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

October 4, 2021
Meeting Agenda

1. OhioMHAS Provider Standards Rule update
2. MAT Quality Framework metrics: Preliminary results
3. SUD 1115 Waiver midpoint assessment
4. SUD 1115 Waiver monitoring monthly data
5. Next steps and discussion
OhioMHAS Provider Standards Rule update

Ohio Department of Medicaid
Ohio Department of Mental Health and Addiction Services
OhioMHAS Provider Standards Rule update

- OhioMHAS residential and withdrawal management substance use disorder services rule (OAC 5122-29-09) was submitted to the Common Sense Initiative Office (CSIO) for review on 9/20/2021
  - The draft rule sent to the CSIO can be found [here](#)
  - Comment end date: 10/8/2021
OhioMHAS Provider Standards Rule update

- Addition since last SAC meeting is (M)(6):
  - "(6) If the provider primarily provides this ASAM level of care to adolescents who have not graduated from high school or who have not passed a general education development (GED) test, offer at least twenty hours per week of a combination of skilled treatment services, clinically managed services and recovery and withdrawal (for 3.5-WM adolescent programs) support services focused on individuals who have significant social and psychological problems. At least ten of the twenty hours is to include individual, group, or family counseling. The provider must also provide year round schooling."
MAT Quality Framework metrics: Preliminary results

Government Resource Center
Ohio Department of Medicaid
Goals for MAT Quality Framework

- **Support 1115 SUD implementation**
  - Core objectives and milestones

- **Complement state and plan level quality measurement**
  - 50+ SUD measures (1115 SUD, HEDIS, MODRN, etc.)

- **Build on Ohio quality programs for opioid use disorder**
  - CICIP, CPC, etc.

- **Facilitate performance improvement opportunities**
  - Data-informed PI to enhance patient care and improve outcomes
What is the MAT Quality Framework?

- Collaborative effort with providers to shape performance measurement approach for MAT care under 1115 SUD
- Intended to demonstrate value of MAT care to key stakeholders
- Designed to support performance improvement processes for improving patient care and outcomes
MAT Quality Framework timeline

Began MAT Quality Framework discussions

Conducted environmental scan & began provider engagement

Selected and tested measures & finalized reporting approach

Share statewide aggregate results

Continue work towards implementation:
- Determine reporting cadence
- Develop strategy for benchmarking
- Report on provider-specific data
- Identify opportunities to support quality improvement
Eligible population

• Age 18 and older as of July 1 of measurement year
• At least six months of non-dual enrollment (not necessarily continuous) during measurement year
• Two measures have additional enrollment criteria:
  o Continuity of Pharmacotherapy: at least six months continuous non-dual enrollment during measurement year and year prior
  o Co-Occurring BH Treatment: at least six months non-dual enrollment (not necessarily continuous) during measurement year and year prior
Measure summary

- Seven metrics proposed with preliminary results available in this slide deck

- Measure sources include the Medicaid Outcomes Distributed Research Network (MODRN) opioid measures\(^1\) and the 1115 SUD Waiver Monitoring

Measure 1: Any MAT

- **Source:** MODRN
- **Measurement Period:** One year
- **Denominator:** Beneficiaries with a claim for OUD in the year
- **Numerator:** Beneficiaries with a claim for MAT in the year (office administered or pharmacy dispensed)

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<tr>
<th>Year</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
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<tr>
<td>2019</td>
<td>103,461</td>
<td>63,450</td>
<td>61.3%</td>
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<tr>
<td>2020</td>
<td>107,627</td>
<td>68,504</td>
<td>63.6%</td>
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Measure 2: Co-Occurring OUD and MH Diagnoses

- **Source**: State-defined, similar structure to MODRN
- **Measurement Period**: One year
- **Denominator**: Beneficiaries with an OUD diagnosis in the year
- **Numerator**: Beneficiaries with a mental health diagnosis in the year

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<td>70.5%</td>
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<td>2020</td>
<td>107,627</td>
<td>76,329</td>
<td>70.9%</td>
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Measure 3: Benzodiazepine and MAT Co-Prescribing

- **Source:** MODRN (shorter measurement period)
- **Measurement Period:** One year
- **Denominator:** Beneficiaries with claims for OUD and MAT in the year
- **Numerator:** Beneficiaries with at least one benzodiazepine prescription in the year

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<th>Year</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
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<tbody>
<tr>
<td>2019</td>
<td>63,450</td>
<td>7,142</td>
<td>11.3%</td>
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<td>2020</td>
<td>68,504</td>
<td>7,476</td>
<td>10.9%</td>
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Measure 4: Opioid Analgesic and MAT Co-Prescribing

- **Source:** MODRN (shorter measurement period)
- **Measurement Period:** One year
- **Denominator:** Beneficiaries with claims for OUD and MAT in the year. *Individuals with a cancer diagnosis in the measurement period are excluded.*
- **Numerator:** Beneficiaries with at least one opioid analgesic prescription in the year

