Stakeholder Advisory Committee for Ohio’s Medicaid SUD 1115 Demonstration Waiver

June 11, 2021
Meeting Agenda

1. Provider Standards – OAC Changes
2. Provider Onsite Reviews Overview
3. Prior Authorization (PA) Request Form Pilot Results
Provider Standards - OAC Changes

Ohio Department of Medicaid
Ohio Department of Mental Health and Addiction Services
Milestone 3: Use Nationally Recognized SUD Program Standards to set SUD Residential Provider Qualifications

Timeline

Update policy and regulatory (rule) package for provider standards

- November 2019
- August 2020
- October 2020
- February 2021
- May 2021
- July 2021
- October 2021
- October 2023
- October 2024

- SUD 1115 waiver approval
- Provider Standards Targeted Workgroups
- Conduct onsite visits
Draft Ohio Administrative Code Changes

OhioMHAS Rules 5122-29-09, 5122-40-01, 5122-40-06, and 5122-40-09
Will need to final file a version of the rule that has current expectations and July 1, 2023 changes.
OhioMHAS OAC 5122-29-09

Residential and Withdrawal Management Substance Use Disorder Services

- Changes are affiliated with the work of the following targeted workgroups:
  - ASAM Level 3.1 and Recovery Housing
  - Medication Access
  - Staffing Needs and Challenges
OhioMHAS OAC 5122-29-09

Residential and Withdrawal Management Substance Use Disorder Services

• Summary of changes:
  o Added definition of family
  o Change related to referrals to other levels of care (LOCs), no longer just lower levels
  o Requirements related to people who are receiving medications
    ▪ Led to changes in opioids rules
  o Specific programmatic expectations for each ASAM residential LOC
  o 3.2-WM and 3.7-WM expectations “matched” to non-WM level of care (3.5 and 3.7)
OhioMHAS OAC 5122-40-01

Definitions and applicability (specific to opioid treatment programs [OTPs])

- Added definition of telemedicine due to use of “telemedical” in OAC 5122-40-09 (C)
- “‘Telemedicine’ means the practice of medicine using technology to deliver care at a distance, over a telecommunications infrastructure, between a patient at an originating site and physician or other practitioner licensed to practice medicine, at a distant site”
Medication administration (specific to OTPs)

- Updated title and carried throughout. This rule is about medication administration, not medication assisted treatment as defined in Ohio Revised Code 340.01.

“(2) "Medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the United States food and drug administration for the treatment of alcoholism or drug addiction, prevention of relapse of alcoholism or drug addiction, or both.”
OhioMHAS OAC 5122-40-06

Medication administration (specific to OTPs)

• New section (S)

• “A patient may receive medication obtained from an opioid treatment program at a community mental health services or addiction services provider certified for the residential and withdrawal management substance use disorder services as defined in Ohio Administrative Code 5122-29-09, a long-term care facility, or a skilled nursing facility while they are a resident. A temporary medication request must be submitted through the SAMHSA extranet and approved by the state authority. Medication orders must be renewed every seven days if needed. Medication approval shall be noted in the patient's record and shall include the following documentation:

  o The patient's signed and dated consent for disclosing identifying information to the program which will provide services on a temporary basis; and

  o A chain of custody document showing that any medication used for medication assisted treatment is transferred from medical staff of the opioid treatment program to medical staff of the partnering provider.”
Non-medication services (specific to OTPs)

- Added new section (B)

“(B) Opioid treatment programs shall provide adequate medical, counseling, vocational, educational, employment, and other assessment and treatment services, and the program sponsor shall document that these services are fully and reasonably available to all patients.

(1) All services shall be provided at the opioid treatment program with the exception of vocational services, educational services, and employment services. All other services may be provided by a community mental health services or addiction services provider certified for the residential and withdrawal management substance use disorder services as defined in Ohio Administrative Code 5122-29-09 as long as the person is receiving that service. The program sponsor, at their discretion, shall enter into formal, documented agreements with private or public agencies, organizations, practitioners, or institutions to provide these services to patients enrolled in the opioid treatment program.”
Provider Onsite Review Process

Ohio Department of Medicaid
Ohio Department of Mental Health and Addiction Services
Overview

As a condition of the Section 1115 Medicaid SUD demonstration, Ohio must establish requirements for residential SUD treatment providers to meet certain standards in the American Society of Addiction Medicine (ASAM) criteria.

The state will develop and implement a process for reviewing residential SUD treatment providers to assure compliance with ASAM standards.

- **Ohio’s SUD residential treatment standards will become effective in 2023**

On-site reviews will help providers understand gaps that exist, if any, between their treatment programs and the Ohio Administrative Code (OAC) updates before they become effective in 2023.

