Welcome and Introductions

- Director Corcoran delivered opening remarks, welcomed meeting attendees, and thanked SAC members for participating in this effort.
- Doug Day with OhioMHAS began facilitating the discussion for the day.
- Meeting Purpose: Goal for today is to utilize the history and expertise of SAC members to advise the State on provider standards for SUD residential levels of care.

Slide 4 & 5

- ODM performed a claim analysis and found that most of the Medicaid claims for SUD residential were for ASAM Levels of care 3.1 (billing code H2034) and 3.5 (billing code H2036).
- SAC Q: If an individual is served under different LOC 3s, would claims billing be shown in both?
  - State A: Yes, slide indicates that there are possible duplicates in the data.

Slide 6 & 7

- Doug Day Reviewed the main discussion points and items to consider during the discussion:
  - Who can clinically manage/medically monitor SUD residential treatment programs?
  - What program staff are needed for each of the ASAM levels of care 3.1, 3.3, 3.5, and 3.7?
  - What are special considerations for adolescent programs?
  - What are the special considerations for co-occurring capable and co-occurring enhanced programs?
  - What are the special considerations for adult special populations?
  - How will programs provide on-site or facilitate off-site access to medications for SUDs?

Slide 8

- SUD 1115 Milestones 2 and 3 are most germane to today’s ASAM conversation.

Slide 9

- Doug reviewed the ASAM clinical and programmatic criteria. ASAM criteria does not replace or supersede the relevant statutory, licensure, or certification requirements of any state or federal jurisdiction. Key point is that ASAM guidelines do give Ohio some latitude on how to design Ohio provider standards for SUD.

Slide 10 & 11

- Definition of Level 3 ASAM was reviewed.
- SUD residential treatment programs are not housing.
- Other states have been going through similar processes to Ohio’s review of how ASAM guidelines are incorporated (links included at end of presentation for information on other states).
- ASAM notes that there are different standards for programs serving adolescents compared to adults. This information is marked in orange throughout the ASAM book and this presentation.

Slide 12 & 13

ASAM Definitions of co-occurring capable and co-occurring enhanced are noted in the presentation and were reviewed with the group.
Slide 14
- LOC 3.1 and 3.5 are both clinically managed but the distinction is the intensity of services in each level.
- Note that adolescents have medium intensity of service whereas adults do not. This was commented on by a SAC member whose agency treats adolescents. His concern was that the treatment needs of adolescents were no less intense than adults and naming the ASAM level “medium intensity” didn’t accurately represent the treatment needs.

Slide 15
- SAC Q: How is staffing to be handled at LOC 3.1. Are organizations expected to staff it themselves or contract this out?
  - State A: Needs to be discussed in broader context of what ASAM LOC 3 programs should look like.
- SAC Q: Who would you recommend to clinically manage? Are we talking about who is onsite every day, 7 days a week? Overall, we are struggling to understand who can clinically manage.
  - State A: Staffing is another item for discussion with SAC and is referenced later in slides 17 and 18.
- SAC Q: What does a LOC 3.1 BH provider look like? One SAC member commented that recovery housing meets all LOC 3.1 requirements except the 5 hours of treatment. But there seems to be larger variation in other residential LOCs with up to 30 hours per week of treatment.
  - State A: Refer to Page 223 of ASAM guidebook as good resource on LOC 3.1 residential treatment. However, this doesn’t resolve confusion about the differences between recovery housing with access to clinical treatment and housing that is considered only housing.
- SAC Q: One difference is that in LOC 3.1 the governance of consumers is by their individualized treatment plan and recovery housing participants are governed by a lease agreement.
  - State A: Our challenge is to determine which practitioners should be able to clinically manage which parts of the treatment in SUD residential settings.