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<td>61,856</td>
<td>9,332</td>
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<td>2020</td>
<td>66,783</td>
<td>8,769</td>
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Measure 5a: Urine Drug Screening Rate – OUD

- **Source:** State-defined 1115 SUD Waiver metric\(^1\)
- **Measurement Period:** One year
- **Denominator:** Beneficiaries with a claim for OUD in the year
- **Numerator:** Number of Urine Drug Screens (H0048) administered in the year

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<tr>
<th>Year</th>
<th>Denominator</th>
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<th>Rate per 1,000 Beneficiaries(^2)</th>
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<td>2019</td>
<td>103,461</td>
<td>892,570</td>
<td>8,627.1</td>
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<td>2020</td>
<td>107,627</td>
<td>756,368</td>
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\(^1\)This measure is an annual version of the monthly waiver metric
\(^2\)To get the rate per beneficiary, divide by 1,000
Measure 5b: Urine Drug Screening Rate - MAT

- **Source:** Modified State-defined 1115 SUD Waiver metric\(^1\)
- **Measurement Period:** One year
- **Denominator:** Beneficiaries with claims for OUD and MAT in the year
- **Numerator:** Number of Urine Drug Screens (H0048) administered in the year

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<tr>
<th>Year</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate per 1,000 Beneficiaries(^2)</th>
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<td>892,570</td>
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<td>2020</td>
<td>68,504</td>
<td>756,368</td>
<td>11,041.2</td>
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\(^1\)This metric uses a different denominator than the Waiver metric
\(^2\)To get the rate per beneficiary, divide by 1,000
Measure 6: Continuity of Pharmacotherapy for OUD

- **Source:** USC [Equivalent to Metric #22 in the 1115 SUD Waiver Monitoring]
- **Measurement Period:** Two years
- **Denominator:** Beneficiaries age 18 and older with a claim for OUD pharmacotherapy at least 180 days before the end of the measurement period, and who were continuously enrolled for at least 180 days before the end of the measurement period
- **Numerator:** Beneficiaries who had at least 180 days of continuous treatment with MAT. Within the 180 days, gaps or breaks of up to 7 days are allowed, with no limit on the number of breaks.

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<td>63,965</td>
<td>33,280</td>
<td>52.0%</td>
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<td>2019-2020</td>
<td>69,628</td>
<td>36,952</td>
<td>53.1%</td>
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Measure 7: Co-Occurring MAT and BH Services

- **Source:** MODRN (modified)
- **Measurement Period:** Two years
- **Denominator:** Beneficiaries with an OUD diagnosis and at least one claim for MAT in the measurement period
- **Numerator:** Beneficiaries with a behavioral health service in the measurement period

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<tr>
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<td>74,847</td>
<td>66,071</td>
<td>88.3%</td>
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<tr>
<td>2019-2020</td>
<td>79,577</td>
<td>70,919</td>
<td>89.1%</td>
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SUD 1115 Waiver midpoint assessment

Government Resource Center
Ohio Department of Medicaid
Midpoint Assessment research team

- Tina Bickert, MA, Project Director, GRC Principal Investigator
- Shawnita Sealy-Jefferson, MPH, PhD, OSU College of Public Health
- Townsand Price-Spratlen, PhD, OSU Department of Sociology
- Thomas Albani, MPH, GRC Senior Research Analytics Specialist
- Leyla Tosun, PhD, GRC Senior Research Analytics Specialist
- Rachel Mauk, PhD, Research Scientist, GRC Principal Investigator
- Audra Phillips, GRC Project Manager
Midpoint Assessment overview

Goals:
- To gain insight into the experiences of people seeking SUD treatment in Ohio;
- To understand the factors that may hinder or facilitate implementation of the SUD 1115 Waiver;
- To gain insight into how organizations, including state agencies, treatment providers, advocacy groups, and managed care organizations are addressing implementation challenges; and
- To understand how COVID-19 has impacted waiver implementation
Key information interviews

• Key Informants
  o State Agency Leadership (7)
    ▪ Ohio Department of Medicaid (ODM)
    ▪ Ohio Mental Health and Addiction Services (OhioMHAS)
  o Residential and Community Treatment Providers (7)
  o Treatment and Recovery Advocates (4)
  o Managed Care Plans (5)

• Interview Topics
  o Access to care along the continuum
  o Medication Assisted Treatment (MAT)
  o Impact of COVID-19 on SUD treatment
Focus group recruitment

- 11 focus groups conducted virtually from May – June 2021 with Medicaid beneficiaries
- Focus groups recruited with the assistance of SUD Advisory Committee members and other treatment/transitional housing providers
Focus group recruitment

• Ohio counties:
  o Ashtabula
  o Clark
  o Cuyahoga
  o Franklin
  o Hamilton
  o Mahoning
  o Montgomery
  o Scioto
  o Tuscarawas

• Facility Demographics:
  o Men only: 1
  o Women only: 3
  o Residential: 7
  o IOP: 9
  o Recovery housing: 3
  o MAT offered: 8

Lack of participation from northwest Ohio is a limitation
Focus group topics

• “What does treatment mean to you?”

