. ODM and OhioMHAS have entered into a collaboration with the Arnold Foundation to pursue three main activities aimed at the overall goal of expanding access to Medication assisted treatment:
   • Improve the clinical quality of MAT practice
   • Expand access to methadone among providers who are solely offering buprenorphine
   • Develop centers of excellence for MAT who can offer technical assistance to other providers in Ohio.

   The project has just begun, and so State staff will provide more updates in the future.

3. State is aware of and beginning to develop implementation policy for coordinating Medicaid benefits with Medicare’s Opioid Treatment Program (OTP) benefit. Short-term guidance to providers is that if they offer MAT and serve individuals who are enrolled in Medicare and Medicaid, they are encouraged to enroll as Medicare providers so they can participate in the new Medicare bundled payment methodology. State staff will provide more information in the future.

Discussion of Milestone 5—Treatment & Prevention of Opioid Abuse and Disorders

Presenters of this section were Dr. Mary Applegate (ODM’s Medical Director) and Blair Cathcart (Ohio Board of Pharmacy). Dr. Applegate began with an overview of how Ohio has addressed the opioid crisis from 2011-2019.

Dr. Applegate and Mr. Cathcart described the purpose of a state Prescription Drug Monitoring Program (PDMP) and noted that Ohio’s PDMP is called OARRS: Ohio Automated Rx Reporting System. OARRS is a database containing a record of all controlled substances that have been prescribed regardless of who the health care payer was for the prescription. It is regarded as the single source of truth for prescriptions of opioids and other controlled substances.

Presenters noted that every prescriber is required by state law to review the OARRS database prior to issuing a prescription for any controlled substance. The purpose of the review is to check the history of prescriptions to their patients. In addition to prescribers having OARRS access, pharmacies can also refer to OARRS as a second layer of safety. Over 1 million checks happen every day, and there has been an uptick as a result of so many medical practices integrating their Electronic Health Records (EHR) with OARRS. Maps of Ohio on slide 31 show the percent of prescribers and pharmacies who have integrated their EHRs with OARRS.

• Question: Are all forms of MAT required to be reported in OARRS?
  o Answer: No, not all forms of MATs are required to be reported to OARRS, but some do report voluntarily.

• Question: Why is that?
  o Answer: Per Federal law – Title 42 (privacy and confidentiality) – opioid treatment programs (OTP) are exempt from the requirement to report to PDMP. There is current effort at the Federal level to possibly change this.

• Question: We have heard that the current opioid epidemic may be followed by an expansion of the use of stimulants – is there any thought on adding Adderall or other stimulants as prescriptions to be reported in OARRS?
  o Answer: Yes, these are tracked in OARRS as they are controlled substances.

• Question: Can more clinicians be allowed to have access to OARRS? (e.g., master’s level social workers) – it would be really helpful for diagnostic and treatment purposes.
• Answer: ODM acknowledged this suggestion and will take it under consideration the in future (managed care plans have expressed interest in this as well).

Mr. Cathcart noted that both prescribers and pharmacists have the authority to delegate their OARRS access to other individuals, although he believes that current delegation is more focused on law enforcement officials and coroners. (The concern about limiting access is with regard to HIPAA and patient protections.) The implication is that it may already be possible for OARRS access to be delegated from a prescriber to another licensed professional on their staff but the staff to whom access is delegated will have to take on the responsibility of protecting access to patient confidential health care information. (State staff will take this discussion as a follow-up item.)

The presenters provided following statistics on how OARRS is being successful in controlling access to opioids.

• Providers prescribing fewer opioid medications: 41% reduction (792 million to 467 million scripts) during the period 2012-2018.
• State has seen a drop in frequency of incidents of “pharmacy shopping” and newly prescribed opioids.
• State has partnerships with 32 states to have a full view of what patients might be taking and now we can benchmark Ohio versus other states (including neighboring states).

The presenters reviewed the predictive analytics slide (slides 38 & 39) which includes overdose risk score for patients and prescribers.

• Question: Are dentists required to use OARRS?
  Answer: Yes, OARRS use is required for any provider that can prescribe.

• Question: Is gabapentin a controlled substance?
  Answer: It is not currently, but we are aware that this is used to enhance opioids; data regarding gabapentin is included in OARRS, and the State is evaluating next steps.

• Question: Is there anything being done with prescribers that don’t check OARRS?
  Answer: The Ohio Pharmacy Board is developing a tool with the State Medical Board. In the past, a report has been sent to State Medical Board and follow up occurred with providers, but issue was that providers weren’t sure if they were in compliance, so the new tool will enhance functionality to allow prescribers to look up their OARRS check history and make sure that they are using OARRS appropriately for any patients for whom they prescribe.

