



Department of Medicaid

January 2, 2019

The Honorable Secretary Alex Azar
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Section 1115 Substance Use Disorder Demonstration Waiver Application

Dear Secretary Azar:

On behalf of Ohio, I respectfully submit the State's Section 1115 Substance Use Disorder Demonstration Waiver proposal.

Like most states, Ohio is experiencing an increase in substance use disorders, including a marked increase in individuals with opioid addictions that result in death, prompting the state to focus on how to increase the availability of treatment services and to encourage greater collaboration with our partner health care providers statewide in addressing the crisis. For the past four years the Ohio Department of Medicaid, in conjunction with our sister agency, the Ohio Department of Mental Health and Addiction Services, has worked with the Centers of Medicare and Medicaid Services to redesign the Medicaid behavioral health benefit package of services to better serve the needs of the citizens of our state. The new service package has afforded mental health and addiction treatment agencies the opportunity to increase provider capacity and to strengthen current efforts to integrate behavioral health and physical health care providing wholistic coverage for those individuals at greatest risk for mental illness and substance use disorders. Central to this work has been a commitment to improve the treatment options for those individuals suffering from substance use addictions. To this end, conversations with CMS and our partner state agencies have lead us to take the next step in our journey to improve substance use treatment options for Ohioans by leveraging opportunities that an 1115 waiver demonstration would offer

The 1115 Substance Use Disorder Demonstration Waiver will establish milestones and goals for the state to standardize substance use treatment under one clinical addiction treatment criteria, to involve the Medicaid Managed Care Organizations in collaboration with state partners and behavioral health stakeholders in a commitment to improve treatment quality and availability, and to support and educate addiction treatment providers towards successful treatment outcomes.

Your consideration of Ohio's 1115 Waiver application is appreciated and if you have any questions or need additional information as you review, please do not hesitate to ask.

Sincerely,



James G. Tassie, Interim Director
Ohio Department of Medicaid

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**Section 1115 Demonstration
Waiver Proposal**

**For Substance Use Disorder
Treatment**

Submitted by the

Ohio Department of Medicaid

OHIO MEDICAID 1115 DEMONSTRATION PROPOSAL FOR SUBSTANCE USE DISORDER TREATMENT

I. SUMMARY

The Ohio Department of Medicaid (ODM) is requesting an 1115 Demonstration Waiver for substance use disorder (SUD) inpatient and residential treatment in managed care and fee-for-service (FFS) for adults and children. Ohio also requests this Demonstration to ensure a complete American Society of Addiction Medicine (ASAM) level of care (LOCs) array is available as part of an essential continuum of care for Medicaid-enrolled individuals with opioid or other SUDs. This Demonstration waiver is requested to be effective immediately upon approval to use in Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

Ohio Medicaid covers all ASAM LOCs 0.5 through 4.0. The Demonstration would permit ODM, largely through our contracted Medicaid managed care programs (MCPs), to maintain critical access to medically-necessary SUD treatment services in the most appropriate setting for the member, regardless of length of stay, as part of a comprehensive continuum of SUD treatment services. Recent Medicaid managed care regulations impose new limitations on ODM's use of IMDs as alternative settings for State plan behavioral health (BH) services. In Ohio, these regulations will impede access to inpatient and residential SUD treatment services at a critical time in Ohio's efforts to implement Medicaid BH reform, and provide SUD treatment to confront Ohio's opioid epidemic.

The Demonstration would also permit ODM, through the FFS program, to provide medically-necessary health care, mental health (MH) and SUD services in the most appropriate setting for individuals who are not eligible for enrollment in managed care. This will permit Ohio to divert individuals from repeat, costly BH admissions at general hospitals to more appropriate and cost-effective community-based BH treatment.

II. BACKGROUND AND THE IMPACT OF THE MANAGED CARE RULE

Background

Modernizing Ohio Medicaid's system of delivering BH services has been an ongoing and sequential process beginning with elevation of the funding of the BH benefits to the State level in 2012, and fully integrating the BH benefit package of services into the MCP on July 1, 2018. In keeping with the goal of modernization, from August 2014 through the end of 2017, ODM, in collaboration with the Ohio Department of Mental Health and Addiction Services (OhioMHAS), developed and implemented a comprehensive redesign of the BH benefit package of services provided by community MH and SUD service providers. The BH Redesign was implemented on January 1, 2018.

The new benefit service package was divided among five separate State plan authorities, and these State Plan Amendments were approved by the Centers for Medicare & Medicaid Services (CMS) for a January 1, 2018 effective date. This comprehensive restructuring of the BH benefit package of services and the transition of the service package to the managed care delivery system created a comprehensive, coordinated system of care for children and adults. Prior to the January 1, 2018 implementation date for BH Redesign, Ohio had not adopted a complete array of SUD services using a national placement criteria (ASAM) or national provider standards, nor had Ohio required providers of BH services to adopt national correct claim coding. Most importantly for individuals in need of SUD treatment, there were limited options for outpatient, community-based SUD services.

Outpatient Hospital Behavioral Health was also implemented in August 2017. Previously, some Ohio Medicaid hospital providers separately obtained certification from OhioMHAS and were enrolled in Ohio Medicaid as a Community MH agency and/or a SUD treatment program in order to provide services in the community under the former BH benefit package. CMS Medicare provider-based regulations prohibit the establishment of separate business entities within a 35-mile perimeter of the main hospital campus. Ohio informed these providers they should relinquish their separate Medicaid enrollment(s) and permitted them to furnish the new BH Redesign services within their outpatient hospital facilities beginning August 1, 2017. Ohio also opened the new BH service package to other outpatient hospitals, both to general hospitals and to psychiatric hospitals, who had not previously been able to furnish outpatient services. Essentially, this allowed the outpatient hospitals to provide the new BH service package on August 1, 2017.

The new BH Redesign benefit package introduced new evidence-based practices, such as Assertive Community Treatment (ACT) for adults and promising practices, such as Intensive Home-Based Treatment (IHBT) for children with MH conditions, while also modernizing the SUD treatment benefit to align with the ASAM LOCs for outpatient and residential treatment. The introduction of ASAM is intended to increase the use of community-based and non-hospital residential programs, and assured that inpatient hospitalizations are primarily utilized for situations in which there is a need for safety, stabilization, or acute detoxification (ASAM LOC 4).

The implementation of the new BH benefit package resulted in integrated BH in capitated managed care for adults and children on July 1, 2018. Since July 1, 2018, the MCPs are responsible for providing all health care (including BH services) for adults and children, targeting the goal of improved models of care focused on supporting individuals in the community and home outside of institutions, increasing outpatient MH rehabilitation services, introducing a continuum of SUD services aligned with the ASAM criteria, and deemphasizing the role of hospitals and large institutions (IMDs) in the delivery of covered services. Note: the MyCare Duals Demonstration plans have been responsible for all BH services, whether furnished by independent

practitioners in the community or by community BH agencies certified by OhioMHAS, since their inception on May 1, 2014.

The Ohio Medicaid MCP currently contracts with five MCPs: Buckeye Community Health Plan (Buckeye), CareSource, Molina Healthcare (Molina), Paramount Advantage (Paramount), and UnitedHealthcare Community Plan (United). For the MyCare Ohio program, ODM contracts with four of those plans (excludes Paramount), plus Aetna Better Health of Ohio (Aetna).

Today, Ohio requires most Medicaid/Children's Health Insurance Program (CHIP) beneficiaries to enroll in capitated managed care. There are a few recipients (≈11%) who receive services under the FFS delivery system. Approximately 89% of Ohio Medicaid/CHIP beneficiaries are enrolled in either Ohio Medicaid MCP or MyCare Ohio, a regional MCP for Medicare-Medicaid dual eligibles. This includes 100% of beneficiaries in Ohio's adult expansion (extension adults) who receive the alternative benefit plan (aligned with the regular State Medicaid plan) and 97% of beneficiaries in Ohio's CHIP program (Healthy Start), which is a Medicaid expansion program.

The Impact of the Medicaid Managed Care Final Rule

As stated previously, ODM has designed the current integrated MCP, including SUD services, with the expectation that Federal Medicaid policy would permit the use of IMDs as cost-effective alternative services. These settings are a crucial part of Ohio's SUD treatment provider network in order to maintain critical access to SUD residential treatment for Ohio Medicaid enrollees.

On May 6, 2016, CMS published new managed care regulations, which permit states to use Federal Medicaid funds for capitation payments to managed care plans for persons receiving treatment in an IMD "in lieu of" other services covered under the Medicaid State Plan. Under this regulation, Federal payments for IMD services are limited to 15 days per month for individuals ages 21-64. In addition, IMD services must be medically appropriate and cost-effective and enrollees cannot be required to accept IMD services "in lieu of" other services covered under the Medicaid State Plan.

Ohio Medicaid is requesting this Demonstration in order to ensure Federal funding for SUD residential treatment and other health care services for people residing in facilities that meet the IMD definition. Seeking an 1115 Demonstration is the logical next step, following successful redesign implementation and managed care integration to continue to ensure Ohio's Medicaid beneficiaries have access to the entire continuum of ASAM LOCs. Ohio has a strong foundation for this Demonstration request already in place due to the redesign and managed care integration completed July 1, 2018.

III. DEMONSTRATION OBJECTIVES

The objective of this Demonstration is to maintain critical access to cost-effective SUD treatment services for Ohio Medicaid enrollees and continue the delivery system

improvements for these services to provide more coordinated and comprehensive SUD treatment by Medicaid.

This Demonstration seeks to improve outcomes for Medicaid individuals diagnosed with SUDs by maintaining critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDs, as part of a full continuum of ASAM LOCs aligned treatment services. Under BH Redesign, Ohio designed a comprehensive, integrated BH benefit that includes cost-effective alternatives to State Plan residential treatment settings by IMDs. However, recent changes to Medicaid managed care regulations and existing IMD limitations in FFS create barriers to ensuring individuals are able to access SUD treatment at a LOC appropriate to their needs using the ASAM criteria. This Demonstration seeks authority so Federal Medicaid managed care restrictions on IMDs as SUD treatment settings do not disrupt the Medicaid SUD treatment continuum in Ohio by inadvertently reducing critical access to SUD treatment recently expanded through BH Redesign.

Implementing the limitations of the Medicaid managed care final rule has the potential to hinder Ohio's progress with BH reform by reducing access to community-based residential treatment services, creating a critical access problem in the State for SUD treatment services, and increasing costs to the State and Federal governments. There may not be enough SUD residential treatment programs in Ohio with 16 or fewer treatment beds to address the extent of the opioid epidemic in the State. This is particularly true since the State expanded Medicaid eligibility (effective January 2014) and such services are available to more than 700,000 Expansion-eligible individuals. Restricting Medicaid funding at this juncture would cripple the State's ability to address the surge of SUD treatment needs for Medicaid enrollees.

The Demonstration will also remove Medicaid payment barriers in FFS for SUD residential treatment for individuals in need of these services. By preserving critical access to residential treatment capacity, Ohio will be able to continue to provide an effective SUD treatment continuum of care with interventions capable of meeting individuals' changing needs for various ASAM LOCs. As individuals move throughout the continuum in their SUD recovery, they may need to transition to LOCs of greater or lesser intensity.

IV. Comprehensive Description of Strategies for Addressing Goals and Milestones

The State's initial approach to key system reform milestones will be addressed in the comprehensive Implementation Plan submitted concurrently with this Demonstration request. The Implementation Plan addresses system reforms required in the 2017 State Medicaid Director's Letter and outlines a path toward an IMD exception using the 1115 Demonstration authority. A brief summary of the State's current environment for each milestone is listed below.

Milestone 1: Access to Critical LOCs for Opioid Use Disorder (OUD) and Other SUDs

Ohio's OUD and SUD treatment systems includes early intervention, coverage of outpatient, intensive outpatient and partial hospitalization services, MAT (medications, as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State), intensive LOCs in residential and inpatient settings, and medically supervised withdrawal management.

The State ensures sufficient coverage by contractually requiring the MCPs to demonstrate network adequacy for services. If services are unavailable within the specific region, the MCP is required to contract for services with providers outside the defined geographical boundaries.

Milestone 2: Use of ASAM Placement Criteria

The State requires all SUD treatment providers to assess and provide services using the ASAM criteria. ODM requires SUD treatment providers enrolled in Medicaid to use multi-dimensional assessments based on the six dimensions of care as outlined in ASAM. In addition, for providers who must be certified by OhioMHAS, the ASAM criteria is required as a condition of certification.

Ohio Administrative Code (OAC) rule [5160-27-09](#) describes SUD treatment services provided to Medicaid recipients regardless of delivery system. This regulation requires the use of the ASAM treatment criteria for addictive, substance related, and co-occurring conditions for admission, continued stay, discharge, or referral to each LOC.

The current ODM MCP provider agreement requires all plans to follow the prior authorization standards established under BH Redesign for both the FFS and managed care delivery systems. On and after July 1, 2019, SUD services provided in the managed care and FFS delivery systems will comply with the ASAM criteria for all prior authorization and utilization review decisions resulting in continued continuity across the Medicaid delivery systems. The MCP provider agreement will be updated to emphasize the required use of the ASAM criteria for all SUD services regardless of site, provider type, or LOC. MCPs prior authorize SUD residential treatment services for their members while SUD residential treatment for individuals enrolled in the FFS delivery system is prior authorized by ODM or its designee. This will ensure members have access to SUD treatment at the appropriate LOC and interventions are appropriate for each person's diagnosis and LOC.

Milestone 3: Use of ASAM Program Standards for Residential Provider Qualifications

ODM and OhioMHAS require Medicaid participating providers of SUD treatment services to use the ASAM criteria. These requirements apply to SUD residential treatment service providers under both the managed care and FFS delivery systems. OhioMHAS' certification regulation in [OAC rule 5122-29-09](#) require residential,

withdrawal management, and inpatient SUD treatment services to be provided in accordance with the ASAM LOC 3. ODM’s rule, 5160-27-09, also requires residential services/inpatient services to be provided in accordance with ASAM LOC 3. ASAM’s LOC 3 and associated sub levels are to be provided as appropriate to the needs of the individual being served and as published in The ASAM Criteria, Third Edition, 2013®.

In the future, Medicaid policy manuals will be modified to include more detail about the ASAM residential program requirements including the particular types of practitioner services, hours of clinical care, and credentials of staff for residential treatment. This will include a requirement that residential treatment providers offer MAT on-site or facilitate access off-site with a MAT provider not associated with the residential treatment owner. Medicaid will also implement a process for reviewing residential treatment providers to ensure compliance with these requirements and for IMD determination.

Milestone 4: Provider Capacity of SUD Treatment including MAT

As part of preparing for the inclusion of BH Redesign benefit package in MCP contracts on July 1, 2018, ODM conducted readiness reviews of the MCPs to ensure the panel standards required of plans were met. This included ensuring each MCP had at least a minimum number of comprehensive Alcohol and Drug treatment providers in each region. If a covered Medicaid service is not available in network, the MCP must arrange for that service to be provided out-of-network at no additional charge to the member.

Ohio has 4,135 SUD residential treatment beds across 178 OhioMHAS-certified SUD residential, withdrawal management, and inpatient SUD service programs that might meet the definition of an IMD.

The estimated number of residential days for each residential LOC based on 2014 data was estimated to be:

STATE FISCAL YEAR 2014	ADULT DAYS	CHILD DAYS	TOTAL ESTIMATED DAYS
ASAM 3.1	0	0	0
ASAM 3.2 Withdrawal Management	371	35	406
ASAM 3.3 (adults only)	22,061	N/A	22,061
ASAM 3.5	70,759	39,171	109,930
ASAM 3.7	5,404	1,868	7,272
ASAM 3.7 Withdrawal Management	3,947	563	4,510
Total	102,542	41,637	144,179

The State expects to be able to develop an assessment of the availability of the providers enrolled in Medicaid and the ability to accept new patients in each of the SUD

residential LOCs within 12 months of Demonstration approval. This assessment will indicate whether facilities accept clients funded through managed care by plan, FFS, or both delivery systems.

Milestone 5: Implementation of OUD Comprehensive Treatment and Prevention Strategies

Opioid Prescribing Guidelines and Other Interventions to Prevent Opioid Abuse

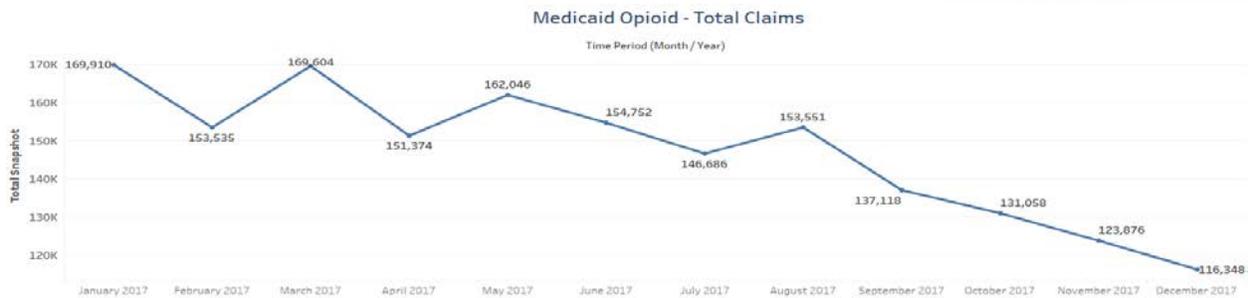
To address the opioid crisis (which is discussed in the next major section below), Ohio has implemented five sets of prescribing guidelines to prevent opioid abuse. Prescribing guidelines addressed the easiest sources of uncoordinated prescription medications through the emergency departments. Tighter guidelines for patients requiring the highest doses of prescription opioids addressed issues for those already taking opioid medications. Additional interventions included:

1. Closing “pill mills” in 2012.
2. Eliminating the possibility of calling in Schedule II drugs such as hydrocodone (Vicodin®).
3. Reducing the number of patients starting their first opioid.
4. Requiring Medicaid MCPs to put edits in place within their pharmacy programs to support prescribing guidelines.
5. Requiring MCPs to implement Medication Therapy Management for those with problematic polypharmacy and a Coordinated Services Program to provide care management services for members who overuse or misuse services.

Over the course of the development of these guidelines and rules, the State of Ohio was able to achieve a 28% reduction in solid doses of opioids prescribed from 196 million doses per quarter in Q2 2013 to 136 million in Q2 2017.¹ For acute pain, prescriptions fell from 70 million per quarter to 51 million over that same time frame with a reduction in number of patients with any opioid falling from 1.29 million per quarter to 948,000 per quarter.

These initiatives have resulted in direct impacts on Medicaid prescribing. The Medicaid opioid claims have reached a low of 116,348 claims in December 2017.

¹ OARRS data, Ohio’s Opioid Epidemic, The Medicaid Experience & Progress to Date, Agency Briefing on Opioids October 2017 SPA-5, Mary Applegate, MD, FAAP, FACP, Slide 33.



Ohio is one of the first states to realize a reduction in opioid deaths related to prescription drugs in the midst of escalating overall deaths driven by illicit drug use. Of all unintentional drug overdose deaths, the percentage of prescription opioid-related deaths in Ohio declined for a fifth straight year in 2016, and the number of these deaths declined 15.4% from 667 in 2015 to 564 in 2016 — the fewest since 2009.²

Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

Ohio has taken steps to prevent drug overdose deaths through the expanded availability and use of the opiate overdose reversal drug Naloxone. One of the most effective steps for expanding coverage included permitting pharmacists to dispense Naloxone without a prescription in 2015. To assist pharmacies, the State of Ohio Board of Pharmacy developed a dedicated web page, www.pharmacy.ohio.gov/naloxone, which features helpful resources including a guidance document, sample protocol, and a listing of all participating pharmacies. The Pharmacy Board also offers printed, no-cost patient educational materials to any participating pharmacy. By 2017, more than 1,600 Ohio pharmacies in 87 counties offer Naloxone without a prescription.