• Barriers to treatment – access and retention

• Facilitators to treatment – access and retention

• Utilization of recovery community support services
Qualitative research methods

• Research staff used Atlas.ti to create and assign codes to passages of text to categorize and label data
• Mix of deductive and inductive coding
• 2 independent coders per transcript
• Refined codes and grouped by prominent themes
• Compiled relevant code reports for each topic
Provider survey

- Distributed through our SAC partners/OhioMHAS/ODM
- Currently being fielded
- Topics:
  - SUD treatment facility demographics (location, hours, services, population, etc.)
  - Access to care
  - Coordination of care
  - Insurances accepted
  - MAT
  - COVID impacts
  - Impact of 1115 waiver
SUD 1115 Waiver
Midpoint Assessment
Impact of COVID-19
Key themes

Key Informant Interviews
- Increase in demand
- Impact on substance use
- Disruption on normal services
- Impact on workforce
- Reduced access
- Use of telehealth services

Beneficiary Focus Groups
- Increase in demand
- Removed support systems
- Reduced access
- Use of telehealth services
Increase in demand for services

- In general, the pandemic has increased demand for behavioral health services [Milestones 1, 4]
  - “There is ... an increased demand for behavioral health services you know we, this will be no different then what folks might have experienced it you know through Katrina or Sandy, or you know those other types of big traumatic events...definitely, you know, seeing upticks in the need for services and...making sure we are paying attention and...have plans in place to be able to address that behavioral health surge as it’s coming up on us.” - Employee at state agency
Impact on substance use

• Under the pandemic, the opioid epidemic continues
  o “Everyone's well aware that while we're in the midst of this pandemic and we're counting COVID numbers that people are dying at increasingly rapid speed due to overdoses” – Managed Care Plan
  o “Clearly, the use of substances has gone up because of COVID. Suicides as well as the use of substances, so we’re exacerbating those problems. We have clearly seen a dramatic fall off on treatment, hospitals, across the board. So, people aren’t accessing the services.” – Employee at state agency

• Relapses aren’t limited to those who have recently recovered
  o “When we first went into quarantine back in March, the biggest impact that we heard over and over again, were not necessarily people who were in active addiction, it was people who had maybe been longer term recovery who no longer had access to the services that they relied on like 12 step meetings or smart recovery or whatever. And it all went virtual. I mean that through and through was the thing that like, like 30, 40 year plus people in recovery starting to relapse because they didn't have access to those services any longer.” – Recovery advocate
Disruption of normal services

• Despite the increased demand, COVID has limited normal operations
  
  o “We saw the blunting of overall behavioral health admissions, including you know, admissions and inpatient settings for detox in March. It sort of climbed back up over the several months, they're, they're still is, you know, somewhere between 8 to 10% fewer admissions overall and...when the governor issues, you know, stay at home or this or that, you know those frightened people including people that need, you know, different levels of care. So, I think there's a global you know there's a global blunting of access to services.” – Managed Care Plan
Impact on workforce

• The COVID-19 pandemic has put strain on providers [Milestones 1, 3, 4]
  o "It's been a struggle. And I think keeping staff, keeping staff motivated and keeping staff...focused on the important thing has been actually difficult, but less difficult than you would think. Because I think you innately know it and you're in a you're not in this field, because you're here for the pay, I mean, you joined it because you care. And this is pulling that out of you right now. The problem is you usually refill the tank. And I don't know anywhere in healthcare that we're refilling the tank right now. We're just burning people out and it's in an area in which we already had a workforce shortage. I don't know if this attracts people to the field or if it drives them away." - Treatment provider
  o "It seems to be more difficult recruiting. We have several open positions. And I think people are just leery about coming into environments such as this to work. So, it's been more difficult, I believe, to recruit staff and like I said just the anxiety. Also, we've had a number of staff that have been in contact with someone that's been positive. And they had to be off. Because of being in contact, even though they've been negative tested, they still had to be off before they could, you know, come back to our environment. For a number of days. I think 14 or 10 to 14 days, something like that." - Treatment provider
Reduced access

Concerns about safety (related to COVID-19) have influenced behaviors around attempting to access services [Milestone 1]

- “There are some individuals who don't want to come in for treatment because of the fear of contamination...particularly there were challenges related to the methadone...patients, with needing to come in every day and the OTPs responded very quickly in terms of using PPE and setting things up, but I mean, you have big long lines on a daily, day to day basis to get your methadone. And that really affected a lot of folks wanting to engage on an ongoing basis in methadone treatment. And the same would be obviously for a Vivitrol injection, it's gotta be one to one close contact, so a lot of folks you know had some hesitancy related to that.” – Treatment provider