Slide 17
- SAC: We lack a common understanding of the ASAM requirements, especially regarding the number of treatment hours required of staff at various levels of care.
- SAC: What about licensure or experience that will be needed?
  - State: We, OhioMHAS, have some experience from a regulatory perspective, but let’s hold on this question and talk through how think the ASAM criteria for SUD residential treatment should look in Ohio. Things to consider:
    ▪ “Allied health” professionals is not a term that is used in Ohio.
    ▪ State can make regulations on 24-hour on-site availability if we would like.
- SAC Q: Who qualifies as clinical staff? Is it everyone on the previous slide or are we overcomplicating it since we are already meeting these standards by employing independent practitioners?
- State Q: We are asking you, advisory committee members, if our current policy comports with fundamental ASAM standards. And then State staff can take your guidance/comments and update the rules and regulations to try to reflect your input. Is there something Ohio regulations are missing or something we should do differently?
• SAC A: This is a scope of practice issue. Are we talking about whether a clinician can manage the patient or the program, and is there a distinction between the two?
• SAC A: From a clinical practice perspective, only independently licensed practitioners can supervise, so then these practitioner types should manage. However, we need to focus on the broader team too. So flexibility is important in how we define staffing.
• SAC Q: Will there be flexibility in the proposed regulatory changes, e.g. what practitioners can provide what services? Professional scopes of practice change over time (e.g., nurse practitioner scope). It will be important to rely on Medical and other professional Boards for up to date guidance.
• SAC A: If you have a physician on the treatment team, they are not always getting reimbursed for that, so we need to figure out how to address this.

State: Remember that SUD 1115 and ASAM requirements emphasize access to medications. From a clinical perspective, this involves our licensed independents, but then there is another level of clinical management, and that may not entail the same group of practitioners. There is value in having an array of practitioners, so they can cover a variety of services like assessments, psychotherapy, physical health all within their respective scope of practice.

Slide 18
• State: Note that ASAM guidance sprinkles in requirement like “the ability to arrange pharmacotherapy” and unique terms like “biomedical enhanced.”

Slide 19
• State: Orange sections in ASAM guidebook include information on adolescents.
• SAC Q & comment: Why is an adolescent LOC 3.5 considered medium intensity and not high intensity? Experienced staff should be managing this and should work with multi-disciplinary team.
• SAC Q: Demarcation seems to be clinically managed vs. medically managed which is a gray area because it is hard to know who is the lead clinician for a patient’s treatment plan. Is that within the scope of the agency?
• SAC A: We agree that licensed independent clinicians fall within this scope.
• SAC Qs: What is the potential for withdrawal complications if managed by a clinical social worker vs. a physician? What about self-administering medications versus nurses dosing medications? If there was no physician involved at all on treatment team, could they be clinically managed? This is where independently licensed staff should be signing treatment plans.
• SAC: We see individuals come in at LOC 3.5 and then level down to 3.1 or go up to 3.7 if needed. Another SAC member mentioned they see patients at multiple levels.
• State Q: Why are patients coming in at different levels of care? How are agencies figuring this out?
  o SAC A: Individuals are brought in based on their LOC. And if they need more help, they will be referred elsewhere.
  o State A: Overall, assessment should drive the LOC intensity. Goal is to deliver best care, while utilizing ASAM as a guide and not becoming too burdensome for individuals to get their services.
• SAC: If you look at intensive outpatient level of care, you could easily have more clinical contact at a lower level of care than at a LOC 3.1, (e.g. Intensive outpatient or partial hospitalization) so there appears to be some cross-overlap among ASAM levels re: the amount of clinical contact.

• SAC: We try to manage this but if we cannot provide more clinical service/impact, that is when we need to make a referral, so the patient receives the more appropriate LOC.

• SAC: Another issue is that some patients are being inappropriately placed in recovery housing when they really need residential treatment. Bed space may be open in recovery housing but not in residential treatment. We need to match capacity to need.

• State: We need to look at intersection of recovery housing and outpatient treatment and develop Ohio based policies to fix some of the problems we are noting here today. LOC 3.1 is an interesting level of care for us to discuss here today given these complications. We appreciate the comments that SAC members are making here today.

• SAC: SUD treatment capacity in the State is very limited and so we should look at blending services in some way.
  o State: One of the major requirements in our SUD 1115 waiver is to perform a provider capacity analysis by LOC to better understand service needs and what provider development needs to occur.