Additionally, as part of an early adoption of components of the BH Redesign project, beginning January 1, 2017, Ohio’s opioid treatment programs are now able to administer and dispense Naloxone and their physicians to personally furnish Naloxone in accordance with the State of Ohio Board of Pharmacy requirements.

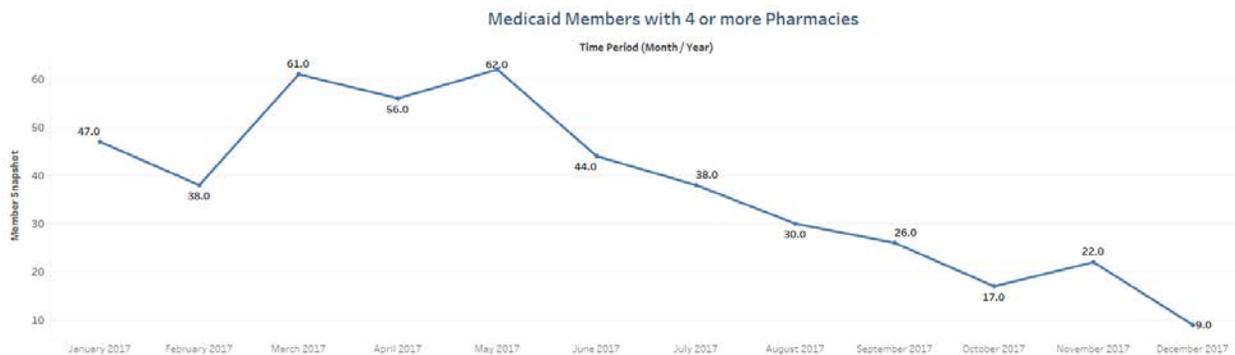
Increasing Utilization and Improving Functionality of Prescription Drug Monitoring Programs

Ohio first mandated use of the Ohio Automated Reporting Rx System (OARRS), the State’s prescription drug monitoring program by prescribers in 2011, with additional provisions added in 2013. OARRS is a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients. OARRS is designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

² Mortality data can be found at the following website:
<http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality>

Since the latest mandate in 2013, the use of the OARRS system has grown. In 2017, the OARRS reported a record high of 265,242 requests by prescribers and pharmacists in a single day. By comparison, the single day high in 2016 was 86,129 prescriber and pharmacist requests. In August 2018, OARRS reported an average of more than 599,000 requests per weekday – more than double the previous year’s high.

OARRS has also documented that fewer Ohioans are using multiple prescribers or pharmacies (i.e., doctor shopping). In 2017, data from OARRS found the number of individuals using more than five prescribers for prescription opiates has decreased 88% since 2011.³ Similarly, the number of Medicaid members with four or more pharmacies has continuously dropped since January 2017.



The State of Ohio plans to leverage opportunities described in SMD Letter 16-003 to help professionals and hospitals eligible for Medicaid Electronic Health Record (EHR) Incentive Payments connect to other Medicaid providers through the integration of OARRS into electronic medical records and pharmacy dispensing systems. All hospitals and pharmacies now have the ability to have OARRS integrated into their EHRs and Pharmacy management systems. Nearly half of physicians now have integrated access to OARRS.⁴ This initiative will allow the State to meet the following objectives:

- Further reduce the number of individuals who doctor shop.
- Provide health care providers critical information regarding a patient’s controlled substance prescription history and expand collection of other data sources to support clinical decision-making.
- Support clinician interventions for patients exhibiting high-risk behaviors.

³ Ohio Board of Pharmacy. [https://www.ohiopmp.gov/documents/Annual%20Report%20\(2017\)%20-%20Executive%20Summary.pdf](https://www.ohiopmp.gov/documents/Annual%20Report%20(2017)%20-%20Executive%20Summary.pdf)

⁴ Ohio Board of Pharmacy. [https://www.ohiopmp.gov/documents/Annual%20Report%20\(2017\)%20-%20Executive%20Summary.pdf](https://www.ohiopmp.gov/documents/Annual%20Report%20(2017)%20-%20Executive%20Summary.pdf)

- Assist providers in achieving the medication reconciliation meaningful use objective and measure.⁵

An additional goal of this integration initiative is to provide as many avenues as possible for an authorized health care provider to access Ohio's Prescription Drug Monitoring Program, including integrated access through Health Information Exchanges (HIEs). In fact, Ohio's two largest HIEs, CliniSync and The Health Collaborative (HealthBridge), have already been integrated with OARRS under this initiative.

Milestone 6: Improved Care Coordination and Transition between LOCs

Ohio has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs, including but not limited to, targeted case management, facility discharge requirements, care coordination in MCP contracts, and the proposed BH Care Coordination Program, also implemented in the managed care delivery system.

V. Comprehensive Plan to Address Opioid Abuse and Assessment of How the Demonstration Complements and Does Not Supplant Other State Activities

The Governor's Cabinet Opiate Action Team (GCOAT) comprises all cabinet-level agencies and is charged with the coordination of all activities addressing Ohio's escalating opioid crisis. This Demonstration is being coordinated with that larger effort and will complement and not supplant State activities called for or supported by other Federal authorities and funding streams.

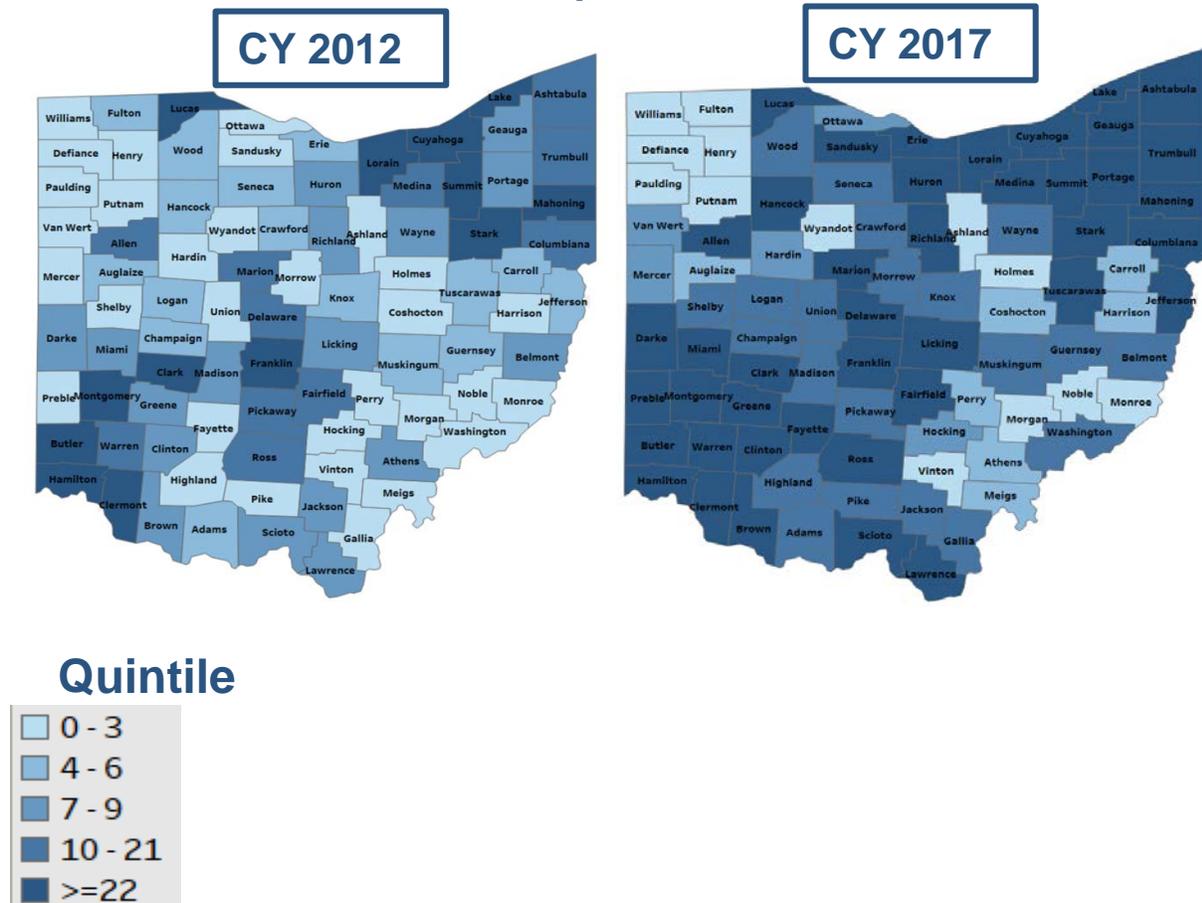
Over the last several years, ODM has played a crucial role in the GCOAT. GCOAT's interventions increased as opioids deaths rose from 1,914 in 2012 to 4,050 in 2016.⁶ See Figure 1 for maps outlining the growth in drug-related deaths in Ohio counties between calendar year (CY) 2012 and CY 2017.

⁵ Stage 3 of Meaningful use consolidates Medication reconciliation into the Health Information Exchange Objective. The objective requires the Eligible Professional provides a summary of the care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT. Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

⁶ Mortality data can be found at the following website:
<http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality>

Figure 1: Map of the rate of Drug-Related Overdose Deaths per 100,000 people in Ohio counties in 2017.

Number of Unintentional Opioid-Related Overdose Deaths



ODM has been particularly assertive in this work as the Centers for Disease Control and Prevention (CDC) reported Medicaid members were prescribed opioids at more than twice the rate as those with commercial insurance and were at greater risk for opioid abuse and death.⁸

ODM efforts have primarily focused on the five prongs of the Health and Human Services (HHS) Opioid Strategy (see Figure 2 for a visual of the HHS Opioid strategy) including:

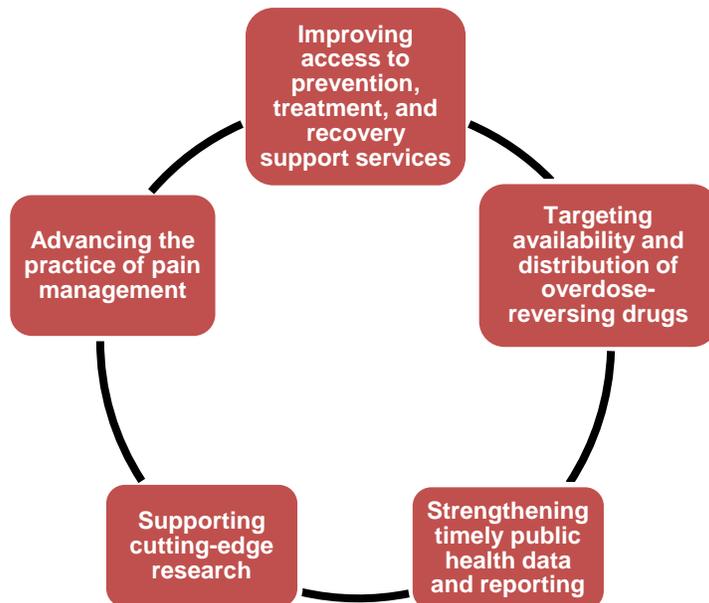
1. Improving access to prevention, treatment, and recovery support services.
2. Targeting distribution of overdose-reversing drugs.
3. Advancing the practice of pain management.

⁷ “Governor’s Cabinet Opiate Action Team Dashboard” (slide 9)

⁸ CDC. Overdose deaths involving prescription opioids among Medicaid enrollees. *Morbidity and Mortality Weekly Report*. 2009; 58:1171-1175, and CDC. Patient review and restriction programs: Lessons learned from state Medicaid programs. *CDC Expert Panel Meeting Report*. Aug 27-28, 2012; Atlanta, GA).

4. Supporting cutting-edge research.
5. Strengthening timely public health data and reporting.

Figure 2: HHS Opioid strategy



VI. DELIVERY SYSTEM

This Demonstration will not change the current FFS and managed care delivery systems. MCPs and MyCare Ohio Plans will continue to operate as approved in ODM's Section 1932(a) State Plan authority for managed care and concurrent 1915(b) waivers.

VII. ELIGIBILITY

Medicaid eligibility requirements will not differ from the approved Medicaid State Plan.

VIII. BENEFITS

Benefits will not differ from the approved Medicaid State Plan. With the CMS approval of SPA 17-013, the State began reimbursing a full array of services using the ASAM criteria effective January 1, 2018. Ohio's Medicaid State Plan and MCP contracts currently cover a full-range of community-based care designed to prevent institutionalization. The benefit package developed over the past several years in close coordination and consultation with CMS and the Substance Abuse and Mental Health Services Administration best practice guidelines includes:

- Outpatient and residential SUD treatment, including withdrawal management, consistent with ASAM LOCs,
- Community-based MH evidence-based practices such as ACT, and

- Promising practices such as IHBT.

The Demonstration will permit Medicaid recipients in Ohio with SUDs to receive high-quality, clinically-appropriate State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

IX. COST-SHARING

Cost-sharing requirements under the Demonstration will not differ from the approved State Plan requirements.

X. HYPOTHESIS AND EVALUATION

The Demonstration will test whether Ohio can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential treatment services as part of a coordinated continuum of care, resulting in increased access and improved health outcomes for individuals with SUD. This approach is particularly relevant given the needs of the Medicaid Expansion population, which has historically been underserved.

Through a contract with an independent contractor, Ohio will conduct an independent evaluation to measure and monitor the outcomes of the SUD Demonstration. The evaluation will focus on the subset of milestones of the Demonstration with performance measures as outlined below. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, emergency department utilization, inpatient hospital utilization, and readmission rates to the same LOC or higher. It will also assess the impact on the drug overdose death rate. A mid-point evaluation will be completed along with an evaluation at the end of the waiver. The evaluation is designed to demonstrate achievement of the Demonstration's goals, objectives, and metrics. As required by CMS, the evaluation design will include the following elements:

1. General Background Information
2. Evaluation Questions and Hypotheses
3. Methodology
4. Methodological Limitations
5. Attachments

The details of the evaluation design will be developed in concert with CMS during the Demonstration negotiation process.

Providing services in a less restrictive and more cost-effective setting for the SUD population is critical to the evolution of the State's BH network. ODM proposes to

evaluate the Demonstration’s success and will include an evaluation of the following milestones, research questions, and hypotheses:

Milestone 1: Improve access to critical LOCs for OUD and other SUDs for individuals in Medicaid. Critical LOCs are defined as early intervention, outpatient services, intensive outpatient and partial hospitalization services, residential and inpatient services, withdrawal management and MAT.	
	Research Question: Has access to critical LOCs as defined below improved in Medicaid? Since the development of the 1115 SUD waiver, are more individuals receiving services at critical LOCs when compared to the numbers prior to the waiver onset?
	Hypothesis: The 1115 SUD Demonstration will increase access to the specified critical LOCs for individuals in Ohio Medicaid compared to prior to the waiver.
	Performance Measures: <ul style="list-style-type: none"> Number and percentage of individuals enrolled in Medicaid with a SUD diagnosis. Number and percentage of individuals enrolled in Medicaid using each of the following critical LOCs: early intervention, outpatient services, intensive outpatient and partial hospitalization services, residential and inpatient services, withdrawal management and MAT. Number and percentage of individuals enrolled in Medicaid using any SUD treatment service, facility claim, or pharmacy claim. Number and percentage of individuals enrolled in Medicaid treated in an IMD for SUD and the average length of stay in the IMD.

Note: There are no research questions, hypotheses, or performance measures for Milestones 2 and 3.

Milestone 4: Improve provider capacity at critical LOCs including MAT for OUD in Medicaid.	
	Research Question: Has the availability of providers in Medicaid and accepting new patients, including MAT, improved under the demonstration?
	Hypothesis: The 1115 SUD Demonstration will increase provider capacity as defined below for SUD treatment at critical LOCs for individuals in Ohio Medicaid.
	Performance Measures: <ul style="list-style-type: none"> Number and percentage of providers enrolled in Medicaid and qualified to deliver SUD services. Number and percentage of providers enrolled in Medicaid and qualified to deliver SUD services and meet the standards to provide buprenorphine or methadone as part of MAT. Number and percentage of providers enrolled in Medicaid and providing each of the following critical LOCs: early intervention, outpatient services, intensive outpatient and partial hospitalization services, residential and inpatient services, withdrawal management and MAT.

Milestone 5: Improvements in comprehensive treatment and prevention strategies to address opioid abuse and OUD for individuals in Medicaid.

	<p>Research Question: Will improvements in treatment and prevention strategies in Medicaid improve outcomes of individuals with SUD in Medicaid as demonstrated by: more effective initiation of treatment, decrease use of opioid at high dosages in persons without cancer, reduce use of multiple opioids from multiple providers, reduce concurrent use of opioids and benzodiazepines, improve continuity of pharmacotherapy for OUD, decreased overdose deaths and access to preventive/ambulatory services?</p>
	<p>Hypothesis: The 1115 SUD Demonstration will improve outcomes for individuals in Ohio Medicaid under the following measures:</p> <ul style="list-style-type: none"> • AOD IET. • Use of opioids at high dosage in persons without cancer. • Use of opioids from multiple providers in persons without cancer. • Concurrent use of opioids and benzodiazepines. • Continuity of pharmacotherapy for opioid use disorder. • Follow-up after discharge from the emergency department for MH or alcohol or other drug dependence. • Rate of overdose deaths among adult Medicaid beneficiaries in the State. • Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD.
	<p>Performance Measures:</p> <ul style="list-style-type: none"> • AOD IET [NCQA, NQF #0004, Medicaid Adult Core set]. • Use of opioids at high dosage in persons without cancer [PQA, NQF #2940, Medicaid Adult Care set]. • Use of Opioids from multiple providers in persons without cancer [PQA, NQF #2950]. • Concurrent use of opioids and benzodiazepines [PQA]. • Continuity of pharmacotherapy for opioid use disorder [RAND, NQF #3175]. • Follow-up after discharge from the emergency department for MH or alcohol or other drug dependence [NCQA, NQF #2605, Medicaid Adult Core set]. • Rate of overdose deaths among adult Medicaid beneficiaries in the State. Report the cause of death as specifically as possible (e.g., prescription versus illicit opioid). • Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD.

Milestone 6: Improved care coordination and transition between LOCs for individuals in Medicaid.

	<p>Research Question: Has the Demonstration impacted access to care for individuals with SUD in Medicaid by linking beneficiaries with community-based services and supports following stays in residential and inpatient facilities and reducing re-admission rates for treatment?</p>
	<p>Hypothesis: The 1115 SUD Demonstration will improve follow-up after discharge from emergency departments and decrease re-admissions for individuals in Ohio Medicaid with SUD.</p>
	<p>Performance Measures:</p> <ul style="list-style-type: none"> • Follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence [NCQA, NQF #2605, Medicaid Adult Core set]. • Number and percentage of re-admissions among beneficiaries with SUD.

XI. LIST OF WAIVER AND EXPENDITURE AUTHORITIES

Waiver Authority

None. The waivers of freedom of choice and comparability are applied via the approved Section 1915(b) Ohio waivers and approved Section 1932(a) State Plan.

Expenditure Authority

ODM is requesting expenditure authority under Section 1115 to claim as medical assistance.

- **Residential Treatment for Individuals with SUDs.**
Expenditures for otherwise covered services furnished to otherwise eligible individuals who are receiving treatment and withdrawal management services for SUDs in an IMD.

XII. ESTIMATE OF EXPECTED INCREASE/DECREASE IN ANNUAL ENROLLMENT AND ANNUAL AGGREGATE EXPENDITURES

Medicaid expenditures and enrollment under managed care are not expected to change as a result of this Demonstration. This Demonstration would permit Ohio to reimburse SUD treatment services, including services for individuals who receive services in an IMD, which is generally a cost-effective alternative setting.