- “And then even in the residential units you know they don't want to necessarily introduce someone or admit someone coming in externally because there's that fear that they may have COVID. And then what we saw is longer times to get them discharged as well because you know you had that same cycle going down to the next level of care whether it's transitional housing getting new admission. So, it definitely has had an impact. We did see an uptick in our average length the stay, just because there was no place to put them that would have been a safe discharge.” – Managed Care Plan
Reduced access from the perspective of those in treatment

• Access was reduced or removed for meetings and support groups
  o “COVID did affect our meetings, like we were in this house for like four months in a row and we couldn't go to one meeting, we couldn't go anywhere. So, like, it did affect our meetings” – Individual in recovery

• Lack of outside access can impact those in recovery and their families in other ways
  o “When COVID started it took everything away. I had visits, it was once a month, I was clean and everything, but it took all that away from me. So that's me knowing my child and my child knowing me. And when they did allow me to do this again, my son didn't want...I felt like he didn’t want no part of me because he didn’t know who I was, if I will go to pick him up, he will scream and kick and cry. I was homeless, so like, they really weren’t looking to try to give him back to me. I went to treatment, until I had a place to stay, until I had a job in January. But in January, I was told, like when I did reach out to them, I was told that January 21, when the state picked it up January 26 is when I entered treatment. So, I was like, five days late, they told me the only thing that I can do is go to Children Services give them my name and where I live until my son is 18 is the only thing I can do. So, I can’t fight for him” – Individual in recovery
Delays in finding or starting treatment

- Waitlists have kept many from getting into treatment quickly [Milestones 1, 4]
  - “I started looking for treatment about the beginning of the COVID, and I couldn't get anywhere like it was always a huge waiting list, everything took two weeks to get to the next step, and I couldn't keep myself out of jail long enough to get into treatment. Eventually I overdosed and ended up in a mental hospital, and then they finally got me in somewhere into here at TCC, but I tried for over a year to get in somewhere, but I couldn't keep myself out of jail enough to get in. The process was so long.” – Individual in recovery

- For mothers trying to get to treatment, COVID has made things more complicated [Milestone 1]
  - “I got all the way there and it was like they expected me to leave my nine-year-old outside. Because of COVID, they weren't taking anyone over the age of four. So, they didn’t tell me that they wouldn’t take us. I get all the way to Cincinnati, with luggage, you know, drive just for them to tell that they can't take me, oh and the time my family dropped me off. ‘She's fine. Go ahead, get back on the road,’ and an hour later, they can't take my nine-year-old because of COVID.” – Individual in recovery
Use of telehealth services

- Telehealth has had mixed reviews from both providers and those in treatment [Milestone 1]
  - “The biggest barrier to me just now is the hours with the, like, during the COVID it was easy, because -- it was easier because it was over the phone, and if I was working, or that, um, I could still accommodate the phone calls, but now they're going into person, and, uh, the job I have it switches hours every two weeks.” – Individual in recovery
  - “COVID helped to uncover, in my view, a good bit of information, which is, when we switched everything to Telemedicine, like most agencies, this is aggregate, mental health patients, substance abuse patients, everybody. Our no-show rates fell by about 35%.” – Treatment provider

- Digital literacy and digital divides can inhibit connection [Milestone 1]
  - More about this in discussion of structural factors
Created greater feelings of restlessness and isolation

• “I know for me, like, I was in here around this time last year when we were in the, um, quarantine. I honestly got so depressed, I wanted to go out and get high. Like I just, it was depressing, you know what I mean, there was nothing really, because we had to do the Telehealth and we were all lined in a little room. It's day after day, it was just repeat, we remain, it's dreaded getting up, you know what I mean? It was really bad.”
  – Individual in recovery

• “Our weekend passes are important because that's the only time we are able to get off the ground and see our families. Our families are not even allowed to come and visit us because of COVID-19. So, you know, we are our passes are important to us.”
  – Individual in recovery
Loss of supports for those in treatment

• “We weren't allowed to see the children we weren't allowed to have our sponsors come in to do step work with us. We weren't allowed to have our family members come visit us there -- it was our -- and we weren't allowed to do meetings for the longest time it was -- we were locked in a facility without pretty much anything it kind of at the beginning, it did start changing but at the beginning, it was just like, kind of we were like, a dry drunk that's how I felt like, like, I was there, I was clean, but I wasn't doing everything I knew I could to stay clean.” – Individual in recovery

• “I had a lot of idle time...because you don't have as many groups you have a lot of like idle time, um, when COVID hit, they quit letting you have visits and you only got like phone calls, um, a couple of times, which now that like I'm sober and I can see what they were doing now, I know a lot of people left because you couldn't have phone calls, like the first two weeks, but I totally get that now, um, but and then I was always worried about what was going on, on the outside...” – Individual in recovery
COVID-19
Questions and discussion
SUD 1115 Waiver
Midpoint Assessment
Structural Factors
Key themes