• SAC Q: Can LOC 3.1 and 3.5 be offered in the same facility?
  o State A: Nothing in the ASAM guidelines prohibits a facility from doing this. There may be some cost efficiencies in this model as well as treatment advantages in not having to physically move individuals.

• SAC A: It is more about the care being offered, not the physical structure.

• SAC Q: Provider capacity study will be interesting because if a facility does offer both LOC 3.1 and 3.5, we are curious how State will measure it. (Once or twice?)
  o State A: OhioMHAS is currently reviewing this.

• SAC: Important to have recovery supporters available especially when transitioning between levels of care to serve as connection to change individual’s life; hopefully care coordination will tie this all together.

• State: should consider adding another staff type – vocational specialists, so when people leave residential treatment and move to recovery housing, clients can have assistance finding employment. [Editors Note: in order for Medicaid to pay for vocational services, ODM would have to receive federal approval]

• SAC: During provider capacity study, State should focus on recovery housing.

• SAC: Best experiences we have seen with recovery is when an individual goes from LOC 3.5 all the way down to 2.1 and then we follow that person afterwards once they get into recovery housing to make sure they are on the right track. Recovery housing is an important part of the full continuum and provides opportunity.
  o State Q: When an individual moves down to 2.1 LOC, are they living in a recovery housing facility?

• SAC A: It depends on what LOC a patient completes; they move to recovery housing after completion of their treatment.

• SAC: The recovery housing model has four levels of recovery housing depending on a patient’s need for treatment and support

• SAC: Housing and treatment should be overlapping.
• State: There is a point when housing becomes treatment because individuals need this type of help to move forward with their lives.

• SAC: Recovery homes in Ohio are considered landlords and agree to leasing terms.
  o State: Important to understand further how this intersects with SUD residential treatment.

• State: SAC members were asked to identify any gaps with case management
• SAC: We need to consider who is doing the care management at these facilities and what their qualifications are.
• SAC: We have concerns about individuals not receiving needed educational information once they leave a SUD residential facility. Hope is their psychiatrist continues to help and gets patients referred and enrolled in special programs as needed.
• SAC: Recommend that the peer recovery support credentialing process be reviewed or changed because we want to see peer recovery supporters succeed and help others.
• SAC: Need to approach care coordination in a way that is able to manage all aspects of what an individual need.

• State Q: Can we discuss how providers offer access to SUD medications as well as other medical and psychiatric conditions?
  o SAC A: Some agencies partner with FQHCs to provide this, perform the physicals and medical treatment, and prescribe the medications. Also, others work with their local pharmacy for drop-offs whenever they can through use of the FQHC.

• State Q: How do you handle MAT?
  o SAC A: We have a psychologist that helps patients with MAT – and we use both telemedicine and doctor visits. We also use vivitrol with a psychiatrist and a nurse on site to administer the injections. We do not admit patients who use methadone – we have not encountered them to date.
  o SAC A: Another example: We have a methadone clinic and individuals get transported back and forth between that clinic and facility. We also have folks on suboxone and some on vivitrol. Challenge is the transportation because some patients come from different sites that are far away from the OTP.

• SAC Q: What does the informed consent process consist of for MAT? And how is a patient able to choose their medication approach?
  o SAC A: Some providers have access to all three MAT types, while other providers do not accept patients using certain medications (methadone) but do for others (buprenorphine, vivitrol).
  o SAC: Individuals negotiate with their physician on what medication is best for them. If the provider does not offer methadone, then they have a referral relationship with another agency to serve them and will help with transporting patient to get methadone.
  o SAC: Overall goal is finding something that will work long-term for patients.
  o SAC: I have heard that physicians have said there is only one medication available to them, so this type of recovery limitation seems confusing – we need to improve patient-centered care.

• SAC: There is a capacity issue; navigators/peer supporters could help make sure patients show up and go to their appointments. There should be more recovery housing available and current system is struggling.
• SAC: Peer recovery supporters are used differently from agency to agency, ranging from case managers to glorified Uber drivers. It depends on the agency and we should discuss this.
• SAC: Case managers and peer recovery supporters are burnt out and have a full caseload and are not paid well enough to compensate them for their work.
• SAC: There is not enough training and preparation for case managers and peer recovery supporters and people who become case managers drop out because they do not know what they were getting themselves into.