Medicaid expenditures and enrollment under FFS are also not expected to change as a result of this Demonstration. Utilization of State Plan-covered services for individuals who receive SUD treatment services in an IMD will only be authorized if ODM, or its designee, determines the admission to a residential setting is appropriately consistent with ASAM placement criteria. This will be cost-effective compared to inpatient hospital admissions.

Budget Neutrality

Milliman, Inc. (Milliman) was engaged by the State of Ohio, Department of Medicaid (ODM) to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver) for SUD residential services. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for the 1115 Waiver will be demonstrated through the use of the per capita method. The budget neutrality projections were developed using CMS budget

neutrality requirements. The SUD residential budget neutrality worksheets prepared by Milliman are attached as Attachment A.

Milliman has relied upon certain data and information provided by ODM in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the ODM for the accuracy of the data and accepted them without audit. To the extent that the data provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

XII. PUBLIC NOTICE AND TRIBAL CONSULTATION

Public Notice Process

Ohio used the following process to provide notice to the public about the opportunity to comment on the proposed SUD 1115 demonstration waiver.

- **Web posting** – On October 24, 2018, Ohio posted a public notice summary with the draft waiver on ODM's website at <https://medicaid.ohio.gov/RESOURCES/Public-Notices/Substance-Use-Disorder-Treatment-Waiver-Proposal>. An abbreviated version of the public notice with a link to the full notice was published online in the Register of Ohio and accessible at the same link.
- **Electronic Mailing** – Individuals requesting the waiver were emailed a copy of the waiver.

Ohio provided the following methods for the public to provide input on the draft waiver:

- **Email inbox** – Ohio established a dedicated email box named sud1115waiver@medicaid.ohio.gov, which received a total of 6 emails by the November 25, 2018 deadline.
- **Mail** – Ohio provided a US Postal Service address for submission of public comments: Substance Use Disorder Treatment Demonstration Waiver, Bureau of Health Plan Policy, Ohio Department of Medicaid, 50 W. Town Street, Suite 400, Columbus, OH 43215. A total of 19 comments were received via this method by the November 25, 2018 deadline.
- **Courier/Drop Off** – Ohio provided the Department street address for delivery of comments. 0 comments were dropped off at the Ohio Department of Medicaid's offices by the November 25, 2018 deadline.

- **Fax** – Ohio provided a fax number (614) 995-1301 for the submission of public comments. 0 comments were received through the fax line by the November 25, 2018 deadline.
- **Public Testimony** – Ohio held two public hearings on November 15, 2018 and November 20, 2018. The first hearing was held during a Medical Care Advisory Committee and held at the Department of Medicaid in Columbus, Ohio. The second hearing was held in Maumee, Ohio. In both hearings, the public was invited to provide comments on the draft waiver. Individuals were also able to view the second hearing proceedings via teleconference/webinar for the Columbus hearing.

At the public hearings, a presentation was given by ODM and OhioMHAS leadership which provided an overview of the proposed SUD 1115 demonstration. Approximately 25 individuals attended the first hearing, at which 0 testified. Approximately 2 individuals attended the second hearing, at which 0 testified.

Summary of Public Comments

A summary of the feedback from commenters is provided in Attachment B.

Tribal Consultation

Ohio does not have any Federally-recognized tribes.

Attachment A: Budget Neutrality

The 1115 Waiver SUD residential services budget neutrality worksheets are below. The rest of this section documents the supporting data and methodology included in the worksheets using guidance provided by CMS in the Budget Neutrality Form.

I. **WoW and WW Projections for Historical Medicaid Populations**

A. Recent Historical Actual Data

Ohio has provided actual historical data in two separate Medicaid eligibility groups (MEGs) for the managed care eligible population and those enrolled in the FFS program. The historical data includes SUD treatment in residential settings for all Medicaid eligible beneficiaries. We have included member months where a beneficiary received SUD treatment of any length. For each of these member months, we have reflected all (both SUD and non-SUD) of their corresponding Medicaid-eligible service expenditures within the month.

Effective January 1, 2018, ODM submitted a 1932 State Plan Amendment for their BH Redesign, which included a full spectrum of SUD treatment following ASAM criteria. This new BH benefit included SUD treatment in a residential facility under specific procedure codes. Prior to January 1, 2018, SUD treatment in a residential facility was not clearly defined. Instead, SUD residential facilities billed for each specific SUD treatment separately (e.g. assessments, counseling, therapy, etc.). As a result, we have limited our historical experience to the first quarter of CY 2018, as it more appropriately reflects the projected PMPM cost during the five-year Demonstration.

B. Bridge Period

The bridge period is April 1, 2018 to June 30, 2018 (3 months). Demonstration Year (DY) 00 reflects the July 1, 2018 to June 30, 2019 time period, with DY 01 set to begin on July 1, 2019. We have applied 10.5 months of aging to get from the midpoint of the historical data (February 15, 2018) to the midpoint of DY 00 (January 1, 2019).

C. WoW and WW Trend Rates, PMPM Costs, and Member Months

Based on CMS guidance regarding SUD 1115 Waivers, both the WoW and WW scenarios equal one another.

As discussed above, ODM implemented a new SUD service array on January 1, 2018, including SUD treatment at residential facilities. We have projected the SUD facility experience during the five-year Demonstration by applying a trend to both the member months receiving SUD facility treatment and the corresponding total PMPM cost. The projected PMPM cost trend reflects the President's budget trend (4.5%). Based on discussions with ODM regarding ramp-up in SUD facility treatment under the BH Redesign and new SUD facility providers coming online to

provide SUD treatment, we are assuming a 10% annual caseload trend over the five-year Demonstration.

II. Cost Projections for New Populations

Not applicable.

III. Disproportionate Share Hospital Expenditure Offset

Not applicable.

IV. Summary of Budget Neutrality

Appendix I illustrates the 1115 Waiver budget neutrality spreadsheet, as well as the supplemental SUD budget neutrality spreadsheet, which both include the following applicable tabs:

- i. SUD Historical
- ii. SUD Without-Waiver
- iii. SUD With Waiver
- iv. SUD Summary (of Budget Neutrality)
- v. SUD Caseloads

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

SUD Historical Spending Data - 5
Years

SUD Residential Services MEG 1	Historical Years Definition:			Calendar Year		Q1 2018	5-YEARS	
	2013	2014	2015	2016	2017			
TOTAL EXPENDITURES						\$75,337,439		
ELIGIBLE MEMBER MONTHS						9,760		
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$7,719.00		
TREND RATES								
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	

SUD Residential Services MEG 2

TOTAL EXPENDITURES						\$3,985,685		
ELIGIBLE MEMBER MONTHS						610		
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$6,533.91		
TREND RATES								
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	

**SUD Without Waiver
Costs**

PB Trend: 4.5%

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	

**SUD Residential Services
MEG 1**

Eligible Member Months	n.a.	10.5	42,435	n.a.	46,679	51,347	56,482	62,130	68,343	
PMPM Cost	n.a.	10.5	\$8,022	4.5%	\$8,383	\$8,760	\$9,155	\$9,566	\$9,997	
Total Expenditure					\$391,313,853	\$449,815,322	\$517,062,439	\$594,363,007	\$683,220,136	\$2,635,774,757

**SUD Residential Services
MEG 2**

Eligible Member Months	n.a.	10.5	2,652	n.a.	2,917	3,209	3,530	3,883	4,271	
PMPM Cost	n.a.	10.5	\$6,790	4.5%	\$7,096	\$7,415	\$7,749	\$8,098	\$8,462	
Total Expenditure					\$20,702,232	\$23,797,210	\$27,354,888	\$31,444,455	\$36,145,404	\$139,444,188

SUD with Waiver Costs

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	

SUD Residential Services MEG 1

Eligible Member Months			46,679	51,347	56,482	62,130	68,343	
PMPM Cost	\$8,022	4.5%	\$8,383	\$8,760	\$9,155	\$9,566	\$9,997	
Total Expenditure			\$391,313,853	\$449,815,322	\$517,062,439	\$594,363,007	\$683,220,136	\$2,635,774,757

SUD Residential Services MEG 2

Eligible Member Months			2,917	3,209	3,530	3,883	4,271	
PMPM Cost	\$6,790	4.5%	7,096	7,415	7,749	8,098	\$8,462	
Total Expenditure			20,702,232	23,797,210	27,354,888	31,444,455	\$36,145,404	\$139,444,188

SUD Residential Supplemental BN
Tests

Without-Waiver Total
Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD Residential Services MEG 1	\$391,313,853	\$449,815,322	\$517,062,439	\$594,363,007	\$683,220,136	\$2,635,774,757
SUD Residential Services MEG 2	\$20,702,232	\$23,797,210	\$27,354,888	\$31,444,455	\$36,145,404	\$139,444,188
TOTAL	\$412,016,084	\$473,612,532	\$544,417,327	\$625,807,461	\$719,365,540	\$2,775,218,946
<u>With-Waiver Total Expenditures</u>						
	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD Residential Services MEG 1	\$391,313,853	\$449,815,322	\$517,062,439	\$594,363,007	\$683,220,136	\$2,635,774,757
SUD Residential Services MEG 2	\$20,702,232	\$23,797,210	\$27,354,888	\$31,444,455	\$36,145,404	\$139,444,188
TOTAL	\$412,016,084	\$473,612,532	\$544,417,327	\$625,807,461	\$719,365,540	\$2,775,218,946
Net Overspend	\$0	\$0	\$0	\$0	\$0	\$0

Add Trend Rates & PMPMs from Table Below to 'SUD Supplemental Budget
Neutrality Test(s)' STC

SUD MEG(s)	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD Residential Services MEG 1	4.5%	\$8,383	\$8,760	\$9,155	\$9,566	\$9,997
SUD Residential Services MEG 2	4.5%	\$7,096	\$7,415	\$7,749	\$8,098	\$8,462

Projected SUD Residential Member Months/Caseloads	DEMONSTRATION YEARS (DY)					
	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD Residential Services MEG 1	10.0%	46,679	51,347	56,482	62,130	68,343
SUD Residential Services MEG 2	10.0%	2,917	3,209	3,530	3,883	4,271

Attachment B: Summary of Public Comments

Waiver Support

Comment: We believe granting this waiver will ensure that patients can access care at the most appropriate setting as part of a comprehensive continuum of treatment services. Ohio is facing a critical time in combating the opioid crisis and the implementation of this waiver will be a positive step forward in the state's efforts to develop creative care solutions.

Thank you for your comment and support.

Comment: The flexibility under the demonstration will allow many more Ohioans gain access to treatment while holding the state accountable in reporting data, ensuring cost neutrality, and meeting CMS required milestones. Most importantly, the waiver will expand capacity of the system during the demonstration period and will reduce wait times for SUD treatment services as Ohio battles the opioid crisis.

Thank you for your comment and support.

Prior Authorization

Comment: Will Ohio Medicaid be requiring prior authorization for all levels of care for SUD treatment? Prior Authorization can be untimely and costly.

Pending CMS approval, under the 1115 Substance Use Disorder waiver, providers will be required to use patient placement criteria and assess treatment needs based upon Substance Use Disorder specific, multi-dimensional assessment tools in accordance with the ASAM levels of care. Providers must use the ASAM criteria for level of care placement for all individuals seeking substance use treatment regardless of setting. In addition, beginning on the implementation date of the waiver, providers will be required to obtain prior authorization for any SUD residential treatment admission using the ASAM LOC criteria. The FFS delivery system and Plans may also require prior authorization for other levels of care where the initial authorization is exceeded or for intensive levels of outpatient care such as partial hospitalization.

Public input/ timeline concerns

Comment: The state should work with stakeholders to address any concerns regarding the implementation plan as needed. Crucial transparency was not provided to stakeholders. Submission should be delayed until 2/15/19.

The state will continue to work with stakeholders throughout the implementation of the 1115 waiver. A summary of the Implementation Plan was included in the waiver and posted for public comment. The waiver Implementation Plan is scheduled to be submitted to CMS in mid-December 2018. Following submission, stakeholders will have an opportunity to review it via the CMS web site and submit public comments for consideration. The Department seeks to work with stakeholders to ensure a smooth implementation process and assuring access to SUD treatment services among Ohio's population in need.

Comment: Per SMD # 18—011 from CMS, the 1115 SMI/SED demonstration waiver opportunity is similar to the SUD 1115 waiver option in that it would allow federal participation in paying for services to individuals with mental health diagnoses who receive short-term services in IMDs, including residential services for children with mental health needs. Waiver submission should be delayed to consider interplay with SMI/SED waiver opportunity.

At this time, the Department is concentrating on submitting the 1115 SUD Waiver in December 2018 and implementing it thereafter. The Department is reviewing the State Medicaid Advisory Letter 18-011 and will determine whether to submit a subsequent waiver application related to SMI/SED services and target population. Thank you for your suggestion.

Bed Reporting/Methodology

Comment: For the waiver application, how is the Department counting beds/ IMD beds, and what is assessment methodology? Will there be a special designation for children and adults?

The approval of Ohio's 1115-SUD waiver requires the department to count beds for reporting purposes only, and is not required until the baseline performance measures are due after waiver approval. ODM is proposing the use of an independent vendor to conduct site visits and collect the needed information regarding SUD residential facilities. Under this waiver, there is no impact of IMD determination as the purpose of this waiver is to assure continued access and federal reimbursement of healthcare services regardless of service setting. There will not be a special designation for children or adults.

Comment: Nursing facilities should either be excluded from providing IMD services or at least be required to forego existing beds intended for consumers of other long-term care services.

The 1115-waiver does not include nursing facilities.

Benefit Package and Delivery System

Comment: Will there be any change to Medicaid benefit plan for these individuals?

ODM and OhioMHAS are not making any changes to the array of services that comprise the behavioral health benefit package, however, certain changes regarding the delivery of substance use disorder services are required under the federal authority of the waiver.

Comment: Will there be a different impact on Children and Adults?

There will be no differing impact on children and adults. The 1115 waiver will include areas of focus on services to youth as well as an accounting of SUD residential services specific to the treatment needs of youth. An independent vendor will be conducting on-site reviews to better understand capacity and assess need. The independent vendor will assist in identifying any possible provider capacity and access issues.

Comment: Will EPSDT requirements for children continue?

Yes

Comment: Please clarify that both the Managed Care Plans and Fee-For-Service Medicaid payment systems will be participating in the waiver.

Yes, both Managed Care and Fee-For-Service delivery systems will be operating under the 1115 waiver.

Assessment Models

Comment: One appropriate care coordinating model for children with complex mental health and substance use disorder needs is high-fidelity wraparound (HFW). Has this model been considered?

This 1115 SUD waiver does not include a proposal to create High-Fidelity Wrap Around services.

Comment: Has the Family First Prevention Services Act (FFPSA) been considered? Can the FFPSA assessment be used as a starting point to determine how the needs of children in Ohio are not being met?

The Family First Prevention Services Act, Public Law (P.L.) 115-123, enacted February 9, 2018, amends Title IV-E of the Social Security Act to provide foster care maintenance payments for children who are placed with a parent who is receiving services in a licensed residential substance use disorder (SUD) treatment program.

Comment: The START trauma program- Sobriety, Treatment, Reducing Trauma-is a model based on SUD peer recovery services. Has the Department considered the START Program when developing the waiver application?

Thank you for your comment. Peer recovery services are already covered as a service under the Medicaid State Plan.

Licensure and Certification

Comment: Will there be clarification from CMS regarding the current OhioMHAS certification process? Is the current certification sufficient to meet the 1115 waiver requirements for licensure, specific to ASAM LOC3?

Medicaid will implement a process for reviewing residential treatment providers enrolled in the Medicaid program to ensure compliance with ASAM. Providers will be held compliant by onsite and administrative reviews, which will include reviews of records and observations and interviews with staff and clients, as appropriate to the process. The Department will provide more specifics once they are available regarding the CMS required site visits to SUD residential treatment facilities providing Medicaid reimbursed services and enrolled in Medicaid.

Outcomes Measurement

Comment: Under Goal 1, we would like to understand the measurement criteria and outcome data ODM intends to include as access measures. What is the baseline measurement period? Will this evaluation consider the impact of the BH Redesign coding and rate changes implemented 1/1/18 on service access? Will this analysis include access to prevention services? How is health and wellness defined?

Details requested by this comment will be addressed in the monitoring plan and evaluation design provided to the State by CMS at a later date. The Department must follow CMS requirements for all performance measurement and outcome criteria. CMS will not give Ohio the official technical specifications until after waiver approval. In general, CMS performance measures under the 1115-SUD waiver only address SUD services including prevention. This section of the draft waiver has been updated to reflect the latest CMS PMs that are publicly available, including the health and wellness measures CMS is requiring for SUD waivers.

Comment: How does ODM intend to define “recovery outcome”? Is this movement to a lower LOC than SUD residential? Is relapse considered a “treatment failure”? How will the lack of a lower level of care in any community be evaluated?

The Department must follow the CMS requirement for recovery outcomes. Definitions of these and other outcome measures will be detailed at a later date as noted above.

Comment: We do not yet see evidence that Ohio’s policies or treatment capacity have begun to reduce the statewide overdose death rates, and as such find this to be an unrealistic goal that would potentially create unnecessary financial penalties. We caution ODM in moving this goal forward and recommend restating the hypothesis to be “decrease the rate at which overdose deaths have been rising annually in Ohio.”

Thank you for your comment, however, ODM is required to follow CMS milestones and outcome measures. The waiver has been modified to reflect the latest information publicly available from CMS.

Budget

Comment: The 5-year budget is based on one quarter of historic data. Does this one quarter of data accommodate all the claims problems and shortfall in spending that has occurred with implementation of BH Redesign?

At the time of developing the 1115 waiver budget neutrality, only one quarter of complete data was available following behavioral health redesign (January 1, 2018 through March 31, 2018). Prior to behavioral health redesign, claims data did not include visibility into SUD residential stays. As a result, the budget neutrality provided was based on one quarter of historical data that included this visibility. We reviewed the available data for reasonableness, and determined it was consistent with time periods prior to the implementation of behavioral health redesign.



Section 1115 Substance Use Disorder Demonstration Implementation Plan

Submitted by the

Ohio Department of Medicaid

Version updated 12/14/2018

Ohio Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan

Nationwide, deaths due to opioids continue to increase, are under-reported and have great variability in the specificity of how they are recorded across the country.¹ Contributing factors to the difficulty of verifying these opioid-related deaths are that a specific drug or cause of death may not be identified or reported, multiple drugs may be listed instead of one, or the primary cause of death may be listed with another diagnosis such as anoxic brain injury or congestive heart failure. From 1999 to 2015, the number of overdose deaths involving opioids in the United States has quadrupled.

Section I – Milestone Completion

In 2011, Governor John R. Kasich announced the establishment of the Governor's Cabinet Opiate Action Team (GCOAT) to fight opiate abuse in Ohio. GCOAT planned to save lives by tackling the oversupply of prescription opioids, preventing prescription drug abuse before it starts, treating those who succumb to drug addiction and utilizing naloxone to reverse drug overdoses. Ohio is combating drug abuse through many initiatives on several fronts at the state and local levels involving law enforcement, public health, addiction and treatment professionals, health care providers, educators, parents and many others. New initiatives were developed, and then launched in 2013 or later; it will take some time for their full impact to be reflected in reducing the number of drug overdose deaths. For more information, visit <http://mha.ohio.gov/gcoat>. See Attachment B for an overview of the actions taken by the State to improve access to SUD services and promote quality and safety standards.



GCOAT is comprised of all the cabinet level agencies and is charged with the coordination of all activities addressing Ohio's escalating deaths. This demonstration is being coordinated with that larger effort and will complement and not supplant State activities called for or supported by other Federal authorities and funding streams.