Focus groups
- Court/CPS involvement
- Structural factors
- Transportation barriers
- Housing instability
- Job/childcare issues
- Mothers in treatment

Key informant interviews
- Prescribing from the bench
- Criminal justice involvement
- Mothers in treatment
- Structural factors
Mothers in treatment

• Challenges in finding treatment while pregnant [Milestone 1, 3, 4]
  o “I found that while pregnant, that was a very hard. Nobody accepts you pregnant like, I came to rehab pregnant last year and [treatment facility] was the only place that would take me. So, I feel like a barrier there is that. Also, I feel like a barrier is if you're in a MAT program, not very many places will take you either. So therefore, like, I feel like MAT is frowned upon in most rehabs which is not fair to people who need MAT to get their recovery.” – Individual in recovery

• Challenges with childcare accessibility and lack of support [Milestone 1]
  o “In residential treatment, people would leave because they didn't have people to take care of their kids. Or some people that I knew couldn't go inpatient because of their job or this or that. But, I guess that's really just what you do like, with those barriers.” – Individual in recovery
  o “I was trying to figure out somebody that would be willing to take my children so I could start the process. And I was un-unable to do so because I don't have family really. And anybody I do have. They were all in active addiction. So that's why I called children's services on myself, so I could get the help I needed.” – Individual in recovery
Restrictive rules as a barrier

• Insurance coverage rules as a barrier [Milestone 1]
  
  o “Another barrier is like, because, like, because of our insurance, we have to be in groups so many hours. While we're here and then, like if our children get sick or if one of us get sick. Like, we have to go to group while ill and it causes other people to get ill and then, like, we're just a bunch of sick people in group, like, we can't, we can't have sick days, because our insurance, like, won't, it won't, like, pay for us to be in treatment. If we miss so many hours, they'll stop our treatment plan, like, we won't be able to be here, because we have to have so many hours a week and grew and if we go below those hours, then they see it as we've, it's not necessary for us to be here anymore” – Individual in recovery

  o “One thing I find very, very sad about this is that when I was reaching out to look for somewhere to go, 99% of it was based on my insurance. Which is sad, because to me, like a lot of these sober homes. It's all a money-making racket. I've been around these rooms and sobriety for like 20 years now. And to me, it's sad, because I'm not saying everybody, but I'm going to say a good portion of it, they do it for money. Like, I called a few places, and they wouldn't take me because of my insurance.” – Individual in recovery
Telehealth

- Isolation and lack of support with telehealth
  - “Yeah, and the one thing that goes with that is, your expected house also and um, telehealth kind of puts you into, because or mental health is not good anyway. So, it puts us deeper into a depression or whatever, because we're in communal living work, we're all in one house. So, telehealth makes it hard for, um, to find sponsors or network in general. So, telehealth is hard on some people.” – Individual in recovery

- Technological literacy as barrier [Milestone 1]
  - “I don't think [COVID’s] affected me at all except meetings, because I'm not...a computer person...I had to have my son come and help me. [Laughs] you know, I'm not much of -- I'm-I'm like, 61 years old and I just like, you know, I, I just don't like all those modern technology.” – Individual in recovery
Telehealth (continued)

• Telehealth facilitating ease of access
  
  o “The biggest barrier to me just now is the hours ... During the COVID it was easy, because it was easier because it was over the phone. If I was working, I could still accommodate the phone calls. But now they're going in-person. The job I have switches hours every two weeks. So, I have to talk to different [providers]. It’s [only] two days a week for two hours now ... It's going to be back in person, so that's my biggest obstacle right now.” – Individual in recovery
Geographical data for action

- Geographical disparities and transportation barriers [Milestone 1, 4]
  - “We’ve noted geography and have been looking at maps/provider locations, and each statistical area--census track we’ve looked at the prevalence of SUD, so we can see from our claims data, you know how many individuals have an SUD diagnosis, and then we can look at provider availability in that area and see that, you know, there are some areas where those ratios are very disproportionate. So, I think the next step is drilling down and, you know, asking ourselves, you know, questions like what is the right ratio.” – State key informant
  
  - “In the small communities, that's a big factor right now [asking] someone please take me to [treatment]. That's an hour and a half away. It's three hour round trip. You don't have the money for the gas, this, that and the other. These people are reaching out, but they have nowhere to go.” – Individual in recovery
  
  - “The continuum of care, we talk about that a lot in our space but um, you know, one of the things that we talked about, like recovery housing, for instance, every community has recovery housing. But every community doesn't have adequate amount of recovery housing, so we can't really say that we have the full continuum of care represented when, say, you know, one of our rural communities only has a house for single women. So, women with children, or women that are currently pregnant don't actually have access to recovery housing. So, then the full continuum of care is actually not represented” – Recovery advocate
Housing instability