Slide 22 & 23
• State: Introduced concept of co-occurring enhanced and co-occurring capable, and noted that there are higher expectations for these programs that are much more comprehensive.
• State: Collaborative documentation is important.

Slide 26
• SAC: The topic of education is not mentioned in the ASAM guidance until LOC 3.5 and 3.7 with adolescents. The point is that adolescents need to continue their education throughout their treatment phases.
• SAC: Adolescents are still able to go to school at the residential treatment program and hopefully work in unison with their home school district.
• SAC: Providers also need to have the ability to evaluate adolescents for their medications. Often, they are evaluated upon admission while they are still under the influence and are not re-evaluated afterwards.

Slide 28
• State: On staffing, teams should be comprised of different types of practitioners who work together to offer treatment to the patients depending on their needs. Can you discuss staffing at residential treatment facilities?
  o SAC: For residential, we have a number of staff who provide services, but they are not billable services. Some services in residential settings may be modeling and / or supporting recovery. Many residential staff are not enrolled in Medicaid because they do not offer treatment services, but these “residential techs” are vital and should be supported.
  o SAC: In a hospital setting, staff are administrative costs and activities. Maybe we should focus on practitioner to patient ratios – we need sufficient number of people to provide the product of successful treatment.
  o SAC: There is an insufficient number of practitioners that can provide this work, so team-based care is especially critical.
  o SAC: We need to be careful to not set us up for failure when we expect services to be rendered by a limited number of licensed practitioners in the State. We should allow for creativity in how teams can be stitched together to meet the needs of clients. ASAM is not prescriptive about who the particular members of the team have to be. Ultimately, we need to have enough staff to serve clients well.

• State Q: Can you please describe medium-intensity for adolescents?
  o SAC A: It is a misclassification to describe adolescents as “medium.” Their needs are growing – with higher levels of intensity and detox.
  o SAC: When adolescents come in for treatment, they do not trust adults and do not tell the whole truth.
• SAC: There are complicating mental health issues that are difficult to manage. There are also legal issues with adolescents as well.
• SAC: We have multigenerational families (e.g., grandparents) who are bringing their children into care.
• SAC: Some of them should not go home after treatment and need a safe place to live while continuing treatment.

Next Steps
• SAC Q: Is there a roadmap to directly answer these questions on the slides? Should we do a deeper dive on these later slides that we were unable to get to today due to today’s lively discussion?
  o State A: We would like feedback/suggestions from the group. We may need to do some sort of survey polling to continue through all the ASAM program components like hours, staffing, etc. State may also want to form a subcommittee to dig more deeply into these topics. We could also take what we have heard here and come back with some recommendations.
  o State: March will be the public forum, though we can always schedule additional meeting between now and April.
• Director Corcoran: Thanks Doug for facilitating today’s meeting. This has been one of the most productive discussions in a long time. Because of the current system in place, the conversation can be intricate, but this is also why holding these conversations is very helpful to distinguish the different areas and fill in our full continuum of care to accomplish one of the requirements for our SUD 1115 waiver. It is important for us to understand nuances of the LOCs and what people need.
• SAC: When thinking about the nuances of LOCs, they are highly influenced by rates, by county judges, and by policy like prior authorization. If objective is to determine what is missing in our continuum, it is difficult to break apart what should be designed based on knowledge of clinical care vs. all these other factors.
  o Director Corcoran: the objective of waiver is to focus on people first and what people need.

Announcements/Updates
• State: March 27th meeting is the public forum and there is not an expectation that SAC members must join in-person. There is a webinar option available and individuals are also able to submit written comments.
  o The public forum is an obligation per CMS. State will provide an advanced briefing on the monitoring and evaluation report that will be submitted to CMS.
  o To SAC: Please let your members know about this public forum.
• SAC: Suggestion to make the public forum less bureaucratic and as digestible as possible.

Editor’s Note: the March 27th Public Forum was cancelled due to the COVID-19 health emergency and will be rescheduled in the near future.