Over the last several years, Ohio Department of Medicaid (ODM) has played a crucial role in the GCOAT. GCOAT's interventions increased as opioids deaths rose from 1,914 in 2012 to 4,050 in 2016.² See Figure 1 for maps outlining the growth in number of unintentional Opioid drug-related deaths in Ohio counties between calendar year (CY) 2012 and CY 2017.³

¹ Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010– 2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI:

<http://dx.doi.org/10.15585/mmwr.mm655051e1>

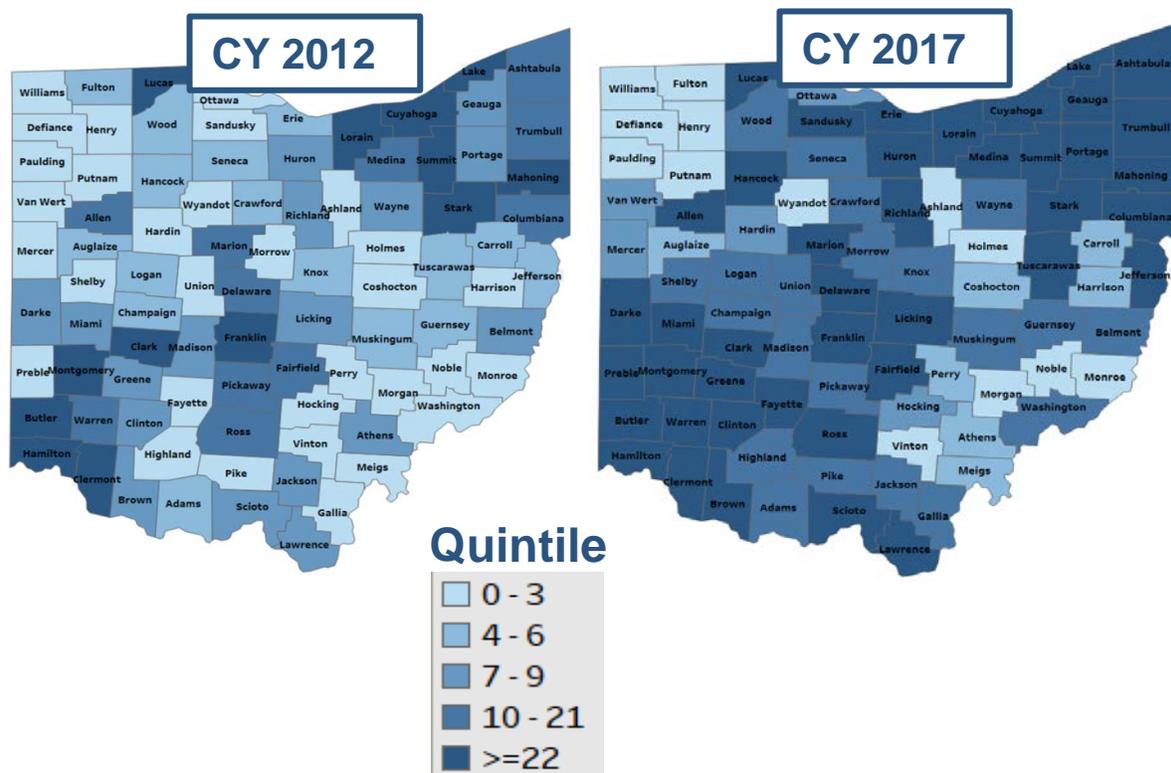
Ruhm, CJ. Geographic Variation in Opioid and Heroin Involved Drug Poisoning Mortality Rates. American Journal of Preventive Medicine, Volume 53, Issue 6, 745 - 753

² Mortality data can be found at the following website:

<http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality>

³ "Governor's Cabinet Opiate Action Team Dashboard" (slide 9)

Figure 1: Map of the rate of Unintentional Opioid Deaths per 100,000 people in Ohio Counties



ODM has been particularly assertive in this work as the Centers for Disease Control and Prevention (CDC) reported individuals enrolled in Medicaid were prescribed opioids at more than twice the rate as those with commercial insurance and were at greater risk for opioid abuse and death.⁴

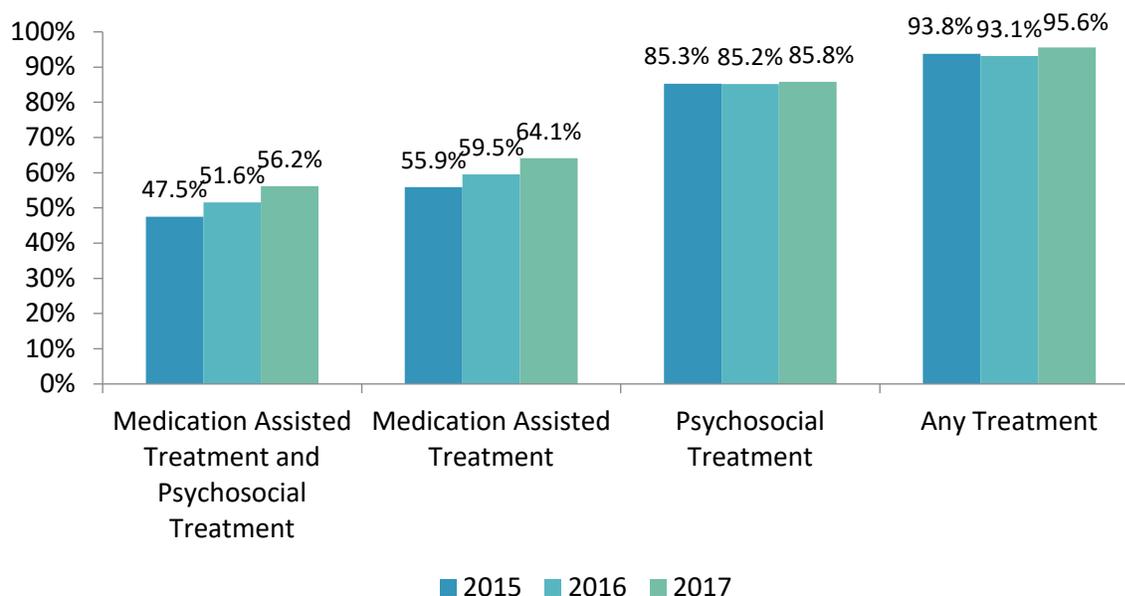
As of August 2018, Ohio averaged about three million individuals enrolled in Medicaid a month. About 8.5% of the Medicaid population has a SUD diagnosis. The number of Medicaid individuals with SUD diagnoses is growing. The largest growth in the number of Medicaid individuals with SUD occurred with the implementation of the Medicaid Expansion group between 2014 and 2015 with a growth in the number of Medicaid individuals with an SUD diagnosis growing 23%. From 2015 to 2016, the number of Medicaid individuals with an SUD diagnosis grew 8%. From 2016 to 2017, the number of Medicaid individuals with an SUD diagnosis grew 4%.

One tenth (9.8%) of Medicaid individuals enrolled in Group VIII received a primary diagnosis for any SUD and 7.9% enrolled in Group VIII received a primary diagnosis for

⁴ CDC. Overdose deaths involving prescription opioids among Medicaid enrollees. *Morbidity and Mortality Weekly Report*. 2009; 58:1171-1175, and CDC. Patient review and restriction programs: Lessons learned from state Medicaid programs. *CDC Expert Panel Meeting Report*. Aug 27-28, 2012; Atlanta, GA).

opioid use disorder (OUD) in 2017 according to Medicaid claims.⁵ Among those with a primary diagnosis of OUD in 2017, 64.1% received pharmacy-dispensed or office-administered Medication Assisted Treatment (MAT), 85.8% received psychosocial treatment, 95.6% received at least one treatment, and 56.2% received both MAT and psychosocial treatment (Figure 2). This reflects an increase in the utilization of treatment from 2015, during which only 47.5% of individuals with an OUD primary diagnosis received both MAT and psychosocial treatment.

Figure 2: Percentage of Medicaid individuals enrolled in Group VIII with a Primary OUD Diagnosis Receiving Treatment, 2015–2017



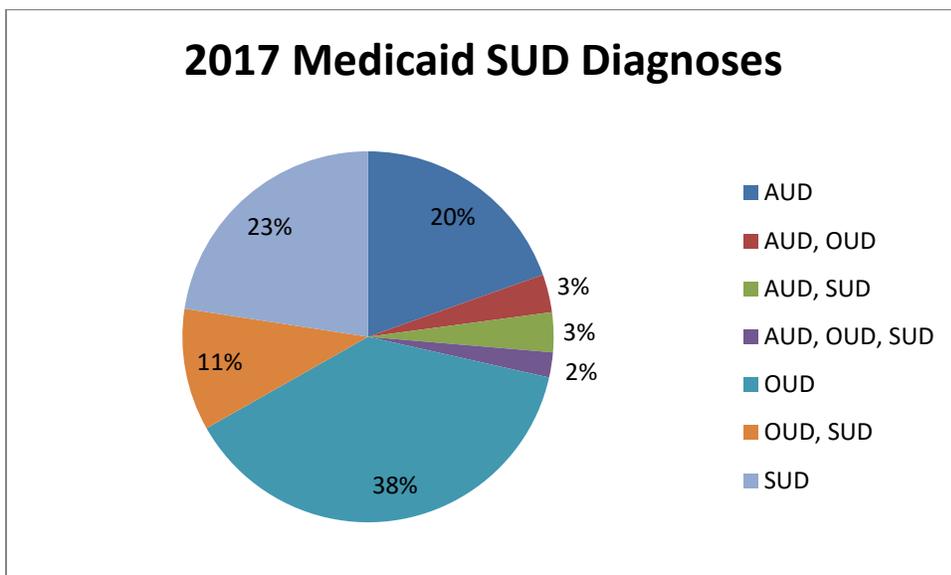
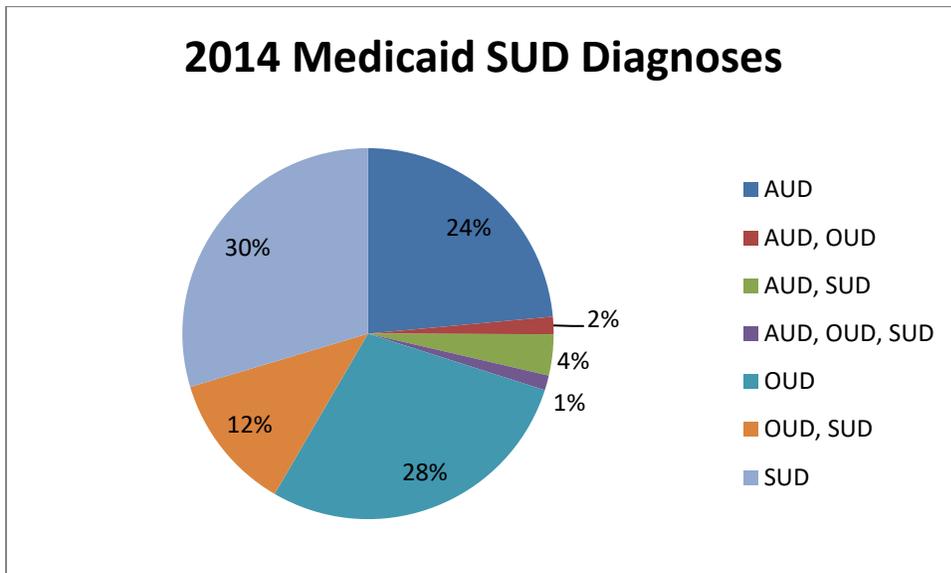
Source: Medicaid Administrative Data

Billing codes used to define MAT and psychosocial treatment are in the Methodological Report

⁵ This finding is based on diagnosed opioid use disorder, which is likely to be an underestimate of the actual prevalence of opioid use disorder.

The type of SUD diagnosis for the Medicaid population varies widely and includes alcohol, opiates and combinations of those drugs and other drugs. Since 2014, as the number of individuals with SUD diagnoses has increased, the proportion of individuals with any given diagnosis has changed over time. Specifically, individuals in Medicaid with an OUD diagnosis have increased as a proportion of the population. See tables below.

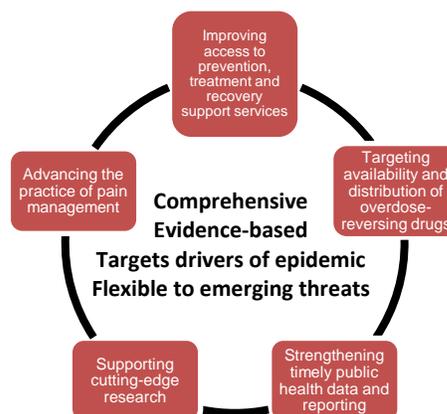
Tables: The type of SUD diagnosis for the Medicaid population



AUD – Alcohol Use Disorder
 OUD – Opioid Use Disorder
 SUD – Substance Use Disorder

Figure 3: HHS Opioid strategy

ODM efforts have primarily focused on the five prongs of the Health and Human Services (HHS) Opioid Strategy (see Figure 3 for a visual of the HHS Opioid strategy) including:



1. Improving access to prevention, treatment and recovery support services.
2. Targeting distribution of overdose-reversing drugs.
3. Advancing the practice of pain management.
4. Supporting cutting-edge research.
5. Strengthening timely public health data and reporting.

A summary of how Ohio already meets each milestone and actions needed is included in the 1115 waiver application.

Table: Summary of Actions Needed

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
None	Milestone 1	
Require fee-for-service (FFS) providers and plans to provide current SUD service array and American Society of Addiction Medicine (ASAM) requirements for assessments, admission and discharge criteria for each SUD outpatient and residential levels of care (LOC).	Milestone 2	July 1, 2019
Require the FFS delivery system and “the plans” including both MyCare Ohio Plans (MCOP) and Managed Care Plans (MCP) to use ASAM standards for utilization review at all LOC.	Milestone 2	July 1, 2019
Review plan policies for utilization review and prior authorization for compliance.	Milestone 2	July 1, 2019
Review plan delivery for program compliance (e.g., treatment plan, provider qualifications, etc.).	Milestone 2	July 1, 2019

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Require the FFS delivery system and the plans to prior authorize of all residential ASAM LOC.	Milestone 2	July 1, 2019
Require the FFS delivery system and plans to utilize ASAM and have an independent process for reviewing all placements in residential treatment settings.	Milestone 2	July 1, 2019
Update the State requirements to reflect residential requirements for the types of services, hours of clinical care, and credentials of staff for each ASAM residential LOC.	Milestone 3	July 1, 2019
Require the plans to comply with ASAM residential requirements.	Milestone 3	July 1, 2019
Implement a standardized State on-site review process of residential provider qualifications against State requirements for ASAM including the types of services, hours of clinical care and credentials of staff for each ASAM residential LOC.	Milestone 3	12–24 months
Implement a single statewide vendor to survey Ohio SUD residential providers to assure they meet certain standards and manage provider enrollment on an on-going basis.	Milestone 3	12–24 months
Require the plans to comply with State processes for credentialing SUD residential providers.	Milestone 3	12–24 months
Educate abstinence-based residential providers on benefits of MAT accessibility and begin cultural shift toward acceptance of MAT as a complementary treatment.	Milestone 3	24 months
Require SUD treatment providers to offer access and to facilitate patient access to MAT while in residential settings.	Milestone 3	July 1, 2019
Require the FFS delivery system and the plans to monitor access to MAT in residential settings including access to MAT counseling.	Milestone 3	12 months

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Create a comprehensive access assessment baseline of all SUD providers and all SUD LOC including, MAT capacity.	Milestone 4	12 months
ODM will create access standards for SUD LOC.	Milestone 4	12 months
Require MCPs to update their SUD network development and management plan to specifically focus on SUD provider capacity by LOC, including MAT.	Milestone 4	12–18 months
Add an indicator for providers accepting new patients to the plan quarterly network adequacy reports.	Milestone 4	12–24 months
Require the plans to adopt access requirements to all ASAM LOC.	Milestone 4	12 months
Continue to onboard new electronic health record (EHR) and pharmacy dispensing system vendors.	Milestone 5	12–24 months
Explore the possibility of analysis to correlate long-term opioid use directly to clinician prescribing patterns in conjunction with the ODM (Action item for the Board of Pharmacy).	Milestone 5	12–24 months
Implement enhanced information within the Ohio Automated Rx Reporting System (OARRS) including: OARRS flags for individuals who are participating in one of Ohio's drug court programs; non-fatal overdose deaths, and naltrexone identification to identify individuals treated for SUD.	Milestone 5	12–24 months
Implement an enforcement plan to minimize the risk of inappropriate overprescribing consistent with prescribing guidelines.	Milestone 5	12–24 months
Enroll Behavioral Health Care Coordination (BHCC) providers.	Milestone 6	February 2019
Attribute members to qualified entities.	Milestone 6	Spring 2019
Report on provider baseline performance.	Milestone 6	January 2019

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Begin BHCC monthly payments.	Milestone 6	July 1, 2019
Issue SUD transition guidance to BHCC entities.	Milestone 6	Within 12 months

Milestone 1: Access to Critical LOC for OUD and Other SUDs

CMS Specifications:

Coverage of: (a) outpatient services, (b) intensive outpatient services, (c) MAT (medications as well as counseling and other services with sufficient provider capacity to meet the needs of individuals enrolled in Medicaid in the state), (d) intensive LOC in residential and inpatient settings and (e) medically supervised withdrawal management.

Current and Future State:

Ohio currently covers all of the critical LOC identified in Milestone 1. Ohio administers its Medicaid SUD treatment services based on the ASAM Patient Placement Criteria.⁶ No additional actions are needed to meet Milestone 1. The below table identifies the ASAM level, brief description, and state plan page number of currently offered services.

Table: SUD service coverage in the Medicaid State Plan

Existing ASAM LOC Coverage	Description	Adult/Adolescent Specific Criteria	State Plan Authority
ASAM Level 1	Outpatient Services	Both	Rehabilitation Authority Item 13-d-2 Page 2 of 9
ASAM Level 1 Opioid Treatment Services	Opioid Treatment Programs (OTPs)	Both	Rehabilitation Authority Item 13-d-2 Page 2 of 9
ASAM Level 1 Opioid Treatment Services	Medically Managed Opioid Treatment	Both	Physician Authority Item 5-a
ASAM Level 2.1	Intensive Outpatient	Both	Rehabilitation Authority Item 13-d-2 Page 2 of 9
ASAM Level 2.5	Partial Hospitalization	Both	Rehabilitation Authority Item 13-d-2

⁶ The MCP provider agreement, July 1, 2018, (Appendix G.1.u) requires managed care plans to provide behavioral health services in accordance with state regulations (OAC 5160-27). State regulations (OAC 5160-27-09) requires SUD treatment services to be defined by and provided according to ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care.

Existing ASAM LOC Coverage	Description	Adult/Adolescent Specific Criteria	State Plan Authority
			Page 2 of 9
ASAM Level 2-WM	Ambulatory Withdrawal Management with Extended Onsite Monitoring	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 2 of 9
ASAM Level 3.1	Clinically Managed Low-Intensity Residential Treatment	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 4 of 9
ASAM Level 3.2-WM	Clinically Managed Residential Withdrawal Management	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 4 of 9
ASAM Level 3.3	Clinically Managed Population-Specific High Intensity Residential Treatment	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 5 of 9
ASAM Level 3.5	Clinically Managed High Intensity (adults) Residential Treatment and Medium Intensity (adolescents)	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 5 of 9
ASAM 3.7	Medically Monitored Intensive Inpatient Treatment (Adults)/ Medically Monitored Intensive Inpatient Treatment Services (Adolescent)	Both	Rehabilitation Authority Item 13-d-2 Page 5 of 9
ASAM 3.7-WM	Medically Monitored Inpatient Withdrawal Management.	Single set of criteria	Rehabilitation Authority Item 13-d-2 Page 5 of 9
ASAM 4 and ASAM-4-WM	Medically Managed Intensive Inpatient Treatment	Single set of criteria	Hospital Authority Item 1

Approximately 90% of all individuals in Ohio Medicaid are enrolled in managed care. MyCare Ohio is Ohio’s dual-eligible demonstration waiver covering individuals in certain counties. Ohio’s plans, both MCOPs and MCPs, currently include all of the above LOC in their contracts. SUD residential LOC in large facilities may be covered under the “in lieu of” authority under managed care rate setting rules.