- Residential treatment safe space/women-only spaces
  - “One other thing that’s not specifically [for] me. A lot of the younger girls, I have noticed, would prefer, at least at the beginning to be in a group that is just women ... I’m not saying all the time. But, at the very beginning, maybe they could have a group for people that feel uncomfortable discussing some things, you know, with a man being in the group. They’re not apt to share as much.” — Individual in recovery

- Concentrated disadvantage, sober transitional housing, sober support
  - “My biggest problem was my environment. Where I lived. The place that I lived in was drug infested, and I choose not to go back there. They helped me see I can't go back there because this would all be useless for me. So it was my environment ... As long as I stay away from that, I know I can do this thing. It's hard because I have family back there. I’ve been wanting to go and say, ‘Hey, look at me, I look good, look how I look.’ I can’t do it ... Especially when you got family that’re using. It's the hardest thing in the world to me.” — Individual in recovery

  - “The housing is terrible here. It's overcrowded. They keep sending the same people to the same places. It is just too small, and they have not expanded, they tore it down [and] they did not [re]build.” — Individual in recovery
External factors

• Prescribing from the bench [Milestones 1, 3, 4]
  o “There is an enormous structural problem with our courts. So, you have all kinds of specialty dockets that have drug court, for example, and many of them mandate, Vivitrol only. I find it interesting that a judge would want to mandate certain kinds of treatment, you wouldn't see that in cancer care or in some other neurological issue, traumatic brain injuries, for example, but they do it in addiction, all the time.” – Treatment provider
Structural factors
Questions and discussion
SUD 1115 Waiver
Midpoint Assessment
Medication Assisted Treatment
Key themes

Beneficiary focus groups

• Stigma
• Forced tapering
• MAT creates barriers to treatment
• MAT critical to the recovery of many

➤ Milestones 1, 3, and 4 throughout

Key informant interviews

• Providers’ philosophical objections and stigma
• Financial barriers, workforce limitations, rules & regulations as obstacles to provision
• Waiver loopholes
• Importance of respecting all paths to recovery
Obstacles to access – Providers’ philosophical objections & stigma

• Stigma among providers: often rooted in abstinence & 12 step philosophies

• Stigma varies by geography

• Differences in stigma by MAT type: antagonist MAT is becoming acceptable, agonist MAT is still stigmatized (esp. methadone)

• Reasons for reticence: lack of education, negative experiences, mistrust of pharmaceutical industry making MAT drugs; importance of bringing everyone to the table

“... there’s a reason that they don’t support MAT. And it is not because they’ve got some backwards, you know, thinking about stuff. It is because over and over again, they’ve seen people getting high off of these drugs. Over and over again, they’ve seen people relapsing off of these drugs. ...you’re talking about a whole bunch of people who got really screwed over by Purdue Pharma and now you’re asking them to trust the same kind of entities to treat the thing that Purdue Pharma created, right?” – Recovery Advocate
Obstacles to access – Forced tapering

• “I really believe that the, the Suboxone is what has kept, kept me alive. It has kept me away from, you know, abusing opiates. So, I'm really scared about [tapering], because also... I'm adjusting to facing my trauma and having my counselors and my peers hold me accountable. Now, you want to wean me off or taper me down, from something that I feel, personally, it, it helped me a lot.” – Individual in recovery

• “Some of the requirements are like set in stone. There's, no give and take, like here they want you to wean down off of your MATs, in order to stay. They want, there's, no exception. Like you have to or you can't stay, in order to complete, you have to be off of it.” – Individual in recovery

• “I've I noticed a girl that she come in, she'd been on [MAT] for about eight or nine years and they told her that she was going to have to come off of it in order to stay in treatment. She left. She's gone, she wasn't off of it.” – Individual in recovery
Receiving MAT presents barriers to treatment

• “... not very many treatment centers approve of MAT. So, like I'm currently on methadone, so that limited my rehab to a very slim number, you know what I mean, like I can’t just go anywhere, I can [only] go somewhere that approves my MAT program...”
  – Individual in recovery

• “... if you're a methadone patient, there's only one [sober living program] in Columbus that let[s] you be on methadone. ... if you're on methadone, you basically have no options for sober living, and it's pretty much the same for inpatient...”
  – Individual in recovery
Obstacles to provision – Financial barriers, workforce, rules & regulations

• Smaller population centers, rural areas can’t sustain because don’t have enough demand
  o Results in geographic variation in availability, limited access to methadone in particular

• Can’t afford to hire MAT prescribers; don’t have clinical staff to administer; insufficient bed space
  o “We’re seeing more and more women present at our front door that need withdrawal management... and currently, we are not able to adequately provide those services because we don’t have the spacing. Nor ... can we afford to have the nursing, 24 hour care, that would be required for that level of care. ... So we have a lot of folks that are falling through the cracks that need detox before they can actually have the treatment.” – Treatment Provider

