

**6/26/20 Meeting Minutes of the
Stakeholder Advisory Committee (SAC)
For Ohio's SUD 1115 Waiver**

Slides 1-4 - Intro/Agenda

- State: Mary Haller welcomes Committee members and audience to the meeting and are provided webinar instructions.
- Also in attendance were ODM consultants (Susan Parker and Rusty Dennison who have been helping us with utilization management (UM) processes and policies.
- Agenda:
 - Review waiver Milestone 2 focused on utilization management goals and milestones.
 - Review the prior authorization (PA) data analysis for SUD residential.
- Finally, we will change topics and talk about next steps on Milestone 3 on SUD residential provider standards.

Slide 5 - Milestone 2: Assure Evidence-Based, Individualized Placement Criteria

- State: Lynne Lyon begins leading the discussion.
- Milestone 2 is focused on evidence-based, individualized placement criteria for SUD services including SUD residential.
- CMS requires Ohio under the waiver to assure that provider assessments are based on multi-dimensional tools such as that developed by the American Society of Addiction Medicine (ASAM). Ohio has adopted ASAM criteria for all SUD services, including residential.
- Other requirements include:
 - a utilization management process for SUD services
 - that services meet patient's diagnosis and level of need and there is an independent process for reviewing placement in residential treatment to confirm it is the right level of care for the patient. States have approached this differently.
- Today we will be discussing how Ohio can meet this requirement. We are committed to reviewing our care management policies, collecting and analyzing utilization management data, and considering policy revisions based on what we learn. As always, we want the input of this committee as part of that process.

Slide 6 - Utilization Management Data Analysis

- State: For today's conversation, we will focus on SUD residential treatment, although we may at a future meeting consider SUD partial hospitalization and inpatient hospitalizations which both require prior authorization.
- Over the past few months, we have analyzed data from the MCPs on their utilization management processes and decisions. We reviewed quantitative data from managed care organizations (MCOs) on approvals, denials and appeals and qualitative info on procedures.
- SAC: Is Ohio going to be analyzing data from providers too or just from the MCOs?
 - State: We have not asked providers for data at this point, but that's something to consider.
- State: We asked MCOs for their data from July 1, 2018 (beginning of BH Redesign) through October 31, 2019. 15 months of data were captured.
- Analysis included ASAM LOC 3.1-3.7 SUD residential treatment. We also collected some data on inpatient, hospital-based SUD-related stays data (LOC 4), but we are doing some additional work before we are ready to discuss that data.

- The data was pulled from each of the MCOs' data systems, so each MCO may record it slightly differently, but we have tried to standardize as much as possible by using common data elements.
- The data is only for SUD residential stays that required prior authorization. For anyone unfamiliar with our current prior authorization policy for SUD residential PA is required for SUD residential stays longer than 30 days for the first or second stay in a calendar year, and then from day one on the 3rd stay within same calendar year.

Slide 7 - Types of Prior Authorization Requests

- State: The data were categorized into "initial" and "continued stay" requests.
- Initial requests refer to the first authorization request during an admission to residential levels of care 3.1-3.7 for a first or second stay during a calendar year as well as the third and subsequent re-admissions to SUD residential facilities.
- Continued stay requests refer to authorization requests for additional days beyond what was authorized in the initial request.
- SAC: What would preclude someone from getting an approval for the third and subsequent stays?
 - State: The PA decision should be based on ASAM criteria, so if the clinical documentation submitted indicates that the patient meets that level of care, then the stay should be approved.
- SAC: In the data that State analyzed, did that data include days requested versus days approved?
 - State: Good question. We will talk with our team about this and may get to it later in presentation.

Slide 8 - Data Definitions

- State: This slide shows the definitions for the different data terminology used in the analysis. It's important to understand the data elements in order to understand the analysis. Here are the definitions:
- Approvals: Means that the service requested is approved, including number of units requested.
- Limited Authorizations: means that the authorization was approved but in a lesser amount than requested. E.g., if asked for 30 days, but only 14 days were approved. Some may call it partial denials.
- Clinical Denials: These are denials where basis of denial was due to medical necessity. These required clinical review, and upon clinical review it was determined the request didn't meet LOC.
- Administrative Denial – The denial is based on some administrative policy/procedure e.g., individual's Medicaid eligibility
- Appeals: The appeal of a PA that was denied.