The Ohio Medicaid covered opioid pharmaceutical therapies are listed below.⁷ Beginning January 1, 2019, the State, in partnership with MCPs, is creating a unified preferred drug list eliminating prior authorization in most instances for MAT for opioid use disorder. All MCPs and FFS will have the same coverage and limitations for these prescribed drugs. Medicare covers prescription drugs for individuals enrolled in MCOPs, so this does not apply to those plans.

The Ohio MAT preferred drug list includes:

- Bunavail® buccal film (buprenorphine/naloxone)
- Buprenorphine SL tablets (generic of Subutex®)
- Buprenorphine/Naloxone SL tablets
- Suboxone® SL film (buprenorphine/naloxone)
- Zubsolv® SL tablets (buprenorphine/naloxone)
- Methadone (for pain)

The current Medicaid prescription coverage includes:

- Buprenorphine
- Buprenorphine-Naloxone [Suboxone]
- Buprenorphine-Naloxone [Bunavail]
- Buprenorphine-Naloxone [Zubsolv]
- Buprenorphine Implant [Probuphine]
- Sublingual Suboxone
- Naloxone Injectable
- Naloxone Nasal Spray [Narcan]
- Oral Naltrexone Tab
- Naltrexone ER Injectable [Vivitrol]

As part of MAT, individuals prescribed one of the opioid pharmaceutical therapies listed above, as well as accessing Methadone through OTPs, have access to counseling and other behavioral health (BH) therapies through the ASAM levels covered under the Medicaid State Plan according to the level of counseling that individual requires.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
None	Milestone 1	

⁷Ohio Medicaid prescription fee schedule and authorization:
<https://druglookup.ohgov.changehealthcare.com/DrugSearch>

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

CMS Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

1. Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
2. Utilization management (UM) approaches are implemented to ensure that (a) individuals enrolled in Medicaid have access to SUD services at the appropriate LOC, (b) interventions are appropriate for the diagnosis and LOC and (c) there is an independent process for reviewing placement in residential treatment settings.

Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines

The State requires all SUD treatment providers to assess and provide services using ASAM criteria. Ohio Department of Mental Health and Addiction Services (OhioMHAS) requires all certified SUD treatment providers to use multi-dimensional assessments based on the six dimensions of care as outlined in ASAM.

Implementation of a UM approach such that (a) individuals enrolled in Medicaid have access to SUD services at the appropriate LOC

Current State:

Ohio Administrative Code (OAC) [5160-27-09](#) describes SUD treatment services provided to all individuals in Medicaid. This regulation requires the use of the ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge or referral to each LOC. All plans are required to follow OAC 5160-27-09 in providing BH services under the plan provider agreement.⁸

The FFS Medicaid provider manual, which also applies to plan service decisions, does not describe the responsibilities for screening, assessment and treatment plan review, including the requirements to substantiate appropriate patient placement at each LOC.

Future State:

For each ASAM level, the Medicaid SUD Provider Manual, managed care provider agreement, and/or OAC will be modified to describe the responsibilities for screening, assessment and treatment plan review, including the requirements to substantiate

⁸ Appendix G.1.u

appropriate patient placement using the ASAM dimensions in assessments, admission and discharge criteria for each SUD outpatient and residential LOC.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Require FFS providers and plans to provide the current SUD service array using ASAM requirements for assessments, admission and discharge criteria for each SUD outpatient and residential LOC.	Milestone 2	July 1, 2019

Implementation of a UM approach such that (b) interventions are appropriate for the diagnosis and LOC

Current State:

Plans are responsible for implementing a UM approach consistent with Milestone #2. The plans perform UM for all LOC. Services may be subject to outlier review, practice management or other UM strategies. Plans are required to implement “clearly defined structures and processes” on UM programs in accordance with OAC 5160-26-03.1.⁹ OAC 5160-26-03.1 requires a plan’s UM program to ensure care decisions are based on medical necessity. The State requirement also outlines additional standards for the UM program policies and procedures, including the following:¹⁰

- The information sources used to make determinations of medical necessity.
- The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria.
- A specification that written UM criteria will be made available to both contracting and non-contracting providers.
- A description of how the plan will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

The UM program must ensure and document the following:

- An annual review and update of the UM program.
- The involvement of a designated senior physician in the UM program.
- The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.
- The use of board-certified consultants to assist in making medical necessity determinations, as necessary.
- That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Ohio Administrative Code. A plan may not impose conditions around the coverage of a medically necessary Medicaid-covered service unless they are supported by such clinical practice guidelines.
- The reason for each denial of a service, based on sound clinical evidence.

¹⁰ <http://codes.ohio.gov/oac/5160-26-03.1>

- That compensation by the plan to individuals or entities that conduct UM activities does not offer incentives to deny limit or discontinue medically necessary services to any member.

The State Plan establishes coverage using the ASAM LOC. The State also requires, through OAC 5160-27-09, that SUD treatment services be defined by and provided according to ASAM treatment criteria for addictive, substance related co-occurring conditions for admission, continued stay, discharge or referral to each LOC. Plans are required to comply with this requirement through the provider agreement, and as such, service authorization criteria must meet this same standard in each plan's policies and procedures. However, the ASAM criteria for admission, continued stay, discharge or referral to each LOC are not defined in the plan contract or OAC rules with specific instructions to plans. Additionally, the plans are required to take steps to ensure adoption of the clinical practice guidelines by specialized BH care providers, and to measure compliance with the Provider Agreement, OAC and other ODM guidelines. The plans are contractually encouraged to employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance. Additionally, the plans are required to perform record reviews.

Plans are required to have a Behavioral Health (BH) Clinical Director as part of its key staff. The BH Clinical Director, a dedicated part-time staff member, must currently be practicing within the scope of his/her license as either a clinical psychologist or board certified psychiatrist with a minimum of three years of experience in a clinical setting. Each plan must have at least one board certified psychiatrist who is a prescriber and performs BH Clinical Director functions like monitoring overall safety of patients with a BH diagnosis with a special focus on safe prescribing, among other activities. The BH Clinical Director duties also include:¹¹

- BH coverage determination for UM to ensure individuals receive appropriate and medically necessary care in the most cost-effective setting.
- Oversight and quality improvement activities associated with care management activities.
- Providing guidance to BH orientation and network development/ recruitment in conjunction with provider relations, value-based contracting, support of episodes of care and full integration of BH services.
- Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to plan staff and providers as appropriate.
- Representing the plan as the primary clinical liaison to individuals, providers and ODM.

Future State:

The state is constantly seeking to improve its review and monitoring of its MCOs relative to UM. Beginning July 1, 2019, SUD treatment services provided in the managed care and the FFS delivery systems will comply with ASAM criteria for all prior authorization and utilization review decisions resulting in continuity across the Medicaid delivery

¹¹ Appendix C.8.d

systems. Effective January 1, 2019, the plan provider agreements will be updated to emphasize the required ASAM standards for LOC criteria for all LOC. Beginning July 1, 2019, plans and FFS will be required to utilize ASAM and have an independent process for reviewing all placements in residential treatment settings. Plans and the FFS program will be required to comply with the policy guidance issued by ODM. Plan policies will be reviewed and approved by ODM as the program evolves.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Require FFS delivery system and plans to use ASAM standards for utilization review at all LOC.	Milestone 2	July 1, 2019
Review plan policies for utilization review and prior authorization for compliance.	Milestone 2	July 1, 2019
Review plan delivery for program compliance (e.g., treatment plan, provider qualifications, etc.).	Milestone 2	July 1, 2019

Implementation of a UM approach such that (c) there is an independent process for reviewing placement in residential treatment settings

Current State:

Currently the provider agreement requires all plans to follow the prior authorization standards established under BH Redesign for both the FFS and managed care delivery systems until July 1, 2019. Consistent with 5160-27-09, the FFS delivery system and all MCPs utilize ASAM for continued stay criteria for residential admissions after 30 days or to prior authorize the third admission to a residential treatment facility. The provider agreement requires plans to authorize a stay in a SUD residential treatment facility as expeditiously as the member’s health condition requires, but no later than 48 hours after receipt of the prior authorization request.¹² Magellan Clinical Guidelines and InterQual guidelines are utilized by some MCPs in addition to ASAM.

Future State:

Beginning July 1, 2019, plans will be required to prior authorize all residential treatment services for enrolled individuals, while residential treatment for individuals enrolled in the FFS delivery system will be prior authorized by ODM or its designee. This will ensure that individuals have access to SUD treatment at the appropriate LOC, and interventions are appropriate for the diagnosis and LOC. The State will clarify that ASAM will be utilized for prior authorization for partial hospitalization and all residential levels of care and utilization review in Ohio Medicaid for all levels of care for FFS and plans after July 1, 2019.

¹² Appendix C.66.c

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Require the FFS delivery system and plans to prior authorize of all residential ASAM LOC.	Milestone 2	July 1, 2019
Require the FFS delivery system and plans to utilize ASAM and have an independent process for reviewing all placements in residential treatment settings.	Milestone 2	July 1, 2019

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

CMS Specifications:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts or other guidance) that meet the ASAM criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings.
- Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards.
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care and credentials of staff for residential treatment settings

Current State:

OAC 5122-29-09 describes OhioMHAS provider certification requirements. OhioMHAS certification requirements define specific LOCs. These requirements apply to facilities providing residential services under both the managed care and FFS delivery systems.¹³

OAC 5122-29-09 requires residential, withdrawal management and inpatient SUD treatment services to be provided in accordance with ASAM Level 3, ASAM Level 3-WM, and associated sub levels as appropriate to the needs of the individual

¹³ <http://codes.ohio.gov/oac/5122-29-09v1>

being served, as published in the ASAM criteria, third edition, 2013. However, the licensing regulations, Ohio Medicaid regulations and the publicly available published Medicaid provider manuals do not detail the service definitions, program requirements, eligibility criteria and detailed provider requirements/qualifications for each level are not currently detailed. Providers must purchase the ASAM criteria and interpret the particular types of services, hours of clinical care and credentials of staff for each of the ASAM residential treatment settings and LOC.

Future State:

Ohio will strengthen the Medicaid provider qualification requirements, based on ASAM criteria, for SUD residential treatment providers through Medicaid FFS provider manuals, OAC and managed care provider manuals. Ohio will align all service definitions, the Medicaid program requirements, eligibility criteria, and detailed provider requirements/qualifications for each level with ASAM in the publicly available published Medicaid provider manual. The Medicaid policy manuals will include more detail about the ASAM residential program standards including the particular types of services, hours of clinical care, and credentials of staff for residential treatment settings.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Update the State requirements to reflect residential requirements for the types of services, hours of clinical care and credentials of staff for each ASAM residential LOC.	Milestone 3	July 1, 2019
Require the plans to comply with ASAM residential requirements.	Milestone 3	July 1, 2019

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards

Current State:

There is currently no standardized state process for the review of residential provider qualifications against State requirements for ASAM Level 3, ASAM Level 3-WM and associated sub levels. Current standards are not enforced through consistent onsite reviews of residential facilities.

Future State:

Medicaid will also implement a process for reviewing residential treatment providers to ensure compliance with these standards. Providers will be held compliant by onsite and administrative reviews, which will include reviews of records and observations and interviews with staff and clients, as appropriate to the process. All visits, except for the initial review, will be unannounced. To ensure compliance, reviews will be conducted during application, renewal, complaints, onsite and as administrative reviews such as desk reviews.

Residential providers contracting to provide Medicaid services as part of the plan networks will be held to certain standards in their plan contracts and will be required to be credentialed by the plans prior to participating in the network. The plans also will ensure compliance with program standards outlined in the ODM provider manuals by monitoring their provider networks via credentialing, monitoring complaints and during the provider re-credentialing cycle.

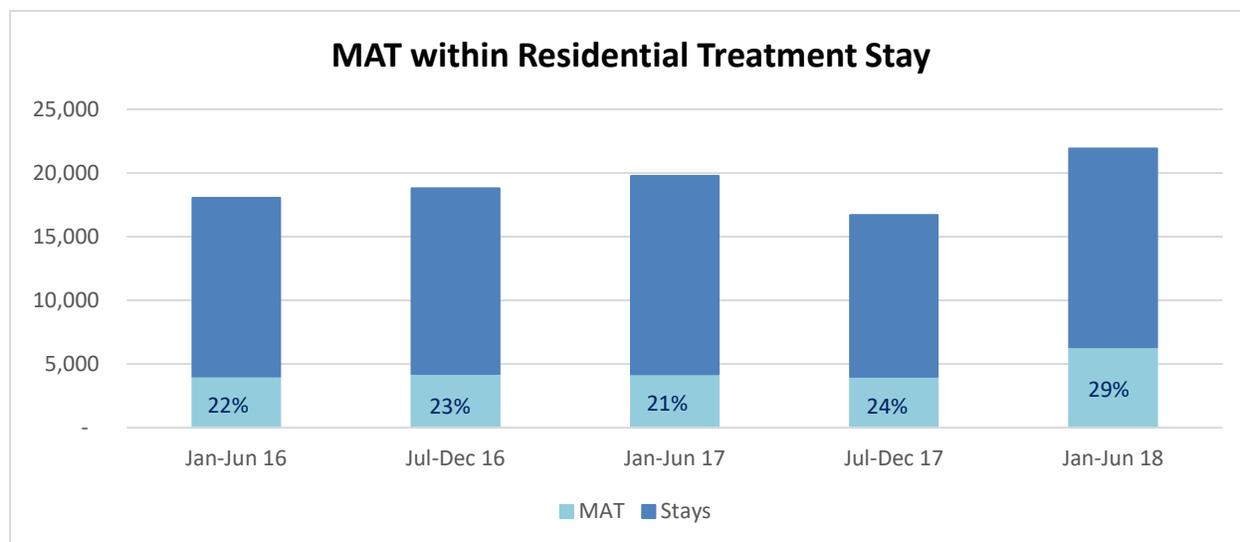
In addition, ODM intends to procure a single, statewide vendor to perform SUD treatment provider management including a qualification and verification function to assure statewide standards are met. It is intended that this will achieve a single, reliable provider registry. This new provider enrollment and qualification system is anticipated to be activated in 2020. Plans will then be limited to credentialing providers from the state’s single source for provider enrollment, allowing ODM to appropriately identify SUD treatment providers in encounter data.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Implement a standardized State on-site review process of residential provider qualifications against State requirements for ASAM including the types of services, hours of clinical care and credentials of staff for each ASAM residential LOC.	Milestone 3	12–24 months
Implement a single statewide vendor to survey Ohio SUD residential providers to assure they meet certain standards and manage provider enrollment on an on-going basis.	Milestone 3	12–24 months
Require the plans to comply with State processes for credentialing SUD residential providers.	Milestone 3	12–24 months

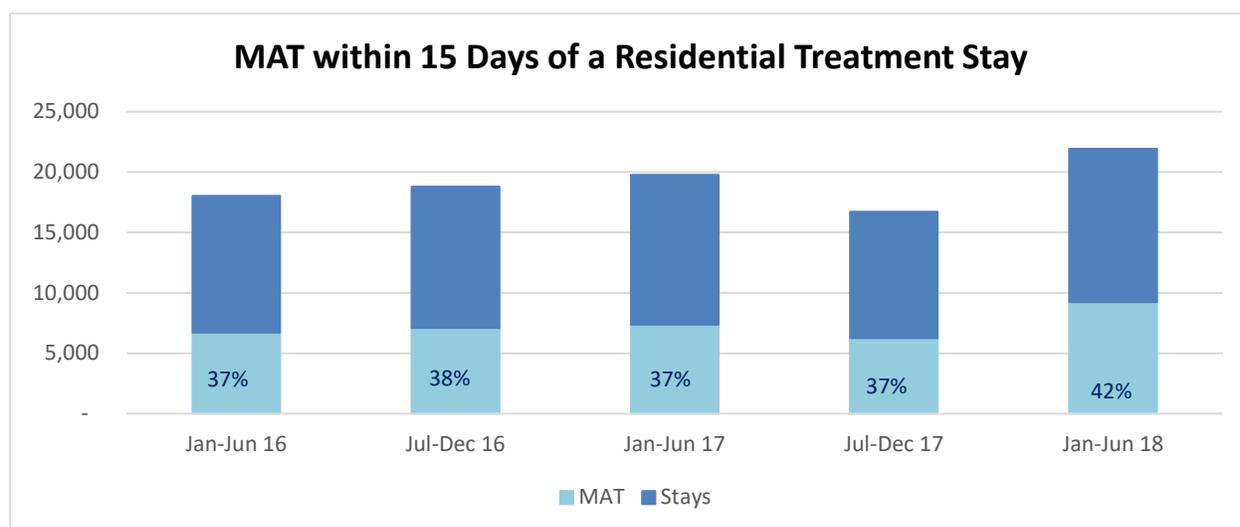
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site

Current State:

Finally, there are no requirements for residential providers to arrange for or provide MAT to their residents. Currently, many residential providers utilize abstinence-based care models and do not provide MAT onsite or facilitate offsite access to MAT. However, by the first half of CY 2018, 29% of individuals received MAT during their SUD residential stay.



Because medication in MAT can remain effective for up to 15 days, Ohio also tracks the number of Medicaid individuals who received MAT within 15 days of a residential stay. The number of Medicaid residential stays where the individual was prescribed MAT within 15 days of a residential stay increased to 42% by the first half of CY 2018.



Future State:

The updated Medicaid provider standards will include a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

OhioMHAS will modify the OAC section 5122-40-15 governing OTPs to add Certified SUD residential/withdrawal management providers to the types of permitted providers under this section.

Over the next 24 months, Ohio will seek to change the culture and attitudes among SUD residential treatment providers to accept and integrate MAT for their residents who choose MAT as a part of their treatment plan. Individuals will continue to have a choice

in treatment, but all residential providers will be required to offer MAT on site or facilitate access to MAT off-site. ODM and OhioMHAS will work together to provide outreach to and education to abstinence-based programs about the importance of adding MAT as a treatment option.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Educate abstinence-based residential providers on benefits of MAT accessibility and begin cultural shift toward acceptance of MAT as a complementary treatment.	Milestone 3	24 months
Require SUD treatment providers to offer access and to facilitate patient access to MAT while in residential settings.	Milestone 3	July 1, 2019
Require the FFS delivery system and the plans to monitor access to MAT in residential settings including access to MAT counseling.	Milestone 3	12 months

Milestone 4: Sufficient Provider Capacity at Critical LOC including for MAT for OUD

CMS Specifications:

- To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical LOC listed in Milestone 1. This assessment must determine availability of treatment for individuals enrolled in Medicaid in each of these LOC, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for individuals in the critical LOC.

Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical LOC throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services, Intensive Outpatient Services, MAT (medications as well as counseling and other services), Intensive Care in Residential and Inpatient Settings, Medically Supervised Withdrawal Management.

Current State:

Ohio has 4,135 SUD residential treatment beds in 178 SUD treatment facilities that might meet the definition of an Institute for Mental Disease (IMD). The number of residential days for each residential LOC based on 2014 data can be seen in the Table below:

Table: Estimated 2014 Residential LOC days

State Fiscal Year 2014	Adult Days	Child Days	Total Estimated Days
ASAM 3.1 (H2034)	0	0	0
ASAM 3.2 WM (H0010)	371	35	406
ASAM 3.3 (H2036 HI)	22,061	0	22,061
ASAM 3.5 (H2036)	70,759	39,171	109,930
ASAM 3.7(H2036 TG)	5,404	1,868	7,272
ASAM 3.7 WM(H0011)	3,947	563	4,510
Total	102,542	41,637	144,179

As described in the Milestone #1 section, MCPs are required to contract with a minimum number of certified SUD treatment providers for each designated Ohio MCP region and must maintain provider panel capacity so that enrolled individuals have access to comprehensive SUD treatment services. Ohio monitors compliance with these provider sufficiency requirements through MCP reporting. The network access monitoring reports for SUD treatment providers are still being developed because SUD treatment was first included in the MCP network on July 1, 2018. As noted above, the State will be developing access standards for each of the ASAM LOC.