• Insufficient workforce to have prescribers in all residential programs

• Rules around keeping MAT on RT premises necessitates transporting patients (logistics, financial barrier)
Concern about evasion of waiver requirements

• Delays in offering MAT to patients
  
  o “…I think it’s very easy for a provider to say, ‘well, we don’t think that they’re clinically ready for that discussion,’ because again, if somebody is getting authorized for 30 days of residential, as an example, and you’re saying ‘well at day 29 we have that conversation with him about MAT. So that’s in compliance with your recommendations’ or they could say ‘well you know the patient is refusing that as a treatment option.’” – Managed Care Plan
Keep in mind all pathways to recovery

• Maintain individual agency in recovery
  o “So how do you create opportunities for individual choice, because there are people who are in recovery who don’t want medication. And … we have to be respectful of that.” – Treatment Provider

• Safe spaces for those who don’t want MAT
  o “… so we know specifically around Suboxone, like that, there are many people in this country that that was their drug of choice. And so making sure that we also have safe spaces for people who don’t necessarily want to be around their drug of choice is also really, really important.” – Recovery Advocate
  o “But how do you do [MAT] in a way that doesn’t threaten someone else’s recovery? Who, to them, they can’t have that around… So I get why the providers are saying, don’t make me have these people in my houses.” – Treatment Provider
MAT critical to recovery of many

“... I feel like methadone medical assisted treatment [has] definitely kept me alive for the last seven, eight years because it's just a lot of the times it's kept me out of harm and kept me from falling victim to the fentanyl overdoses. Just having that service, I really feel like that's the reason I'm here today.” – Individual in recovery

“... treatment is different this time for me because it's my first time on methadone. ... So, when it started working then I was like, okay, so now we have a goal to aim for, which was really relieving to me because then all of a sudden there's light at the end of the tunnel...” – Individual in recovery
MAT
Questions and discussion
SUD 1115 Waiver monitoring monthly data

Government Resource Center
Ohio Department of Medicaid
CMS 1115 SUD Waiver monitoring: Overview

• CMS requires states implementing 1115 Demonstration Waivers to regularly submit data for metrics to monitor performance of the approved demonstration.
  o Each year states are required to submit four reports to CMS. Reports consist of two parts: a data workbook and a narrative document.
  o Monitoring reports can be found here: https://bh.medicaid.ohio.gov/SUD-1115

• CMS metrics are based on established quality metrics (such as NCQA HEDIS) and CMS constructed metrics where no appropriate pre-defined metrics exist.
  o Ohio has received approval to include certain modifications to align value sets and other criteria with Ohio-specific treatment rules (e.g., MAT).
CMS 1115 SUD Waiver monitoring: Overview

• This presentation focuses on a subset of monthly metrics corresponding to core ASAM levels of care, plus withdrawal management and MAT.
  o Beneficiaries may be reported in multiple metrics within the same month if services occur on different days or with different billing providers.
  o If beneficiaries receive different levels of service from a single billing provider on a single day, only the highest level of service is assigned for that day.

• Beneficiaries must be enrolled with full Medicaid benefits for at least one day in the month and receive the service (or be discharged from the treatment setting) within the month.

• Data is available from October 2019 through June 2021.
Subpopulation definitions

CMS also requires reporting of specific subpopulations to assess whether the demonstration is impacting vulnerable populations. **Bolded** categories will be shown today.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUD</td>
<td>Opioid use disorder diagnosis recorded in the month</td>
</tr>
<tr>
<td>Youth</td>
<td>Under age 18 as of the first day of the month</td>
</tr>
<tr>
<td>Adult</td>
<td>Age 18-64 as of first day of the month</td>
</tr>
<tr>
<td>Older Adult</td>
<td>Age 65 and over as of first day of month</td>
</tr>
<tr>
<td>Dual*</td>
<td>Full-benefit dual (includes both MyCare and non-MyCare duals)</td>
</tr>
<tr>
<td>Pregnant*</td>
<td>Women age 13-49 with a pregnancy-related claim in the month or two months prior</td>
</tr>
<tr>
<td>Criminal Justice Involved*</td>
<td>MPRE enrollment (defined by intended release date occurring in the month or 12 months prior)</td>
</tr>
</tbody>
</table>

*Complementary subpopulation also reported. These groups tend to trend with the overall demonstration population due to large size.
Metric #7: Early intervention

- Includes alcohol/drug screening and SBIRT services
  - G0396, G0397, H0049, H0050, 99408, 99409
  - SUD diagnosis must be reported on the claim
Metric #7: Early Intervention – All Medicaid