Slide 9 - Data Table

- State: This slide shows a summary of the data collected across all MCOs and sub-levels of SUD residential care (LOC 3.1-3.7).
- 11,297 initial authorization requests – broken out by approvals, limited authorizations, and appeals. Of the 11,297, over 4,000 had a request for a continued stay.
- clinical and administrative denials are combined
- SAC: Is State telling us there were no appeals asked for during this time?
 - State: In top section under initial authorizations, see that there were 62 requests for appeals of denials, and no requests for any appeals of denials for continued stays.
 - SAC: Seeing this number suggests that collecting provider data might be a good idea.

- SAC: I don't think MCOs count peer-to-peer reviews as appeals, but providers likely assume a peer-to-peer review is an appeal to a denial of an authorization. Can we learn how many peer-to-peer reviews were requested?
 - State: Correct, this figure is not peer-to-peer reviews. This number represents a provider appeal of a denied PA. We'll note this as item to take back.
- SAC: How many of the appeals resulted in overturning the MCO denial.
 - State: As we were reviewing these slides, we found discrepancy in how the MCOs and State staff interpreted this data element. We need to take another look at this and get back with corrected information.
- SAC: Going back to Milestone 2 requirement of an independent process of reviewing placement in SUD residential treatment, will the state consider this solely the purview of MCOs only or are you looking at true independent review performed by an entity without a fiscal motivation in the PA outcome?
 - State: CMS gives states the flexibility to determine what that independent process looks like. The requirement is that the process and LOC decision be independent of the provider rendering the service.
 - SAC: Can that really be independent since you have a payer making the decision?
 - ODM Consultant: The State Medicaid Director letter from CMS giving guidance on this says that there is an expectation of an independent process for reviewing placement in SUD residential treatment centers. States have flexibility in how they develop an approach that achieves that independent process. Nothing prohibits MCOs or independent entities making the UM decisions.
 - SAC: Is the state interested in seeking true independence or will the State rely on the MCOs for that independence?
 - State: We don't have preconceived idea the future of this. This decision will be researched and discussed during the first 24 months of the waiver before proposing any revisions to current policy. We want to hear input from this committee, providers and consumers regarding their experiences. We also want to consider coordination of care.
- SAC: Is there a requirement that residential stays are prior authorized from day one?
 - State: CMS gives states flexibility on developing their UM process. Some states do require PA from day one for residential, but there is flexibility. Ohio's current policy does meet CMS expectations, although Ohio has committed to reviewing that policy and considering changes.
- SAC: Was this just a sampling of MCO data or includes all the reports? My agency received a number of continued stay denials and those don't seem to be included here.
 - State: The data was not a sampling. We understand that you believe the number of continued stay denials seem too low and we will look into that.
- SAC: Other data we've seen indicated that Ohio's average length of stay (ALOS) at LOC 3.5 is 25 days. This seems to conflict with this data which shows a 7,000 difference between initial authorizations and continued stay authorizations. So, based on that it seems that many consumers don't even reach 30 days of treatment.
 - State: This data represents only instances when an authorization was required. So, if the client received less than 30 days of residential service that isn't reflected in this table.
 - This table shows both people who require > 30 days (for first or second stay) plus those with 3 or more visits in a calendar year which required PA from day one. We did ask MCOs to report on the number of SUD residential stays that didn't require authorization, and fairly consistently, the MCOs reported that most SUD residential stays did not require PA. So overall, average length of stay does seem to be <30 days.