In addition to identifying gaps, on-site reviews will advise providers on the steps they can take to address such gaps, if any, to assure compliance with the OAC updates beginning in 2023.
Objectives

Evaluate whether providers deliver care with provisions in OAC that reflect key standards in the ASAM Criteria, and if gaps are identified, describe the steps providers can take to address such gaps.

Collect information regarding the characteristics of residential SUD treatment providers to support the state’s abilities to determine to what extent the residential SUD treatment provider meets the criteria of an Institution for Mental Disease (IMD) as described in federal guidelines.

Enhance Ohio’s knowledge of the residential SUD treatment provider network, both in terms of adherence to key programmatic standards as outlined in OAC as well as organizational characteristics related to the federal IMD criteria.

After completion of on-site reviews, aggregate findings will be shared publicly.
Scope

- In FY20, the following numbers of SUD treatment providers submitted claims for each ASAM LOC:

<table>
<thead>
<tr>
<th>Residential LOCs</th>
<th>Number of Providers¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Clinically Managed Low Intensity Residential Services</td>
<td>34</td>
</tr>
<tr>
<td>3.3 Clinically Managed Population-Specific High Intensity</td>
<td>5</td>
</tr>
<tr>
<td>Residential Services</td>
<td></td>
</tr>
<tr>
<td>3.5 Clinically Managed High Intensity Residential Services</td>
<td>75</td>
</tr>
<tr>
<td>3.7 Medically Monitored Intensive Inpatient Services</td>
<td>18</td>
</tr>
</tbody>
</table>

- Desk reviews and on-site reviews will be conducted for all programs

¹Providers identified by Medicaid billing ID
Approach

**DESK REVIEWS**

- Desk reviews will be conducted prior to on-site reviews.
- Review Medicaid claim utilization, and additional data to understand levels of care provided in preparation for the on-site reviews.
- Review the current community behavioral health agency certification administered by OhioMHAS for each provider participating in the review process.
- Confirm the specific proposed OAC provisions and ASAM LOCs for which the provider will be reviewed during the on-site review process.

**ON-SITE REVIEWS**

- Collect information regarding to what extent:
  - Provider delivers care consistent with specific proposed provisions in the OAC.
  - Provider’s organizational characteristics in relation to the federal IMD criteria.
- Provide in-person debriefing to provider management and staff prior to leaving the physical location of the on-site to:
  - Educate providers on why they do or do not appear to deliver care consistent with proposed OAC provisions.
  - Describe steps providers can take and assistance available to implement programmatic changes to deliver care consistent with proposed OAC provisions.
# Phases

<table>
<thead>
<tr>
<th>Objective</th>
<th>1.0 Develop on-site review tools and processes</th>
<th>2.0 Pilot test of on-site review process</th>
<th>3.0 Statewide on-site provider reviews</th>
</tr>
</thead>
</table>
| Activities | • Develop review tools to conduct on-site reviews, support the development of on-site review reports, and provide a basis for sharing findings with stakeholders  
• Develop a report template to document key findings and observations | • Identify a small cohort of providers (approximately 10) who wish to participate in a pilot test of the on-site review process  
• Revise the on-site review tools and processes according to feedback received | • Complete desk reviews of current certification, Medicaid claims, and additional data in preparation for on-site reviews  
• Perform on-site reviews of residential SUD treatment providers participating in the Ohio Medicaid program |
| Outcomes | Creation of standardized evaluation tools and processes | Identify opportunities for iteration and process improvement | Help providers understand gaps that exist, if any, between their treatment programs and the Ohio OAC updates |
Prior Authorization (PA) Request Form Pilot Results

Ohio Department of Medicaid
Ohio Department of Mental Health and Addiction Services
The PA Form Pilot Program was designed to test the use of a uniform PA request form to reduce delays in treatment, number of programmatic denials, and additional documentation requests.

The PA request form was completed by providers of substance use disorder (SUD) treatment services requiring PA in accordance with Ohio Administrative Code (OAC) rule 5160-27-09.

The pilot occurred from March 1, 2021 - April 30, 2021 and included 7 payers and 12 providers.