When preparing for the inclusion of BH in the MCP benefit package on July 1, 2018, ODM conducted readiness reviews of the MCPs to ensure the panel requirements were met. This included ensuring each MCP had at least a minimum number of comprehensive alcohol and drug treatment providers in each region. See table below. If a covered Medicaid service is not available in network, the MCP must arrange for that service to be provided out-of-network at no additional charge to the member.

The State ensures sufficient coverage by contractually requiring the MCPs to meet network adequacy standards for services. MCPs are required to contract with any willing opioid treatment provider who is appropriately licensed and certified. This includes Methadone providers licensed by OhioMHAS and Buprenorphine based medications providers certified by Substance Abuse and Mental Health Services Administration and/or possessing a Federal DEA waiver. MCPs must also contract with a minimum number of SUD treatment providers determined at the county level (described in table below). MCPs must maintain provider panel capacity so that enrolled individuals have access to the following services with reasonable and timely access:¹⁴

- Alcohol/drug screening analysis/lab urinalysis
- Ambulatory detoxification
- Assessment
- Case management
- Crisis intervention

¹⁴ MCP provider agreement, July 1, 2018, [Appendix H 4.c.ix. Behavioral Healthcare Providers](#)

- Individual counseling
- Group counseling
- Induction of buprenorphine
- Injection of naltrexone (for addiction treatment)
- Intensive outpatient (for addiction treatment) and
- Medical somatic services

Table: Managed Care Plan Contract Standards for OhioMHAS-certified SUD treatment Providers in Each County

Minimum SUD Provider Agencies for MCPS to Contract by County								
Region	County	SUD	Region	County	SUD	Region	County	SUD
W	ADAMS	-	W	GREENE	1	CEN/SE	NOBLE	1
W	ALLEN	2	CEN/SE	GUERNSEY	1	W	PAULDING	-
NE	ASHLAND	1	W	HAMILTON	15	CEN/SE	PERRY	1
NE	ASHTABULA	3	W	HANCOCK	1	CEN/SE	PICKAWAY	1
CEN/SE	ATHENS	2	CEN/SE	HARDIN	1	CEN/SE	PIKE	1
W	AUGLAIZE		W	HENRY	1	NE	PORTAGE	3
CEN/SE	BELMONT	1	W	HIGHLAND	1	W	PREBLE	1
W	BROWN		NE	HOCKING	1	W	PUTNAM	1
W	BUTLER	4	NE	HURON		NE	RICHLAND	10
W	CHAMPAIGN		CEN/SE	JACKSON	1	CEN/SE	ROSS	3
W	CLARK	2	CEN/SE	JEFFERSON	1	W	SANDUSKY	1
W	CLERMONT	2	CEN/SE	KNOX	1	CEN/SE	SCIOTO	7
W	CLINTON		NE	LAKE	5	W	SENECA	-
NE	COLUMBIANA	1	CEN/SE	LAWRENCE	4	W	SHELBY	1
CEN/SE	COSHOCTON	1	CEN/SE	LICKING	1	NE	STARK	6
CEN/SE	CRAWFORD	1	CEN/SE	LOGAN	1	NE	SUMMIT	9
NE	CUYAHOGA	29	NE	LORAIN	4	NE	TRUMBULL	1
W	DARKE	1	W	LUCAS	11	NE	TUSCARAWAS	1
W	DEFIANCE	1	CEN/SE	MADISON		CEN/SE	UNION	-
CEN/SE	DELAWARE	1	NE	MAHONING	8	W	VANWERT	1
NE	ERIE	2	CEN/SE	MARION	1	W	WARREN	1
CEN/SE	FAIRFIELD	2	NE	MEDINA	3	CEN/SE	WASHINGTON	1
CEN/SE	FAYETTE		W	MERCER	1	NE	WAYNE	4
CEN/SE	FRANKLIN	19	W	MIAMI	1	W	WILLIAMS	-
W	FULTON		W	MONTGOMERY	10	W	WOOD	1
CEN/SE	GALLIA	5	CEN/SE	MORGAN	1			
NE	GEAUGA	3	CEN/SE	MUSKINGUM	1			

The readiness reviews found that the MCPs had differing levels of access compared to the standard. See table below:

Table: MCP capacity analysis as of September 10, 2018

MCP	Number of Counties Meeting Network Standard for SUD	Percent of Counties* Meeting Network Standard for SUD
Buckeye Health Plan	81	92%
CareSource	88	100%
Molina	88	100%
Paramount	86	98%
United Healthcare	88	100%

*Percent of 88 counties

The MCPs are tasked with monitoring provider capacity of their networks. Each MCP develops and maintains a provider Network Development and Management Plan, which ensures the provision of core benefits, and services will occur. It includes the MCP’s process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services. The plan demonstrates access to BH services, identifies gaps in network and describes the process to ensure services are delivered. The plan provides geo mapping of providers to geographically demonstrate network capacity. The plan has policies detailing how it will provide or arrange for medically necessary covered services should the network become temporarily insufficient and will monitor the adequacy, accessibility and availability of its provider network to meet the needs of enrolled individuals. MCP Network Development and Management Plans are updated at least annually or more often as needed to reflect material changes in network status.

The MyCare Ohio contracts (both the Provider Agreement and the three-way contract) do not define specific SUD network requirements like those described above. However, MCOPs are held to the same standard of “assuring access to all-Medicaid covered BH services.”¹⁵ The MCOPs are also required to demonstrate an adequate provider network “sufficient in number, mix, and geographic distribution” to ensure access to BH services.¹⁶ MCOPs as described in the Provider Agreement are required to evaluate each region’s network capacity of BH services using the minimum capacity standards located in the table below:

Table: MyCare Ohio Contract Standards for OhioMHAS-certified SUD treatment Providers in each region

Region	OMHAS SUD Provider Agencies
Central	8
East Central	8
Northeast	8
Northeast Central	6

¹⁵ Section 2.7.10 of the three-way contract

¹⁶ Section 2.6.1.1 of the three-way contract

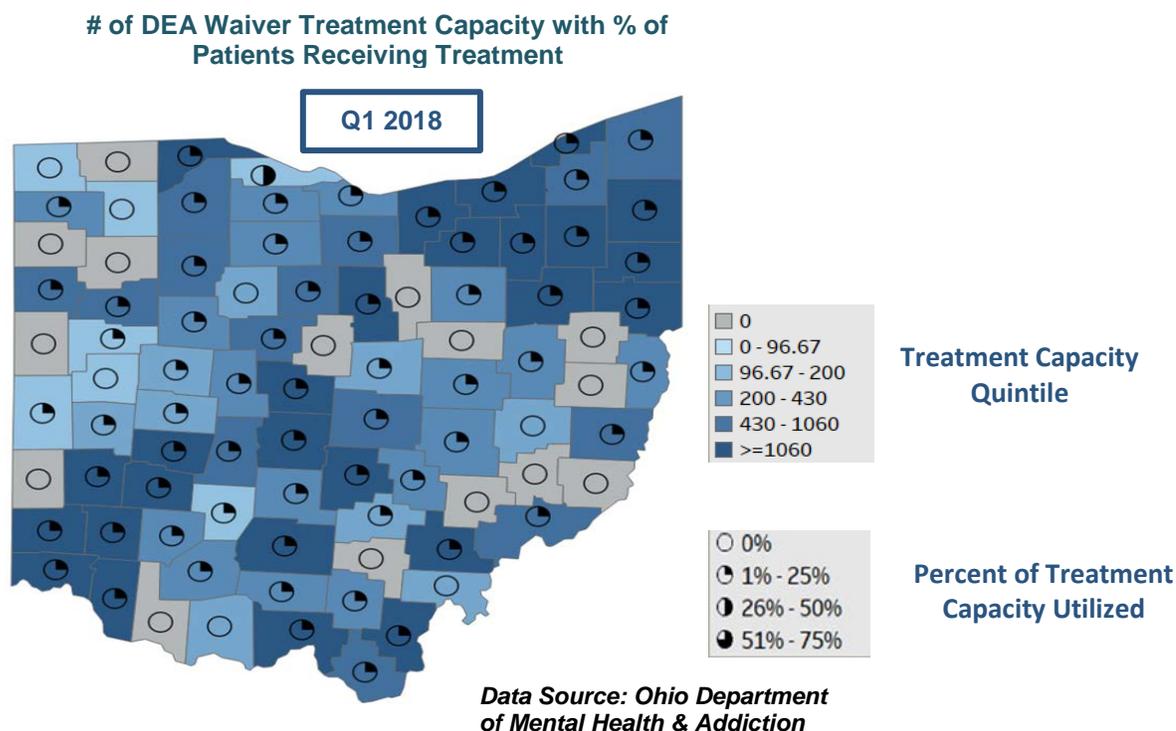
Region	OMHAS SUD Provider Agencies
Northwest	6
Southwest	8
West Central	6

The number of individuals receiving SUD treatment continues to grow. Ohio has tracked the increased capacity in the system through the increased number of individuals in treatment and the improved treatment rates of this population (i.e., increase SUD services penetration rate). See table below:

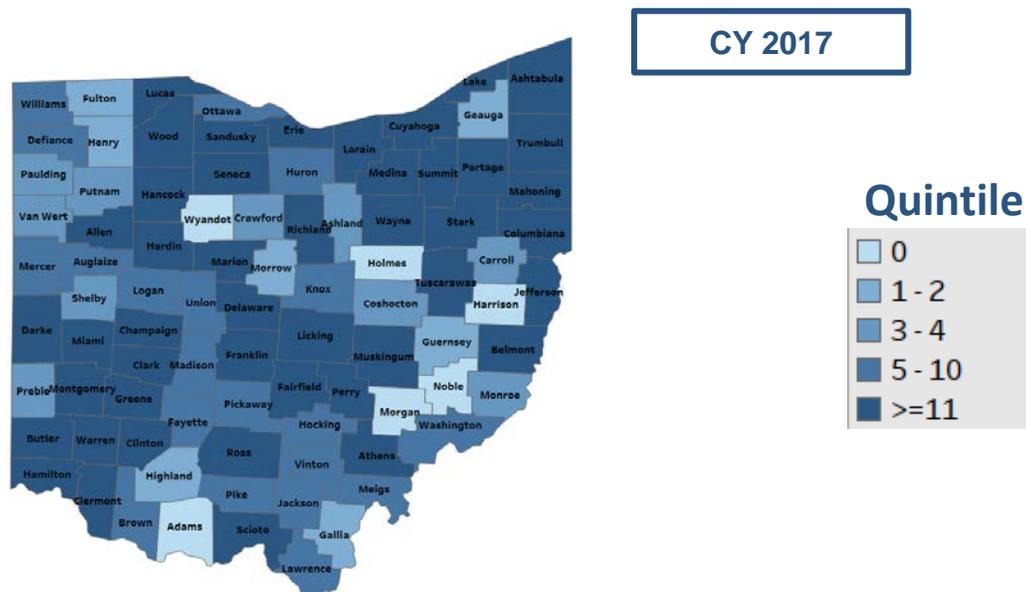
Table: Increased SUD treatment capacity, penetration rate and MAT usage 2014–2017.

Year	Any Primary SUD Diagnosis	Any SUD Diagnosis	General SUD Treatment	Appropriate MAT Usage	Population with any SUD diagnoses receiving SUD services (Penetration Rate)
2014	103,144	183,598	107,300	27,559	58%
2015	129,767	225,684	134,075	37,653	59%
2016	147,519	244,384	151,572	48,531	62%
2017	161,034	254,925	165,642	56,982	65%

The State also monitors MAT providers. The State trends the number providers with Drug Enforcement Agency waivers as well as the capacity of those providers. The monitoring also includes the number of providers prescribing Vivitrol. See figures below:



Number of Providers Prescribing 1 or more Vivitrol



Data Source: Ohio Department of Mental Health & Addiction Services

Per the MCP contract, MCPs are allowed to provide services to members between the age of 21 and 64 for up to 15 calendar days per month in large facilities providing both SUD and mental health services in accordance with 42 CFR 438.6(e). Medicaid will not compensate the MCP for the provision of such services beyond 15 days per calendar month through either direct payment or considering any associated costs in Medicaid rate setting. MCPs are also required to report to the State any stays longer than 15 days per month in large SUD or mental health facilities.¹⁷

Future State:

Ohio will create an assessment of the availability of SUD treatment providers enrolled in Medicaid and accepting new patients in the critical LOC¹⁸ throughout the state including those that offer MAT. The State expects to be able to develop the assessment of the availability of the providers enrolled in Medicaid and accept new patients in each of the LOCs within 12 months of demonstration approval. This assessment will include:

- Whether facilities accept clients funded through the managed care, FFS or both delivery systems.

¹⁷ MCP Provider Agreement, July 1, 2018, Appendix G.3.e. Institutions for Mental Disease (IMDs)

¹⁸ ASAM 1: Outpatient Services; ASAM 2.1/2.5: Intensive Outpatient Services/Partial Hospitalization; ASAM 1-WM/2-WM: Medication Assisted Treatment (medications as well as counseling and other services); ASAM 3.1/3.3/3.5/3.7/4: Intensive Care in Residential and Inpatient Settings; ASAM 3.2-WM/3.7-WM: Medically Supervised Withdrawal Management

- Anticipated penetration rate and geographic distributions of providers at each LOC.
- Plans for enhancement of capacity based on assessments of provider availability.

ODM will establish new access standards for the new array of BH State Plan services including all SUD ASAM LOC. MCPs will be required to meet the new access standards and to report on their SUD treatment provider network development and management plans, specifically focusing on SUD treatment provider capacity, including MAT. Geo mapping will also be expanded to monitor access to MAT inclusive of a reporting mechanism for how many providers are accepting new patients.

MCPs will submit network adequacy reports to ODM on a quarterly basis inclusive of counts of available network providers by LOC and by provider type. The quarterly network report package additionally will include GeoAccess mapping for all SUD network providers by ASAM LOC capacity. Should gaps in access or adequacy be identified, the MCPs are required to submit gap analyses and ad hoc network development plans with their quarterly report package.

The MCOP contract currently specifies that each MCP must have 6–8 SUD providers in each region’s network. Future plan contracts will outline geographic access requirements for maximum travel time and/or distance requirements for each ASAM LOC.

As an additional treatment strategy, physicians, Advanced Practice Registered Nurses and Physician Assistants will be encouraged to become certified dispensers. According to the Drug Addiction Treatment Act of 2000 (DATA 2000), which expands the clinical context of medication-assisted treatment for persons with OUD, certified physicians are permitted to dispense or prescribe specifically approved Schedule III, IV and V narcotic medications such as buprenorphine, Suboxone, and Subutex in settings other than an OTP. DATA 2000 reduces the regulatory burden on physicians who choose to practice OUD treatment by permitting qualified physicians to apply for and receive waivers of the special registration requirements defined in the Controlled Substances Act.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Create a comprehensive access assessment baseline of all SUD providers and all SUD LOC, including MAT capacity.	Milestone 4	12 months
ODM will create access standards for SUD LOC.	Milestone 4	12 months
Require MCPs to update their SUD network development and management plan to specifically focus on SUD provider capacity by LOC, including MAT.	Milestone 4	12–18 months

Add an indicator for providers accepting new patients to the plan quarterly network adequacy reports.	Milestone 4	12–24 months
Require the plans to adopt access requirements for all ASAM LOC.	Milestone 4	12 months

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

CMS Specifications:

- Implementation of opioid prescribing guidelines, along with other interventions to prevent opioid abuse.
- Expanded coverage of and access to, naloxone for overdose reversal.
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs (PDMPs).

Implementation of opioid prescribing guidelines, along with other interventions to prevent opioid abuse

Current and Future State:

Opioid Prescribing Guidelines

Since 2012, Ohio has implemented five sets of opiate prescribing guidelines as part of the GCOAT. This multi-pronged approach has advanced Ohio’s fight against the opioid epidemic. (See Attachment 1) Changes in prescribing guidelines addressed the easiest sources of uncoordinated prescription medications including prescriptions obtained via hospital emergency departments. The State also included guidelines for patients already taking opioid medications and safeguards for the highest doses of prescription opioids. The updated guidelines include:

- The first Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guideline was released in April 2012 for hospital emergency departments and acute care facilities to address the large proportion of opioids prescribed from these settings, disconnected from routine sources of care for chronic pain conditions.
- In October 2013, GCOAT introduced Opioids Prescribing Guidelines for Treatment of Chronic, Non-terminal Pain for Ohio’s opiate prescribers as the risk for overdose became increasingly apparent across the country.
- In January 2016, GCOAT launches Guidelines for the Management of Acute Pain *Outside* of Emergency Departments and acute care facilities. These guidelines addressed “new starts” and to further encourage non-opioid therapies and pain medications for the management of acute pain expected to resolve within 12 weeks.
- In August 2017, Ohio implemented prescribing limits for acute pain (seven days for adults and five days for minors). In order to be able to monitor adherence to

these requirements, in December 29, 2017 prescribers were required to include the first four alphanumeric characters of the diagnosis code or full procedure code on opioid prescriptions. The inclusion of a diagnosis/procedure code (CDT) will be required for all other controlled substance prescriptions on June 1, 2018. The final requirement was a days' supply limit on all controlled substance and gabapentin prescriptions.

- A final unifying guideline was rolled out in 2018, emphasizing the need for vigilance and persistence in ensuring safety and screening for misuse and abuse. Documentation recommendations were delineated, with a “press pause” at the lower threshold of 50 Morphine Equivalency Dosage (MED) instead of the 80 MED described in prior chronic pain guidelines.

Progressive Opioid Prescribing Guidelines for a Safer Ohio

	Emergency Department & Acute Care Facilities	For Chronic, Non-Terminal Pain	For Acute Pain Outside of Emergency Department	Prescribing Limits For Acute Pain	For Subacute Pain
Effective Date	April 2012	October 2013	January 2016	August 2017	October 2018
Specific Goals	Stop inappropriate prescribing from ED & Urgent Care Centers	Ensure long-term patient safety	Limit first use of opioids and decrease availability of unused opioid medications	Limit type & amount of opioids for acute pain	Establish a continuum of safe prescribing with express informed consent
Prescribing Limitations	<ul style="list-style-type: none"> • No more than 3 day supply • No recurrent refills for chronic conditions • No long-acting opioids • Connect to usual source of chronic care 	<ul style="list-style-type: none"> • At ≥ 80 mg MED “press pause” • Caution with co-prescribing of benzodiazepines • Mandatory written agreement • Prescribe Naloxone • Mandatory OARRS checks and monitoring 	<ul style="list-style-type: none"> • Discuss pain management expectations • First consider non-pharmacologic and non-opioid therapies • Limit pills per script • No Long-acting opioids • 2 week check point 	<ul style="list-style-type: none"> • 7 day supply for adults • 5 day supply for youth • 30 MED average 	<ul style="list-style-type: none"> • At ≥ 50 MED, “press pause” • Informed consent • Screen for OUD • At ≥80 MED, subspecialty consultation • At 120MED, pain medicine specialist

1

MCPs implemented state-standardized claim edits requiring prior authorization for short-acting opioid prescriptions as well as prior authorization for all long-acting opioids. These claim edits were designed to help “enforce” the board’s guidelines.