- SAC: Did the MCOs report on the number of days that they authorize? Different plans have different standards.
 - State: We'll get into that shortly. But we have observed that there is some variation in how ASAM is applied to the UM process. So the State will be focusing on this.
- SAC: Could we also look at people's experiences to determine how long people stayed in treatment, relapse rates, and if/how individuals were able to stay in treatment?
 - State: Thank you for suggestion.
- SAC: The reported numbers seem low. And 78% approval for initial PA requests does not seem consistent with what I've heard from providers. 88% approval for continued stays doesn't seem consistent either. I would guess that should be about 60% approved. Also, MCOs perform authorizations differently, which impacts what providers request. E.g., if the MCO says providers won't get approved for certain number of days, then providers ask for what the MCO will approve even if they don't think that is clinically right for the client. So, these numbers don't tell the whole story, or the administrative work needed to get PAs approved.
 - State: We've heard this anecdotally. This data wouldn't show those differences. Your comments help to provide context. This data was intended as a baseline and so it can't answer all questions.
- SAC: Could we review the current policy of PA required after the first 30 days and compare it to clinical data about what is actually effective? What do studies show as most effective length of stay for certain levels of care, what's the science driving these decisions? This would help inform future policy.
 - State: Thank you. Good point.

Slide 10 - Identification of SUD Residential Admission and Discharge Dates

- State: One our challenges is that, under the waiver, CMS requires states to try to achieve a statewide average of 30 days or less for SUD residential stays. Our current systems and policy doesn't tell us admission and discharge dates so we can measure average lengths of stay. Neither the State or the MCOs can clearly identify admission or discharge dates. E.g. since there is no PA for the first 30 days, the date of admission isn't readily available.
- Also, claims are only submitted for days when a service is rendered even though the person continues to reside in the treatment facility.
- The lack of clear admission and discharge dates prevents us from accurately measuring a statewide average length of stay. We need so we can quantify lengths of stay.
- One possible solution might be developing a notification process for SUD residential admission/discharge. This would inform the state and MCOs and aide in coordination of care upon admission and discharge. The notification process would not necessarily be the same PA and may or may not require PA.
 - SAC: Not sure what goal of notification is. But if it involves administrative work the process should be consistent across MCOs and it should be automated and electronic. I am concerned how this would work if some claims are denied.
 - State: Thank you.
- SAC: Who needs this admission/discharge data? Isn't this being collected by ODM?
 - State: No. ODM and the MCOs only receive service dates via service claims. The purposes of this data would be to inform the state and MCOs that someone is in SUD residential. MCOs have a responsibility to support their members with any services medically needed in their treatment and to offer care management supports, especially in transitioning from residential setting back to the community.

- SAC: Is the assumption that providers don't notify MCOs for coverage beginning at the day of admission?
 - State: Yes. it is not required under our current PA policy – PA not required until day 30. ODM is required under the CMS waiver to monitor lengths of stay in SUD residential. We need this data to report to CMS. We can't report on it without knowing dates of admission and discharge.
- SAC: We need to talk about lengths of stay for all ASAM levels of care and not just 3.0. Need to understand clinical needs of individuals coming to treatment. When talking about admission/discharge, it's not as simple as the date you walked in the door. It's also about your level of care when you entered and how is your treatment progressing through levels of care. The LOC piece, from a clinical perspective, is most important. We want to know if people are getting proper care based on treatment needs. Reporting this information must be simple and go to just one place, not to 5 different MCOs. Also, I am not sure if MCOs offer substantial additional support, especially when it comes to housing, e.g. for those at IOP levels of care. My experience is that for housing related issues MCOs say the provider has better resources than MCOs. Providers need additional time and funding to access services that aren't always medical or treatment-related, but tie to recovery.
 - State: Good comments to take back.