Overview
Reporting Methodology

- Participants tracked results using a standardized template
- Each payer tracked results by provider, and each provider tracked results by payer
- Definitions for tracking results:
  - **Total Requests**: Number of requests submitted using pilot form (include initial and continued stays)
  - **Requests Approved**: Number of requests approved for the requested Level of Care (LOC) and requested number of days or units
  - **Partial Approvals**: Number of requests that were approved for a fewer number of days or units than requested
  - **Medical Necessity Denials**: Number of requests that were denied for lack of medical necessity for the LOC or service requested
  - **Administrative Denials**: Number of requests denied as administrative denials
  - **Required Additional Documents**: Number of requests that required submission of additional documentation (other than the required prior authorization form, ITP, and most recent assessment) for the payer to make a determination

### Example: Tracking template for Providers

<table>
<thead>
<tr>
<th></th>
<th>Total Requests</th>
<th>Requests Approve</th>
<th>Partial Approvals</th>
<th>Medical Necessity Denials</th>
<th>Administrative Denials</th>
<th>Required Additional Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td></td>
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<tr>
<td>Buckeye</td>
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<td>CareSource</td>
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<td>Molina</td>
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<td>Paramount</td>
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<td>UHC</td>
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<td>Permedion (FFS)</td>
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</tbody>
</table>

### Type of additional documentation requested by reviewer

<table>
<thead>
<tr>
<th>Documentation Type</th>
<th>Number of requests</th>
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<tbody>
<tr>
<td>More current clinical documentation</td>
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<tr>
<td>Information about transition of care or discharge planning activities</td>
<td></td>
</tr>
<tr>
<td>Information about interventions to reduce barriers to progression</td>
<td></td>
</tr>
<tr>
<td>Updated individualized treatment plan (ITP)</td>
<td></td>
</tr>
<tr>
<td>Clinician signature on ITP</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>
### Aggregate Payer Results

Partial Approvals, Medical Necessity Denials, Administrative Denials, and Required Additional Documentation are not mutually exclusive. Therefore, the sum of these numbers may not reflect the number of Total Requests.

<table>
<thead>
<tr>
<th>Total Requests</th>
<th>Requests Approved</th>
<th>Partial Approvals</th>
<th>Medical Necessity Denials</th>
<th>Administrative Denials</th>
<th>Required Additional Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>266</td>
<td>182 (68%)</td>
<td>43 (16%)</td>
<td>33 (12%)</td>
<td>0 (0%)</td>
<td>7 (3%)</td>
</tr>
</tbody>
</table>

1 Partial Approvals, Medical Necessity Denials, Administrative Denials, and Required Additional Documentation are not mutually exclusive. Therefore, the sum of these numbers may not reflect the number of Total Requests.
## Aggregate Provider Results

<table>
<thead>
<tr>
<th>Total Requests</th>
<th>Requests Approved</th>
<th>Partial Approvals</th>
<th>Medical Necessity Denials</th>
<th>Administrative Denials $^2$</th>
<th>Required Additional Documentation $^3$</th>
</tr>
</thead>
<tbody>
<tr>
<td>373</td>
<td>269 (72%)</td>
<td>65 (17%)</td>
<td>39 (10%)</td>
<td>2 (&lt;1%)</td>
<td>15 (&lt;1%)</td>
</tr>
</tbody>
</table>

$^1$ Administrative Denials included late submissions

$^2$ Required Additional Documentation included more current clinical documentation, updated individualized treatment plan (ITP), peer-to-peer reviews, and additional client identifiers
Feedback Themes

Concern about **time to complete form** and **duplicative paperwork**

Appreciation for **added checkboxes, LOC dimensions, and open-ended response sections**

Forms were **beneficial for completing reviews**

Forms **reduced need for additional documentation requests** and **peer-to-peer reviews**
Next steps

- Develop approach for training and statewide rollout of the PA form
- Finalize format based on pilot feedback
- Confirm plan submission methods
Appendix
## Detailed Feedback Summary

### Provider Feedback

“After talking to the counselors, most really like the PA form but a few wanted it to be more user friendly, with more checkboxes and less typing responses.”

“The pilot required completing double the work with the ASAM, treatment plan, and pilot form. A standardized form, unified process, and a user-friendly format that does not require duplication of paperwork is needed.”

“There was no consistent form submission method for MCOs – some were emails sent with a date and time stamp, and others were a fax. Some MCOs claimed they never got the fax. Staff appreciated the new form with boxes to be checked and space for narrative.”

“We noticed that determinations still seemed to be driven primarily by minute details of the ITP rather than the ASAM criteria and additional details in the pilot form.”
### Provider Feedback Continued

“It is **more time consuming** for clinicians to complete the new process. Additionally, since beginning of the PA requests for residential treatment, **we have only been asked once for an assessment and once for the medication list which now appears routine with the new paperwork.**”

“The new prior authorization form is **appreciated for the checkboxes and inclusion of level of care dimensions.** Receiving a response within 48 hours from the insurance providers is very helpful for discharge planning and continuation of care.”

### Payer Feedback

“We found the forms **beneficial for completing reviews for prior authorizations.** When the PA form is completed, it contains all the required documentation to complete a medical necessity review.”

“No additional information was requested on these submissions. No Peer to Peers were completed on the denials. It appears that **the SUD Pilot PA Form has assisted in guiding providers on information that would be relevant for establishment of medical necessity for service.**”