Other Statewide interventions

Additional interventions included:

1. Closing “pill mills” in 2012.
2. Eliminating the authority of physicians to telephone in prescriptions for Schedule II drugs such as hydrocodone (Vicodin®).
3. Reducing the number of patients starting their first opioid.
4. Requiring Medicaid MCPs put edits in place within their pharmacy programs to support prescribing guidelines.
5. Requiring MCPs to implement Medication Therapy Management for those with problematic polypharmacy and a Coordinated Services Program (CSP) to

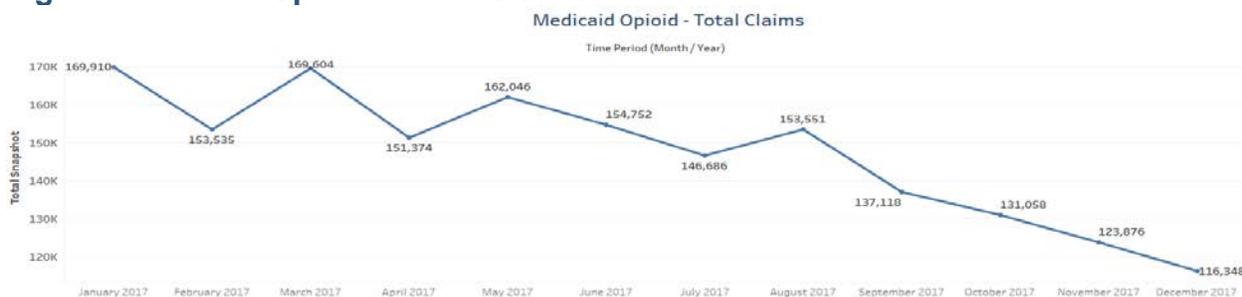
provide care management services for members who overuse or misuse services (described in greater detail below).

6. Implementing acupuncture as a covered Medicaid service as an evidence-based, non-opioid alternative treatment.
7. Creating a youth drug prevention program called, *Start Talking*, which was launched in January 2014.
8. Requiring MCPs to implement a CSP as described in OAC rule 5160-20-01. Currently the Medicaid MCPs have approximately 3,400 members in the CSP. The OAC rule establishing CSP has been amended to specify additional lock-in criteria beginning January 1, 2019. The changes are expected to increase the number of individuals enrolled in CSP.

Over the course of these guidelines and rules, the State of Ohio was able to realize a 28% reduction in solid doses of opioids prescribed from 196 million doses per quarter in Q2 2013 to 136 million Q2 2017.¹⁹ For acute pain, prescriptions fell from 70 million per quarter to 51 million over that same time frame with a reduction in number of patients with any opioid falling from 1.29 million per quarter to 948,000 per quarter.

These initiatives have resulted in direct impacts on Medicaid prescribing. The Medicaid opioid claims have reached a low point of 116,348 claims in December 2017.

Figure: Medicaid Opioid – Total Claims

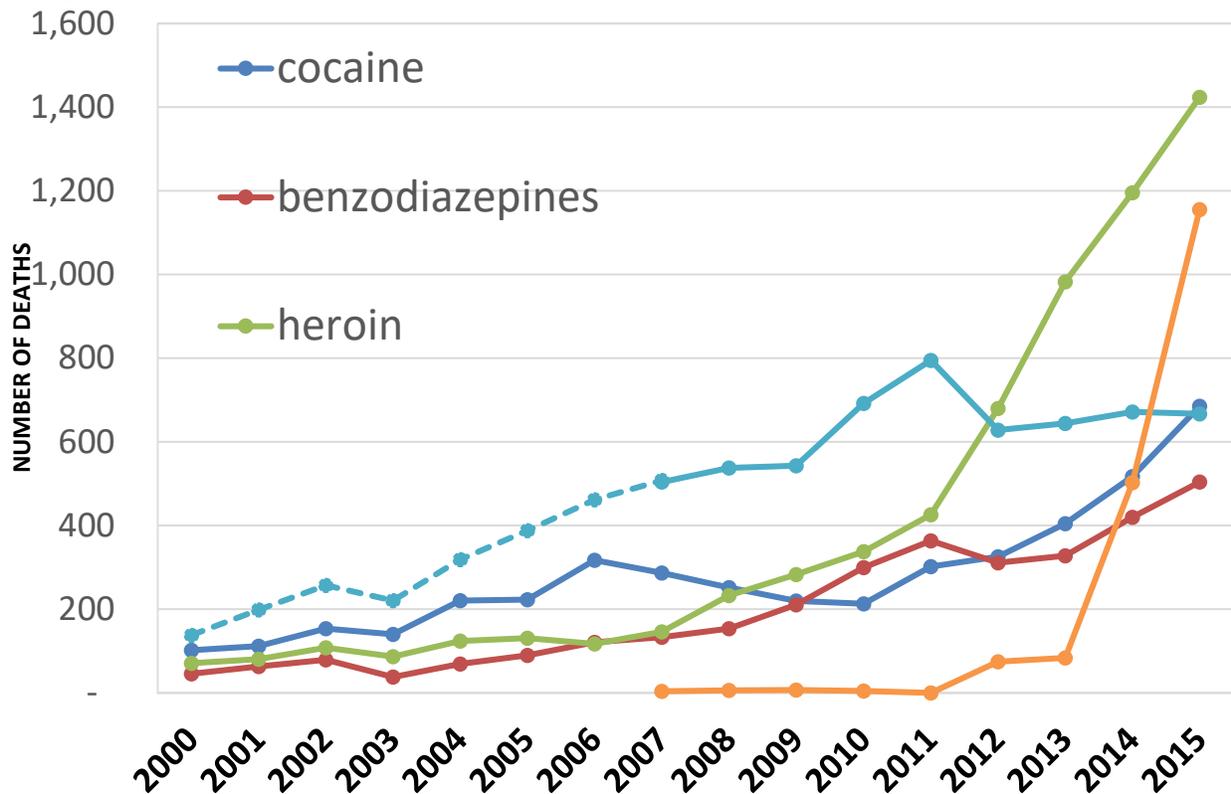


Ohio is one of the first states to realize a reduction in opioid deaths related to prescription drugs in the midst of escalating overall deaths driven by illicit drug use. Of all unintentional drug overdose deaths, the percentage of prescription opioid-related deaths in Ohio declined for a fifth straight year in 2016 and the number of these deaths declined 15.4% from 667 in 2015 to 564 in 2016 — the fewest since 2009.²⁰ See figure below.

¹⁹ OARRS data, Ohio's Opioid Epidemic, The Medicaid Experience & Progress to Date, Agency Briefing on Opioids October 2017 SPA-5, Mary Applegate, MD, FAAP, FACP, Slide 33.

²⁰ Mortality data can be found at the following website:
<http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality>

Figure: Unintentional Drug Overdose Deaths of Ohio Residents by Specific Drug(s) Involved, 2000–2015*



- Prescription Opioids not including Fentanyl;
Fentanyl was not captured in the data prior to 2007 as denoted by the dashed line

Source: October 2017 **Ohio’s Opioid Epidemic: The Medicaid Experience & Progress to Date** Dr. Mary Applegate

Medicaid Managed Care Interventions

To implement these prescribing guidelines in the Medicaid program, the Ohio Association of Health Plans convened a series of meetings to develop a comprehensive plan to address the opioid epidemic in Ohio. The most well received suggestion (or action strategy, etc.) was the high Morphine Equivalent Dosing (MED) intervention shared by one of the MCPs. MED determines a patient’s cumulative intake of any drugs in an opioid class in a 24-hour period. This involved identification of members receiving ultra-high MEDs and approaching the prescriber. The intervention included escalating letters and phone calls to the provider insisting on evidence-based practice and weaning when appropriate. There were provider consequences for non-compliance. The program has had well-documented success with a significant impact on total number of opioids prescribed.

In 2016, ODM challenged the MCP pharmacy directors to consider options specific to inappropriate opioid prescribing, aligning with internal plan efforts on the provider side of

their programs. ODM FFS and the MCPs limited the number of opioid claims paid in a rolling 30 days to five, so that the sixth claim would reject for prior authorization. Both programs also tightened the allowable “early refill provisions, setting thresholds at 90%, which equated to no refills being allowed before day 27 in a 30-day month, for example. As the MCPs agreed on these sorts of standards, there were operational considerations at the Pharmacy Benefit Manager (PBM) levels in terms of implementation. PBMs could allow the claim to pay, but send a message to the pharmacy. They could deny the claim, but allow the pharmacist to override after reviewing the message (and, one would hope, the patient’s history and the PDMP, and maybe call one or more prescribers). Alternatively, they could deny the claim and require prior authorization. The MCP PBMs did not achieve standardization to this degree of operational detail, but they were aligned. The PBMs for all of the MCPs and FFS utilized many other options to contain unsafe prescribing practices including using a preferred drug list, point of sale edits, step therapy, prior authorization, dispensing limits, age restrictions, prospective drug utilization review (DUR) edits like early refills, therapeutic drug duplication and drug interactions.

In 2012, ODM began coverage for MAT. While preferred MAT drugs varied by plan, as attention shifted to special populations such as the incarcerated who chose court-ordered treatment in lieu of incarceration, all of the MCPs worked together to remove barriers. As Vivitrol was, the form of MAT preferred most by the judicial system, all MCPs removed prior authorization for Vivitrol, as did FFS, simplifying yet another aspect of the pharmacy program.

Ohio’s BH benefit was integrated in to managed care July 1, 2018, prompting significant efforts to further remove administrative barriers to MAT utilization, ensuring the provision of MAT for individuals as well as concomitant psychosocial care. After considering the option of “gold-carding” providers, the MCPs agreed to remove all prior authorization requirements for all oral forms of short-acting buprenorphine, and build a robust standardized retrospective DUR program on the back end. Some edits related to very young ages or pregnancy status may apply as the MCPs are still held to standards of patient safety. Long-acting or injectable forms of MAT (other than Vivitrol) are still subject to documentation requirements.

The MCPs also made sequential changes as the landscape of prescribing guidelines and limits evolved. In October 2017, FFS and all MCPs agreed to require prior authorization for all long-acting opioids prescribed for acute pain, supporting the state guidelines. In July 2018, all MCPs and FFS agreed to place a limit on days’ supply and MED for short-acting opioids in new start patients, again stepping up to support evolving state prescribing limits by January 2018.

In 2017, alternative pain management strategies were evaluated to ensure that ODM was fully supporting strategies to minimize inappropriate prescribing of opioids. As FFS began to cover acupuncture for headache and low back pain, initially by physicians, extending to chiropractors and acupuncturists, the MCPs followed suit.

The MCPs have been active participants in many programs targeting special populations challenged with OUD consequences. The recently incarcerated were already mentioned. A Pre-Release program was developed allowing inmates to choose a Medicaid MCP in the 90 days before release, allowing for a video case conference and connectivity to needed community health services such as continuation of OUD treatment. Pregnant women are particularly affected by OUD as their infants may be born with Neonatal Abstinence Syndrome, associated with long Neonatal Intensive Care Unit stays and CPS involvement. ODM has partnered with the Ohio Perinatal Quality Collaborative to develop models of care such as those described in the Maternal Opiate Medical Support program, in which the MCPs participate actively. Addressing associated social determinants of health has been particularly challenging as these are prominent issues for those with OUD, but Ohio continues to advance the field of ideal care with the support of our MCPs.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
None	Milestone 5	

Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

Current and Future State:

Ohio has taken steps to prevent drug overdose deaths through the expanded availability and use of the opiate overdose reversal drug Naloxone. One of the most effective steps for expanding coverage included permitting pharmacists to dispense Naloxone without a prescription in 2015. To assist pharmacies, the State of Ohio Board of Pharmacy developed a dedicated web page, www.pharmacy.ohio.gov/naloxone, which features helpful resources including a guidance document, sample protocol, and a listing of all participating pharmacies. The Pharmacy Board also offers printed, no-cost patient educational materials to any participating pharmacy. By 2017, more than 1,600 Ohio pharmacies in 87 counties offer naloxone without a prescription.

Other steps taken by the state to expand access to Naloxone include:

- Creating and implementing a naloxone education and distribution program called ProjectDAWN (Deaths Avoided with Naloxone).
- Establishing an online training course for law enforcement and an educational video for the public regarding the administration of naloxone.
- Negotiating rebates with naloxone manufacturer Amphastar Pharmaceuticals, Inc., regarding rebates for public entities that purchase Amphastar naloxone.
- Funding for local health department distribution to purchase naloxone for law enforcement.

- Passing a law in 2016 with a “good Samaritan” provision that provides immunity from prosecution to those who seek emergency help for the victim of an overdose.
- Issuing guidance to hospitals on providing naloxone to patients upon discharge and to Emergency Medical Service organizations on providing naloxone to individuals treated for an opiate overdose.
- Passing a 2017 law allowing facilities that interact with high-risk individuals to have on-site access to naloxone including homeless shelters, halfway houses, schools and treatment centers.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
None	Milestone 5	

Increasing Utilization and Improving Functionality of Prescription Drug Monitoring Programs

Current State:

Ohio first mandated use of the OARRS, the State’s PDMP by prescribers in 2011, with additional provisions added in 2013. OARRS is a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients. OARRS is designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

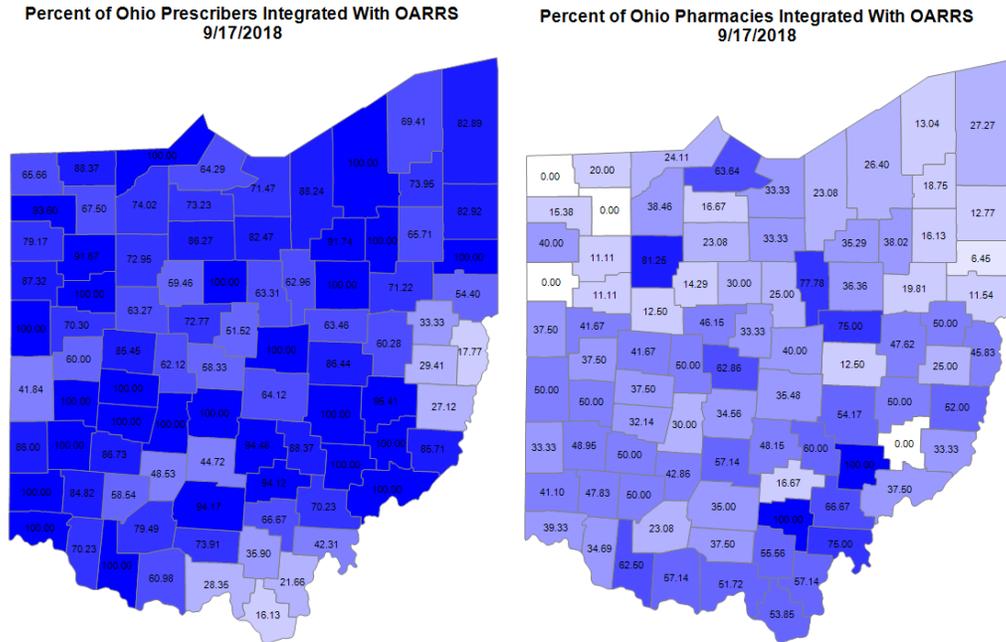
Since the latest mandate in 2013, the use of the OARRS has grown. In 2017, the OARRS reported a record high of 265,242 requests by prescribers and pharmacists in a single day. By comparison, the single day high in 2016 was 86,129 prescriber and pharmacist requests. In August 2018, OARRS reported an average of more than 599,000 requests per weekday — more than double the previous year’s high. Notably, OARRS integration with EHRs statewide includes the following as of August 31, 2018:

- Nineteen major health systems and outpatient clinics, such as: Promedica, Mount Carmel, Mercy Health, MetroHealth, The Ohio State University Wexner Medical Center, Cleveland Clinic, Avita Health, Southwest General, University Hospital (Cleveland), Aultman, Adena, Genesis Healthcare, Kettering Health Network, Premier Health, Magruder Health, Nationwide Children’s, Christ Hospital Health, Toledo Clinic Health and Licking Memorial.
- Two hundred and six independent Ohio pharmacies.
- Nine chain pharmacies, including: Discount Drug Mart (seventy-three stores), Kroger (two hundred and one stores), Giant Eagle (five stores), Costco (fourteen stores), Fruth (eleven stores), Ritzman (twenty-five stores), Acme (seventeen stores), Meijer (forty-one stores) and Walmart (174 stores).
- One hundred and forty-four physician offices.

- Fourteen hospitals.

For an overall picture of the percentage of prescribers and pharmacies integrated with OARRS, see the figure below.

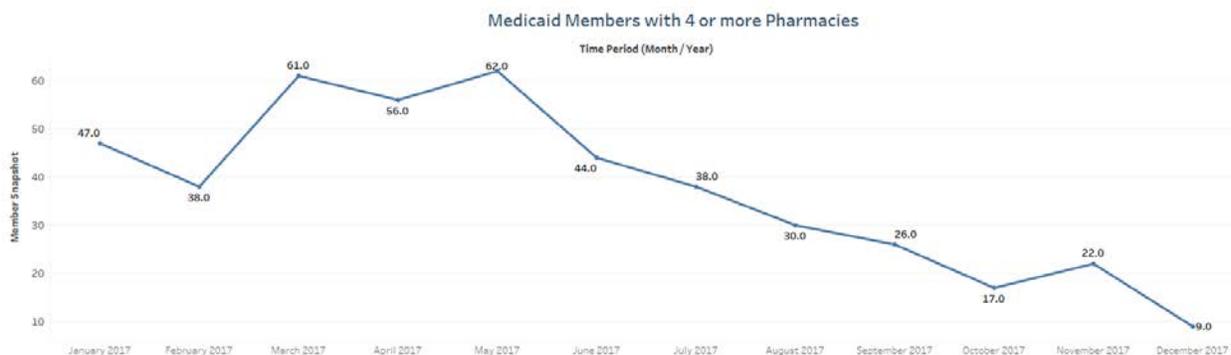
Figure: Percent of Prescribers and Pharmacies integrated with OARRS



OARRS has also documented that fewer Ohioans are using multiple prescribers or pharmacies (i.e., doctor shopping). In 2017, data from OARRS found the number of individuals using more than five prescribers for prescription opiates has decreased 88% since 2011.²¹ Similarly, the number of Medicaid members with four or more pharmacies has continuously dropped since January 2017 (see figure).

²¹ Ohio Board of Pharmacy. [https://www.ohiopmp.gov/documents/Annual%20Report%20\(2017\)%20-%20Executive%20Summary.pdf](https://www.ohiopmp.gov/documents/Annual%20Report%20(2017)%20-%20Executive%20Summary.pdf)

Figure: Medicaid Member with four or more Pharmacies



The State of Ohio has leveraged opportunities described in Severely Mentally Disabled Letter 16-003 to help professionals and hospitals eligible for Medicaid EHR Incentive Payments connect to other Medicaid providers through the integration of OARRS into electronic medical records and pharmacy dispensing systems. All hospitals and pharmacies now have ability to have OARRS integrated into their EHRs and Pharmacy management systems. Nearly half of physicians now have integrated access to OARRS.²² This initiative allows the State to meet the following objectives:

- Further reduce the number of individuals who doctor shop.
- Provide health care providers critical information regarding a patient’s controlled substance prescription history and expand collection of other data sources to support clinical decision-making.
- Support clinician interventions for patients exhibiting high-risk behaviors.
- Assist providers in achieving the medication reconciliation meaningful use objective and measure.²³

An additional goal of this integration initiative is to provide as many avenues as possible for an authorized health care provider to access Ohio’s PDMP, including integrated access through Health Information Exchanges (HIEs). In fact, Ohio’s two largest HIEs — CliniSync and The Health Collaborative (HealthBridge) — have already been integrated with OARRS under this initiative. As both of the state’s HIEs are integrated, there are no future plans for enhanced connectivity at this time.