Slide 11 - Changes in ASAM Levels of Care During SUD Residential Stays

- State: Building levels of care in our policy for residential stays has been challenging especially when combined with decisions about when PA is required. There variation in how MCOs operationalize this aspect of state policy. There is also variation in how sublevels of residential care are reported. Some MCOs capture sublevel information and some don't. This issue - admission/discharge, and level of care changes within that stay – is an area we believe needs work and policy guidance.
- SAC: A client may need a lower LOC but there are no lower LOC resources available and they're not ready for discharge. Then what does our policy mean? People move from one level of care to another in treatment. Some organizations have the resources to flex them; others don't. There are times when someone needs a higher level of care but cannot access it. Whole idea of ASAM levels of care is to acknowledge there are multi-dimensions at play in smoothly transitioning folks. Flexibility, consistency, and simplicity are critical.
 - State: Good points, thank you.
- SAC: This policy also relates to BH parity. Consider how levels of care work in a hospital setting. How does someone move between an intensive care unit (ICU), step down unit, and a regular bed. A physician makes the medical necessity decision but doesn't send it to an MCO for UM review beforehand. We need similar flexibility in SUD treatment to allow treatment to flex with clinical judgment and client need.
 - State: Thank you.
- SAC: Current policy requires PA when someone is transferred from LOC 3.5 to SUD Partial Hospitalization (PH). That same policy doesn't exist in the MH world for Medicaid. MH day treatment does not require PA. So, when we are talking about changes in ASAM LOC, this appears to be an anomaly. You can get a higher LOC without PA, but if you want to transition into a lower LOC, namely PH, PA is required. This isn't congruent with BH parity.
 - State: Good observations. Important to discuss parity, moving up/down LOCs, and about similarity to hospital services and what we can learn from that.

Slide 12 - Application of ASAM Criteria in the Utilization Management Process

- State: In reviewing Medicaid data, policies and procedures, and anecdotal information from stakeholders, we acknowledge there is inconsistent application of ASAM criteria and varying requirements among MCOs for clinical documentation.
- One possible solution to is offering ASAM refresher training to increase consistency. Another idea is to develop uniform requirements for clinical documentation required when seeking PA. We have a standardized PA form but maybe we should revise and expand that form and make more consistent the requirements for clinical documentation to support PA requests.
- Dr. Trevino: This slide speaks to some of the oversight and inconsistencies that we've been talking about. Important to highlight.
- SAC: If we are going to do training, it has to be providers and MCOs together – not MCOs training providers. Needs to be cross-sectional agreement about the various LOCs and a focus on clinical needs of the patient. PA should not be driven by motivation of fiscal management. Documentation requirements should be simple. Providers don't have the resources to vary according to MCO-specific expectations. It's complicated dealing with five different entities. Standardization and consistency are really important.
 - State: Thank you. Any other areas that we may have missed around UM for SUD residential?
- SAC: Until we have an appeals process that goes to someone other than the MCO that denied the PA, I'm not sure there will be any change. Providers shouldn't be required to interpret ASAM according to the needs of each MCO.
 - State: What suggestions do you have (other than ones talked about today) to make short-term improvements using the existing process and structure?
 - SAC: Either create an independent review panel or have the state agencies take responsibility.
- SAC: Regarding the suggestion to revise and expand the PA request form, I don't favor expanding any more paperwork.
 - State: Fair point. How would you suggest the documentation be provided to whoever makes the authorization decision? Electronic or something else?
 - SAC: It should be electronic and should follow the ASAM dimensions for admission and continued stay.
 - State: Thank you.
 - Dr. Trevino: Suggest this could be done by gathering groups of providers to discuss. Documentation should include certain broad areas like assessment and treatment progress. But if we have five different formats, we need to look at framework and set clear expectations based on how organizations document clinical levels of care.
- State: As a next step we would like to identify some short-term improvements, and then consider longer-term policy changes. We suggest smaller work groups of this committee be formed to discuss these issues in greater detail. State staff will take comments made today and reply to the Committee with suggestions on how to move forward with subcommittees. We'll need to include MCO representatives and may pull in subject matter experts, especially on the UM topic.

Slide 13 - Milestone 3 – SUD Residential Provider Standards Summary of February 28th Discussion

- State: Doug Day takes over as facilitator.
- This slide offers a recap of February 28th SAC meeting. In that meeting we discussed LOC 3.1 and some of 3.5. SAC members provided us lots of discussion and suggestions along the way.
- We talked about 3.1 recovery housing and recovery housing in general. We also discussed Medication access and staffing needs and challenges. And also, specific considerations of ASAM for adults and adolescents

- Meeting minutes are available on the OH Medicaid BH website.