• Question: What is the work that you see occurring in the future?
  Answer: Goal is to meet more routinely on treatment and prevention, and to better understand the prescribing patterns for pain medicine (especially back pain), support alternatives, physical therapy, explore transportation, early identification, and patient engagement. We also need to better understand the differences between opioid prescribing vs. pharmaceuticals used for medication assisted treatment. Further, we are using our unique data sets to increase patient incomes and track those patients and prescribers who are using the greatest number of controlled substances (highest Narx scores.)
• Question: Why aren’t more prescribers showing up on the Ohio map as being integrated with OARRS in their EHR systems?
Answer: Not sure. Important to understand that the State Board of Pharmacy provides funding to prescribers to integrate with OARRS. The actual integration is free to all prescribers and pharmacies who are eligible.

• Suggest that we use OARRS as a “backwards SBIRT-type tool” to screen prescribers. Once identified as problematic prescriber, they are sent to a 3-day remedial prescribing course (30% from Ohio are sent there because they aren’t checking orders). When a prescriber name keeps coming up who are regularly prescribing controlled drugs to addicts, the prescriber is sent a letter they are negatively affecting the patient, and we try to have the patient sign release of information form and encourage them to enter treatment.
Answer: As we refine our data, this gives us another way to view prescribers; we will take this back to leadership.

Milestone 6-Care Coordination
• State staff reviewed CMS requirements for care coordination especially related to patient transitions between levels of care.
• State reviewed model components – target population, attribution process, care coordination activities, provider criteria, Medicaid payment rate, and Federal authority.
• State asked for input from this group and noted that they will be providing “concept paper” sometime soon as a discussion vehicle for specific feedback.
• SAC members offered the following comments:
  o Often, we see patients go from residential to a partial hospitalization or outpatient level of care and provider and the new provider requires that a new assessment be done for the patient. Suggest that the new provider make use of the original assessment to build on the existing information and shorten the lag time between assessment and actual treatment beginning. (The new providers should be able to have access to the previous assessments.)

  o State Note: We need to learn from our experiences, be open to opportunities and priorities, and determine what works best with help from this stakeholder group.
    ▪ Suggestion: Talk to health homes and other agencies that have seen improvements and understand their experiences.
    ▪ State Suggestion: We need to continue understanding the process measures/functions to advance a person’s outcomes. Along with our Federal partners, we can suggest better ways to treat a person’s health.

  o Continuum of care – We need to assure that communities have behavioral health care coordination available to them, let alone having access to the health home type of care coordination.

  o We should learn from the lessons of our Medicaid health homes project of a few years ago. We should focus attention on what happens with the other providers (non-health home) who are also serving health home clients and what impact they have on the health home clients. Comment is particularly focused on BH providers for youth and families.
o Suggest that we ask providers who are performing comprehensive care coordination similar to, but not officially “health homes,” (whether or not they were designated as such) how they have been measuring outcomes, what worked, what didn’t.

o It would be great to align health care outcomes across large providers that offer a wide variety of services and across the different programs like CPC and BHCC.

o Are there any examples of care coordination with primary SUD population? State staff welcome any input on this topic.

o Minority and special populations need to be represented in the target population for care coordination.

o Ohio has concentrations of BH providers in many urban areas and other areas of the State but a lack of providers in certain other (rural) areas of the State. The challenge with a care coordination proposal is how to make it something other than a one-size-fits-all application, especially in more rural areas of the State. Care coordination doesn’t need to be one thing.

o Capacity to provide the service – electronic record, licenses are not enough. Moving to implementation takes a lot of work. We should view the implementation of care coordination in phases over time.

o There is a lot of pent up interest among the Ohio BH provider community in care coordination. There is some speculation that this is never going to happen. It would be good for the State to communicate that this is really moving forward as a comprehensive model.

o One of the main lessons learned from our previous health home experience is that we didn’t spend enough time up front doing training. Comprehensive care coordination isn’t just a new way of paying for care coordination.

o During the first phase, the State should examine the use of health information exchanges (HIEs) as the data reporting vehicle for health homes. They already collect and report on many of the measures that may be needed and to use existing HIEs would relieve the provider burden. HIE can also help with info about hospital admissions, discharges, prescribing to the BH providers, especially the freestanding psychiatric hospitals. We do need to keep in mind and respect CFR 42 Part 2 which requires some extra care in SUD patient releases of information.

o Learn from the experiences about how it has worked best and why. There is a disconnect between a population health approach to focus on those at the higher risk (of death, e.g.) vs. everyone in Medicaid as high risk. We need to be able to do risk tiers. Attribution of clients based on the data that indicates risk. We want to hear what works best. How would you react to a list of people who are the highest risk? Some of the former health homes
have achieved the goals and outcomes that the State wanted. It just took longer and maybe wasn’t captured in the outcome measures. We need to be clear about the outcomes that we are trying to achieve.

  o The area of care that is the most missing in the standardized measures are the BH outcomes, e.g., 7-day follow up after hospitalization isn’t enough. We need to know more about what follow-up post hospitalization is actually occurring.

**Upcoming Meeting**

  • Next SAC meeting will occur on 2/28/20 at this same time, 1-3 pm, at the same location, ODM, C621, 50 W. Town Street, Columbus, OH.