- Early Intervention services (not in conjunction with other same-day services) declining prior to pandemic; have stabilized since mid-2020.
- Observed decrease in billing of G0397 (SBIRT > 30 min) after October 2019.
Metric #8: Outpatient

- Includes various outpatient services that are not IOP/PH or Residential Treatment, including services billed by PT 95
  - Individual or group counseling, CPST, E&M services, etc.
  - SUD diagnosis must be reported on the claim
  - Includes services delivered via telehealth
Metric #8: Outpatient – All Medicaid

- Small decline in outpatient services during pandemic, but overall counts of beneficiaries receiving outpatient services for SUD is rising.
- Seasonal minimum in November/December each year.
Metric #8: Outpatient – Youth and CJI/MPRE

- Larger declines in outpatient services among youth during early months of pandemic; counts have not returned to pre-pandemic levels.
- Stable count of individuals in CJI/MPRE population accessing outpatient services.
Metric #8: Outpatient – Pregnant individuals

- Small decline in pregnant individuals accessing outpatient SUD services in spring 2020.
- Increase over summer 2020, followed by decline during winter 2021 coronavirus surge.
Metric #9: Intensive Outpatient and Partial Hospitalization

- Includes just Intensive Outpatient and Partial Hospitalization services billed with HCPCS H0015
  - Service must have SUD diagnosis on claim
- Beneficiaries are assigned to a reporting month based on the discharge or last service date, and claims with consecutive service days (allowing a 2-day gap) are combined into spans
Metric #9: IOP/PH – All Medicaid

- Sharp decline in IOP/PH discharges during early months of COVID-19 pandemic.
- Recent months have exceeded pre-pandemic discharge counts.
Metric #9: IOP/PH – Pregnant, CJI/MPRE, and Youth

- Decline in IOP/PH discharges during COVID-19 pandemic for all three groups.
- Discharges appear to have stabilized at a slightly lower level in recent months.
Metric #10: Residential Tx and Inpatient – All Medicaid

• Includes residential treatment and inpatient SUD services
  o Some residential codes require a primary SUD diagnosis, while others have no diagnosis requirement (e.g., POS 55)
  o Inpatient claims require primary SUD diagnosis

• Metric does not distinguish between residential (ASAM 3.1, 3.3, 3.5, 3.7) and inpatient (~ASAM 4)

• Sequential stays are combined if gaps between service dates are 2 days or fewer
  o Inpatient stays combined for gaps of 1 day between discharge and admission
Metric #10: Residential Tx and Inpatient – All Medicaid

- Sharp reduction in residential treatment/IP discharges during early months of COVID-19 pandemic.
- Recent months have exceeded pre-pandemic discharge counts.
• Decline in discharges in April 2020 for all three subpopulations.
• Discharges among Pregnant individuals and Youth began to decline later in 2020. MPRE has stabilized at a new, slightly lower level in recent months.
Metric #11: Withdrawal Management

- Includes withdrawal management and detoxification services (acute and sub-acute)
  - Services must have an SUD diagnosis on the claim

- Withdrawal management treatment spans are collapsed for gaps of 2 days or fewer for professional and outpatient claims, and for gaps of no more than 1 day for inpatient claims
  - Beneficiaries are counted monthly based on final date of span
Metric #11: Withdrawal Management – All Medicaid

- Decline in withdrawal management setting discharges during April 2020.
- Recent months have exceeded pre-pandemic discharge counts.
Metric #11: Withdrawal Management – Pregnant and CJI/MPRE

- Decline in withdrawal management setting discharges during April-May 2020.
- Counts are relatively stable compared to increase noted in prior slide.
Metric #12: Medication Assisted Treatment

• Includes office administered and pharmacy dispensed MAT
  o No SUD diagnosis required on claim

• Medications include buprenorphine, buprenorphine/naloxone, methadone, naltrexone (oral and IM), acamprosate, and disulfiram
Metric #12: MAT – All Medicaid

- Steady increase in number of individuals receiving MAT since October 2019.
- Rates may be important here to understand full landscape of treatment.
Metric #12: MAT – Pregnant and Youth Subpopulations (Dual Axis)

• Decline in pregnant individuals and youth receiving MAT since the start of the COVID-19 pandemic.
• May be seeing an increase among youth in more recent months.
Monitoring
Questions and discussion
Additional input

• Send any comments, questions or suggestions to: MCD_SUD1115@medicaid.ohio.gov

• State staff monitor this mailbox and will forward any related questions or comments to GRC
Next steps and discussion
Next steps and discussion

• SUD Prior Authorization (PA) form
  o The SUD PA form was recently updated to incorporate provider and plan requests for additional space for open-ended responses
  o The updated form is available [here](#)

• Preparations for provider on-site reviews are ongoing

• Comment period for SUD 1115 Waiver amendment ended on 9/30
  o ODM will request approval from CMS for an amendment to prospectively adjust projections to account for increases in managed care capitation rates