Slide 14 - Summarizing May 29th Discussion

- State: During the last May 29th SAC meeting, we finished discussing LOC 3.5, 3.3, and 3.7.
- Repeated language around clinical and medical focuses. We had a good conversation on co-occurring capable and co-occurring enhanced, touched on staffing needs and challenges, and talked about the LOC 3.3 populations.
- Meeting minutes are available on the OH Medicaid BH website.
- We have not gone through LOCs 3.2 and 3.7 withdrawal management.

Slide 15 - Provider Standards

- State: These topics are all part of Milestone 3, using nationally recognized SUD program standards to set residential provider qualifications. It includes:
 - updating state policy (rules and manuals) to meet CMS requirements
 - and assessing the need for changes to state policy or credentialing standards to assure ASAM compliance and
 - MAT access.
- Bottom of slide lists straight forward items involved OhioMHAS certification rules, ODM coverage rules, BH provider manual, and OTP manual.
- Wild card on this list is the CARF-ASAM certification. Still unsure where this will end up.
- Unsure how to address provider standards for the ASAM withdrawal management levels. We are willing to do what the group thinks is best. The State recommends that we take some of points raised in the last 2 meetings and form a small work group with SAC members (and others if needed) to work discuss the details. We'd like your feedback on what areas should be in that discussion.
- SAC: Are you looking for comments on whether these are right standards to look at or how to use these standards?
 - State: Both. It's a requirement under the waiver with CMS. This ties back to nationally recognized program standards. There are requirements in our OAC and in our manuals that don't align. There is also a need for some alignment between ODM and OhioMHAS rules. Timing on this work is that we need it done before we initiate on-site provider reviews.
- SAC: There is not a nationally recognized SUD program standards manual. Right now, the national standard is Joint Commission, CARF, or another.
 - State: That "another" reference is to ASAM. It's written that way to keep it open in case other standards come along.
 - SAC: Concern for agencies that are Joint Commission, but not CARF, what is mechanism for them?
 - State: Guiding standard is ASAM. CARF indicates on their webinar they will issue CARF certification even if not CARF accredited. On slide 13 we are trying to offer general summations of issues raised in conversation. E.g. staffing needs and challenges and how to address staff competencies, whether in rule or through your hiring practices. There are opportunities here, like with medication access. Also need to think through ASAM details in rural counties.
- SAC: Some of us listened to the CARF-ASAM webinar the other day. We hope this isn't just a great idea that becomes cost prohibitive. It's a great goal to have similar national standards so everyone is evaluated using the same criteria. Concern is that MCOs may want different criteria. Consistency is very important.
 - State: Based on the February and May SAC meetings, are these the right themes? Have we included all the important summary points? We need to begin working on what needs

adjusted – whether in manual, OAC, etc. We recommend developing small workgroups work to discuss these issues and make recommendations to the SAC at a later time.

- SAC: Time is of an essence, and we should take part in this. Keith H. and Tom S. volunteer to be part of newly formed subgroup.
- State: We'll review themes from today, group topics, and then communicate back with SAC members about organizing working groups.

Slide 16 - Upcoming Meetings

- OhioMHAS Director Criss: Feedback and conversation was very helpful. We look forward to smaller workgroups that will dive in and shape work to present to rest of SAC. This will help continue our efforts moving forward with the waiver and CMS. Thank you for today's conversation.
- State: Any other comments?
 - SAC: We're looking at some of the original documents that had timelines on milestone activities. We are wondering if ODM is going to change some of the milestone timelines. This will help us to know when things are happening.
 - State: Yes, we can do this. We acknowledge we have to push things back due to the COVID-19 crisis. We'll plan to share updated milestone timelines at next meeting if not sooner.
 - Dr. Trevino: Thinking about how our policies and processes fit together with national standards. We want to ensure consistency and buy-in across the board.
- State: Reminder that July 16th is the SUD 1115 public forum. Any interested party may comment on waiver questions/progress/goals. Webinar registration link is available on this slide. The first 15 minutes of webinar will include an overview of the waiver, it's goals and milestones. Then we'll open up for public comments. People can submit comments ahead of time in writing or can speak during the webinar. We encourage your members or staff to attend and share thoughts.
- July 31st meeting of the SAC is being repurposed to organize small workgroups to discuss the topics raised in today's meeting. State staff will follow up later with more details.
- End of meeting.