²² Ohio Board of Pharmacy. [https://www.ohiopmp.gov/documents/Annual%20Report%20\(2017\)%20-%20Executive%20Summary.pdf](https://www.ohiopmp.gov/documents/Annual%20Report%20(2017)%20-%20Executive%20Summary.pdf)

²³ Stage 3 of Meaningful use consolidates Medication reconciliation into the Health Information Exchange Objective. The objective requires that the Eligible Professional provides a summary of the care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT. Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

Prescription Drug Monitoring Program Functionalities

Ohio's Board of Pharmacy and OARRs system participate in the PMP Interconnect. The system allows a user to search PDMPs in 20 other states, including all of Ohio's Border States. Ohio will continue to grant access to PDMP users from other states via the Project Manager Professional (PMP) Interconnect platform. This will depend on each State's ability to share data.

Ohio is the first state in the country to pay all costs for the integration of PDMP data into EHRs and pharmacy dispensing systems. This allows for instant access to PDMP data as part of the healthcare providers workflow. County-based integration statistics are included as an attachment to this document.

Currently, there are no activities within OARRS to correlate long-term opioid use directly to clinician prescribing patterns.

Ohio has adopted Appriss Health's NarxCare program as its PDMP platform. NarxCare is a comprehensive platform that aggregates and analyzes prescription information from providers and pharmacies and presents visual, interactive information, as well as advanced analytic insights, complex risk scores and more to help physicians, pharmacists and care teams to provide better patient care and safety. Furthermore, NarxCare provides tools and resources that support patients' needs and connects them to treatment, if necessary. This information, insight and functionality is all accessed in clinical workflow via EHRs and pharmacy management systems, as well as through the PDMP website.

Ohio recently transitioned from the original AWARxE patient matching algorithm, to Axis, Appriss' new master patient index. Axis uses not only PDMP data, but also a number of external data sources (USPS change of address, credit headers, etc.) to inform the system as to which similar entries may be the same patient, versus which are actually two different individuals.

Unlike the previous generation of patient matching software, Axis is capable of improving its matching capabilities over time. As Board of Pharmacy staff identify instances where the matching was incorrect, Axis is able to use that information to make better matching decisions in the future.

Ohio recently implemented rules limiting the provision of initial prescriptions of opioids to treat acute pain. With limited exceptions, a prescriber is not permitted to prescribe more than a five-day supply for a minor or a seven-day supply for an adult. Additionally, the prescriptions cannot exceed 30 morphine equivalent daily dose. The rules went into effect in August 2017. The Board of Pharmacy is currently developing an enforcement plan with the State Medical Board, Nursing Board and Dental Board. In order to account of the exemptions, Ohio regulations require the inclusion of a diagnosis code on all prescriptions for controlled substances.

Future State:

The Board of Pharmacy will continue to onboard new EHR and pharmacy dispensing system vendors with the goal of achieving a 90% integration rate of all providers (prescribers and pharmacies). Contacting vendors and coordinating the completion of legal agreements and testing is the responsibility of OARRS Integration Project Manager in collaboration with the PDMP vendor, Appriss Health.

The Board of Pharmacy will explore the possibility of analysis to correlate long-term opioid use directly to clinician prescribing patterns in conjunction with the ODM.

NarxCare allows the Board to collect additional non-PDMP based data for inclusion in the PDMP report. The first non-PDMP data to be included will be flags in the system for those who are participating in one of Ohio’s drug court programs. There are plans to include other data sources such as death after a non-fatal overdose. The Board is also working on the inclusion of naltrexone to be reported to the PDMP to identify individuals who have been treated for substance use disorder. The PDMP Administrator along with the PDMP Vendor, Appriss Health, are responsible for the development of processes and system testing for the inclusion of additional patient data. The Ohio Supreme Court is working to compile regular data sets of drug court participants.

The Board of Pharmacy will implement an enforcement plan to minimize the risk of inappropriate overprescribing consistent with prescribing guidelines. The PDMP Administrator will be responsible for the development of a referral report to the appropriate prescriber regulatory boards. Ohio’s prescriber regulatory boards will implement education and enforcement actions against prescribers who are in violation of the rules.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Continue to onboard new EHR and pharmacy dispensing system vendors.	Milestone 5	12–24 months
Explore the possibility of analysis to correlate long-term opioid use directly to clinician prescribing patterns in conjunction with the ODM (action item for the Board of Pharmacy).	Milestone 5	12–24 months
Implement enhanced information in the OARRS including: OARRS flags for individuals who are participating in one of Ohio’s drug court programs; non-fatal overdose deaths, and naltrexone identification to identify individuals treated for SUD.	Milestone 5	12–24 months

Implement an enforcement plan to minimize the risk of inappropriate overprescribing consistent with prescribing guidelines.	Milestone 5	12–24 months
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Milestone 6: Improved Care Coordination and Transitions between LOCs

CMS Specifications:

- Implementation of policies to ensure residential and inpatient facilities link individuals, especially those with OUD, with community-based services and supports following stays in these facilities.
- Additional policies to ensure coordination of care for co-occurring physical and mental health conditions.

Current State:

ODM approaches care coordination by promoting a population health management approach as well as other reforms to create a system to better care for all individuals in Medicaid including those with SUD diagnoses. Specifically, ODM identifies and monitors individual patients within specific groups such as individuals with BH diagnosis. Data are used to risk stratify Ohio individuals in Medicaid and group them into population streams, one of which is BH. Strategies specific to risk levels and population streams are then developed by ODM and contracted managed care plan partners to improve patient outcomes and experience of care. Value-based purchasing strategies further enhance the promotion of evidence-based and comprehensive care for patients with SUD.

Ohio has undertaken multiple interventions and strategies to improve coordination of care for individuals with SUD and the transition between LOCs along the continuum of care including, but not limited to, facility discharge requirements in OhioMHAS certification standards, Ohio's Comprehensive Primary Care (CPC) program, care management and transition of care requirements in MCP contracts, and targeted case management.

Facility discharge requirements in OhioMHAS certification standards

OhioMHAS certification requirements at OAC 5122-29-09 require that each residential, inpatient and withdrawal management provider have an affiliation agreement with at least one provider for referral to less intensive LOC. Each provider is also required to have written policies and procedures to ensure its referral process is appropriately implemented and managed and includes:

- Referral decisions made to the appropriate LOC as determined utilizing the American society of addition medicine criteria protocols for LOC.
- Discharge plan stipulating specific recommendations and referrals for alcohol and drug addiction treatment.
- Documentation of referral and discharge must appear in the client record.

Comprehensive Primary Care Program

CPC is a patient-centered medical home program, which is a team-based care delivery model led by a primary care practice (PCP) that comprehensively manages a patient's health needs. The goal is to empower practices to deliver the best care possible to their patients, both improving quality of care and lowering costs. There is an expectation that all Medicaid individuals seen by CPC practitioners will benefit from the CPC practice transformation that includes the integration of Behavioral healthcare into physical health sites. Most medical costs occur outside of a PCP, but primary care practitioners can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Each CPC practice works with BH partners to coordinate care for individuals with co-occurring BH and physical health (PH) conditions. This includes coordination on SUD treatment. Joining the CPC program gives practices access to data and reports that provide actionable, timely information needed to make better decisions about outreach, care and referrals.

Each CPC practice is required to create care plans for all high-risk patients as identified by the practice's risk stratification system. The practices must ensure follow-up after hospital discharges. To do this the CPC practice establishes relationships with all emergency departments (EDs) and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care.

The MCP plays a key role in supporting the CPC practice's with achieving optimal population-level health outcomes. MCPs have a relationship with each CPC practice and provide support as requested by the CPC practice (e.g., cross system collaboration, information sharing, addressing social determinants of health, transition of care, etc. MCPs may also choose to care manage members who are not identified by the CPC practice's high-risk stratification algorithm as further described below.

Care Coordination in Plans

MCOPs are required to provide care management to all enrolled members. MCPs must assure care management services and supports are available to individuals when needed. Expectations for both care management programs are similar and are outlined below. The plans' care management programs incorporate: person and family centeredness; timely, proactive planned communication and action; the promotion self-care and independence; emphasis on cross continuum and system collaboration (e.g., BH) and the comprehensive consideration of physical, behavioral and social determinants of health.

In order to determine the level of care management services and supports, the plans conduct assessments of members' physical and behavioral health, social and safety needs including identification of co-occurring conditions. Based on the needs assessment, a person centered care plan with goals, interventions and outcomes is developed in conjunction with, and support of, the managing clinician and then member. The plans' care manager and team then work to identify, address and remove barriers

to care, secure resources, coordinate with providers across systems and facilitate transitions.

The plans also manage transitions of care between both PH and BH settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The plans provide transition support to members attributed to CPC practices upon request. The plans are required to have a process for the following:

- Identify members who require assistance transitioning between settings.
- Develop a method for evaluating risk of readmission in order to determine the intensity of follow up required for the member after the date of discharge.
- Designate plan staff who will communicate with the discharging facility and inform the facility of the plan's designated contacts.
- Ensure timely notification and receipt of admission dates, discharge dates and clinical information is communicated between plan departments, care settings and with the primary care provider, as appropriate.
- Participate in discharge planning activity with the facility including arranging for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the plan.
- Obtain a copy of the discharge/transition plan.
- Arrange for services specified in the discharge/transition plan.
- Conduct timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.

When a plan is contacted by an inpatient facility with a request to participate in discharge planning, plans ensure a safe discharge placement and services are arranged for the member.

Targeted Case Management

Ohio has historically offered SUD targeted case management to individuals in Medicaid receiving alcohol or SUD treatment services from a certified or licensed treatment program. This includes individuals with SUD transitioning to a community setting. As part of this program, case management services are made available for up to 180 consecutive days of a covered stay in an inpatient medical institution, which is not an IMD or inmates of public institutions. However, this demonstration will allow case management funding for individuals transitioning from large SUD residential facilities.

SUD Case Management includes four components: assessment/reassessment, development and revision of an individualized care plan, referral and monitoring and follow up activities. The goal of SUD Case Management is to determine the need for any medical, educational, social or other services as the individual transitions to the community and to address those needs on an on-going basis to ensure the success of the individual in the community.

Future State:

Ohio will implement the BHCC program in 2019. Individuals enrolled in MCPs may enroll in BHCC instead of SUD Targeted Case Management (TCM). This program attributes individuals to certified Qualified Behavioral Health Entities (QBHEs) providers, who are responsible for rendering the BHCC services and are best equipped to serve member needs, through advanced member-provider matching and specific identification criteria aimed at individuals with SUD. The BHCC program clearly defines the roles and responsibilities of QBHEs, PCPs and MCPs. Fundamentally, the program aims to reduce disruptions/gaps in to care through increased collaboration between all providers (PCPs, CPCs, MCPs, and QBHEs). This enhanced collaboration will result in improved SUD recovery support services.

The program integrates PH and BH care services by increasing the presence of care coordinators and using innovative tools to enhance data sharing. The program will allow increased focus on SUD issues. Reports will go to providers on a quarterly basis that will include PH, BH and specific SUD measures. In addition, there will be risk flags for SUD diagnoses on an individual-level provided in additional files. The program will improve chronic condition management through interdisciplinary care coordination and expand the role of providers in comprehensive care plan development. The program will use UM and preventive health programs, such as depression screenings, to bolster access to specialty providers and reduce barriers to care. BHCC efforts will illustrate improved treatment adherence through deliverables measurement, including treatment and follow-up adherence rates.

Under the proposed BHCC program, a QBHE will provide MCP members who are attributed to that entity with all of their BHCC. Ideally, the QBHE shall be the member's primary entity for managing BH needs and will coordinate with the member's comprehensive PCP or primary care provider to ensure a comprehensive, integrated approach to managing the member's needs. If a QBHE is unable to engage a member after attribution, the MCP may choose to care manage the member until the QBHE is able to successfully engage the member or the MCP may request ODM attribute the member to a different QBHE. The MCP will play a key role in supporting the QBHEs, as requested, with achieving optimal population level health outcomes by providing assistance with cross system communication, addressing social determinants of health, etc. This program is anticipated to begin July 1, 2019.

Ohio has developed a care management hierarchy for members to ensure optimal BH care management for each individual. For example, while members receiving care from Assertive Community Treatment and In-home Based Treatment teams will continue to be attributed to a QBHE, they will receive their care management from those evidence-based teams with coordination from the QBHE. Members not receiving care from one of these teams would be eligible to receive BHCC services through their attributed QBHE provider.

The QBHE providers will be responsible for ensuring successful member transitions between providers or sites of care. The QBHE will use care coordinators to lead outreach to the primary care provider after major BH events, such as an inpatient stay, to discuss implications for PH care and transition needs (e.g., transportation, medication restrictions, etc.). The QBHE will establish relationships with EDs and hospitals and monitor admissions and discharges. The QBHE will be accountable for focusing on admissions and discharges related to BH treatment.

When a member is in SUD residential and remains in BHCC, key elements of BH care coordination are retained, including transitions to services provided at lower LOC under ASAM at the same or another SUD facility. Additionally, members may opt-out of BHCC and choose to receive mental health or substance abuse treatment from a non-BHCC participating provider. Members may receive SUD residential and BHCC simultaneously, but BHCC reimbursement is paused while a member receives SUD residential treatment and the BHCC provider responsibilities continue for the duration of the residential treatment.

Additional guidance is forthcoming on how the new BHCC coordinates care between SUD LOC: inpatient, residential and outpatient.

Summary of Actions Needed	Milestone	Timeline Post Waiver Approval
Enroll BHCC providers.	Milestone 6	February 2019
Attribute members to qualified entities.	Milestone 6	Spring 2019
Report on provider baseline performance.	Milestone 6	January 2019
Begin BHCC monthly payments.	Milestone 6	July 1, 2019
Issue SUD transition guidance to BHCC entities.	Milestone 6	Within 12 months

Section II. Implementation Administration

Contact information for Implementation Plan Point of Contact:

General Policy

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Managed Care Policy

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Section III. Relevant Documents

Attachment A. SUD Health Information Technology Plan

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health Information Technology (IT) Plan include:

- Enhancing the health IT functionality to support PDMP interoperability.
- Enhancing and/or supporting clinicians in their usage of the state’s PDMP.

The state should provide CMS with an analysis of the current status of its health IT infrastructure/”ecosystem” to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration — or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support — and specific actions and a timeline to be completed over the course of the demonstration — to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table: State Health IT/PDMP Assessment and Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: <ul style="list-style-type: none"> • Enhance the state’s health IT functionality to support its PDMP. • Enhance and/or support clinicians in their usage of the state’s PDMP. 	Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians’ use of the state’s health IT functionality to achieve the goals of the PDMP.	Provide an overview of plans for enhancing the state’s PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians’ use of the health IT functionality to achieve the goals of the PDMP.	Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
PDMP Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data.	Ohio’s PDMP participates in PMP Interconnect. The system allows a user to search PDMPs in 20 other states, including all of Ohio’s border states.	Ohio will continue to grant access to PDMP users from other states via the PMP Interconnect platform. This will depend on each state’s ability to share data.	As data sharing is dependent on other states (including necessary changes to state law), there are no milestones that can be listed.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Enhanced “ease of use” for prescribers, other state and federal stakeholders.	Ohio is the first state in the country to pay all costs for the integration of PDMP data into EHRs and pharmacy dispensing systems. This allows for instant access to PDMP data as part of the healthcare providers workflow. County-based integration statistics are included as an attachment to this document.	The Board of Pharmacy will continue to onboard new EHR and pharmacy dispensing system vendors with the goal of achieving a 90% integration rate of all providers (prescribers and pharmacies).	Contacting vendors and coordinating the completion of legal agreements and testing is the responsibility of OARRS Integration Project Manager in collaboration with the PDMP vendor, Appriss Health.
Enhanced connectivity between the state’s PDMP and any statewide, regional or local HIE.	Ohio’s two HIEs are now fully integrated with the state’s PDMP.	As both of the state’s HIEs are integrated, there are no future plans for enhanced connectivity at this time.	N/A
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns ²⁴ (see also “Use of PDMP” #2 below).	Currently, there are no activities to correlate long-term opioid use directly to clinician prescribing patterns.	The Board of Pharmacy will explore the possibility of engaging in this type of analysis in conjunction with the ODM through the hiring of a data analyst.	The ODM will be responsible for the provision of funding to hire an additional data analyst for the Board of Pharmacy.
Current and Future PDMP Query Capabilities			
Facilitate the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the state’s master patient index strategy with regard to PDMP query).			
Use of PDMP – Supporting Clinicians with Changing Office Workflows/Business Processes			
Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues, which follow.	Ohio is the first state in the country to pay all costs for the integration of PDMP data into EHRs and pharmacy dispensing systems. This allows for instant access to PDMP data as part of the healthcare	The Board of Pharmacy will continue to onboard new EHR and pharmacy dispensing system vendors with the goal of achieving a 90% integration rate of all providers (prescribers and pharmacies).	Contacting vendors and coordinating the completion of legal agreements and testing is the responsibility of OARRS Integration Project Manager in collaboration with the

²⁴ Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>providers workflow. County-based integration statistics are included as an attachment to this document.</p>		<p>PDMP vendor, Appriss Health.</p>
<p>Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP — prior to the issuance of an opioid prescription.</p>	<p>Ohio has adopted Appriss Health's NarxCare program as its PDMP platform. NarxCare is a comprehensive platform that aggregates and analyzes prescription information from providers and pharmacies and presents visual, interactive information, as well as advanced analytic insights, complex risk scores and more to help physicians, pharmacists and care teams to provide better patient care and safety. Furthermore, NarxCare provides tools and resources that support patients' needs and connects them to treatment, if necessary. This information, insight and functionality is all accessed in clinical workflow via EHRs and pharmacy management systems, as well as through the PDMP website.</p>	<p>NarxCare allows the Board to collect additional non-PDMP based data for inclusion in the PDMP report. The first non-PDMP data to be included will be flags in the system for those who are participating in one of Ohio's drug court programs. There are plans to include other data sources such as non-fatal overdose deaths. The Board is also working on the inclusion of naltrexone to be reported to the PDMP to identify individuals who have been treated for SUD.</p>	<p>The PDMP Administrator along with the PDMP Vendor, Appriss Health, are responsible for the development of processes and system testing for the inclusion of additional patient data. The Ohio Supreme Court is working to compile regular data sets of drug court participants.</p>
<p>Master Patient Index/Identity Management</p>			
<p>Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.</p>	<p>Ohio recently transitioned from the original AWARD patient matching algorithm, to Axis, Appriss' new master patient index.</p>	<p>Unlike the previous generation of patient matching software, Axis is capable of improving its matching capabilities over time. As Board of</p>	<p>The Board of Pharmacy PDMP staff will continue to monitor the Axis system to ensure that appropriate matches are being</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>Axis uses not only PDMP data, but also a number of external data sources (USPS change of address, credit headers, etc.) to inform the system as to which similar entries may be the same patient, versus which are actual two different individuals.</p>	<p>Pharmacy staff identify instances where the matching was incorrect, Axis is able to use that information to make better matching decisions in the future.</p>	<p>made. As incorrect matches are identified, they will be corrected so that the system can continue to improve on its abilities to accurately match patients.</p>
<p>Overall Objective for Enhancing PDMP Functionality and Interoperability</p>			
<p>Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing — and to ensure that Medicaid does not inappropriately pay for opioids.</p>	<p>Ohio recently implemented rules limiting the provision of initial prescriptions of opioids to treat acute pain. With limited exceptions, a prescriber is not permitted to prescribe more than a five-day supply for a minor or a seven-day supply for an adult. Additionally, the prescriptions cannot exceed 30 morphine equivalent daily dose. The rules went into effect in August 2017. The Board of Pharmacy is currently developing an enforcement plan with the State Medical Board, Nursing Board and Dental Board. In order to account of the exemptions, Ohio regulations require the inclusion of a diagnosis code on all prescriptions for controlled substances.</p>	<p>The Board of Pharmacy will implement an enforcement plan to minimize the risk of inappropriate overprescribing.</p>	<p>The PDMP Administrator will be responsible for the development of a referral report to the appropriate prescriber regulatory boards. Ohio’s prescriber regulatory boards will implement education and enforcement actions against prescribers who are in violation of the rules.</p>

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

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Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment B: GCOAT Timeline

