Medicaid Innovation Accelerator Program (IAP)

Substance Use Disorders
Targeted Learning Opportunities (TLO)

TLO 9: Combating the Opioid Crisis with a Multifaceted Approach
Logistics

• Please mute your line and do not put the line on hold
• Use the chat box on your screen to ask a question or leave comment
  – Note: chat box will not be seen if you are in “full screen” mode
  – Please also exit out of “full screen” mode to participate in polling questions
• Moderated Q&A will be held periodically throughout the webinar
• Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience
Speakers (1 of 7)

- John O’Brien, MA
- Senior Policy Advisor, Disabled and Elderly Health Programs Group, Centers for Medicaid and Medicare
Speakers (2 of 7)

• John Coster, PhD, MPS
• Director, Division of Pharmacy, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services
Speakers (3 of 7)

• Charissa Fotinos, MD, MS
• Deputy Chief Medical Officer, WA State Health Care Authority
Speakers (4 of 7)

- Lisa Millet, MHS
- Injury & Violence Prevention Manager, Public Health Division, Oregon Health Authority
Speakers (5 of 7)

• Robert Kent, JD
• Chief Counsel, Office of Counsel and Internal Controls, Office of Alcoholism & Substance Abuse Services (OASAS)
Speakers (6 of 7)

- James Becker, MD
- Medical Director, WV Bureau of Medical Services, WV Department of Health and Human Resources
Speakers (7 of 7)

- Rahul Gupta, MD, MPH, FACP
- State Health Commissioner, Bureau for Public Health, WV Department of Health and Human Resources
Moderator

• Catherine Fullerton, MD, MPH
• Senior Research Leader, Truven Health Analytics
Agenda

• Introduction from CMS
• State Experience: Washington
• State Experience: Oregon
• Break for Discussion
• State Experience: New York
• State Experience: West Virginia
• Break for Discussion
• Wrap Up & Sharing of Resources
Purpose and Learning Objectives

• Participants will learn about innovative state Medicaid policies that aim to reduce prescription drug abuse and prevent opioid overdoses

• Participants will learn how Medicaid programs have collaborated with PDMP to combat the opioid crises
Introduction

John O’Brien, MA
Senior Policy Advisor, Center for Medicaid and CHIP Services

John Coster, PhD, MPS
Director, Division of Pharmacy, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services
Why Focus on Prescription Opioids

**US prescription opioid deaths quadrupled between 1999 - 2013**

- CDC identified addiction to prescription opioids as the **strongest risk factor** for heroin addiction
- Medicaid enrollees are prescribed prescription opioids at **twice the rate** of non-Medicaid patients
- Medicaid enrollees are at **higher risk of prescription opioid overdose** than non-Medicaid patients
- One state found that Medicaid enrollees made up **45% of all prescription overdose deaths** between 2004-2007
Why Focus on Methadone for Pain

Methadone accounts for a disproportionate share of opioid pain medication overdoses and deaths

Between 2002 – 2008, methadone represented less than 5% of analgesic prescriptions

Methadone also represented 30% of opioid-related deaths during that same period

In one state, the overdose rate of Medicaid enrollees was 10 times higher for methadone than other prescription opioids

Overdoses involving methadone were twice as fatal compared to other prescription opioids
Secretary’s Initiative on Opioid Abuse: Launched March 2015

Priority Areas

- Opioid prescribing practices
- Expanded use and distribution of naloxone
- Expansion of medication-assisted treatment

Two Primary Goals:
(1) Decrease opioid overdoses and overdose mortality
(2) Decrease prevalence of opioid use disorder
Presidential Memorandum: Issued October 2015

**Goals**

- Reduce prescription opioid and heroin deaths
- Promote appropriate and effective pain medication prescribing
- Improve access to treatment

**Actions**

- Train federal prescribers
- Identify barriers to accessing MAT in federal health programs
- Review the use of methadone as a preferred or first-line pain reliever
CMS Initiatives on Opioid Use Disorder

- **July 2014**: Informational Bulletin on MAT issued
- **April 2015**: Parity rule proposed
- **October 2014**: Medicaid Innovation Accelerator Program initiative on SUD launched
- **Upcoming efforts** to support Secretary’s Initiative and President’s Memorandum
- **July 2015**: Section 1115 demonstration opportunity for SUD announced
MAT Coverage: A Snapshot

MAT is evidence-based treatment for a chronic disease

FDA-approved medications for opioid dependence
- Buprenorphine
- Methadone
- Naltrexone

Prior Authorization
- 48 states have prior authorization for buprenorphine
- Prior authorization for antipsychotics leads to higher rates of hospitalization and higher total Medicaid expenditures

Very low utilization of extended-release injectable naltrexone
Expanding Coverage to MAT

- Review limitations for barriers to access
- Medical, psychological and rehabilitative services in conjunction with medication management
- Data analytics on
  - Penetration rates (diagnosed and receiving SUD treatment, including MAT)
  - Network adequacy and MAT provider availability
  - Inactive authorized prescribers
  - Concurrent behavioral therapies delivery rates
Medicaid Pharmacy Benefit Management Strategies

- Preferred Drug List placement
- Preferred drug criteria
- Step therapy
- Prior authorization
- Quantity limits
- Provider education and prescribing guidelines

- Drug Utilization Review
- Patient Review and Restriction Programs
- Prescription Drug Monitoring Program
  - Mandated prescriber use shows reductions in controlled substance prescribing and multiple provider episodes (75% in New York)
Medicaid Strategies for Expanded Use of Naloxone

- Formulations: Vial-and-syringe, nasal spray, auto-injectable
- Preferred Drug List placement
- Reviewing benefit design for barriers to access (e.g. prior authorization)
- Co-prescribing and at-risk prescribing
State Strategies for Expanded Use of Naloxone

- Making naloxone available without a prescription or third-party prescribing
- Overdose response training for professionals and laypersons
- Good Samaritan laws
- Community-based naloxone education and distribution programs reduce opioid overdose deaths
Polling Question – Introduction

• Has your state implemented any of the following strategies to combat the opioid epidemic?
  – Provider Education
  – Pharmacy Benefit Management Restrictions
  – Drug Utilization Reviews
  – Use of PDMP
  – Increasing Access to Naloxone
  – Expanding access to Opioid Use Disorder Treatment
State Experience: Washington

Charissa Fotinos, MD, MSc
Deputy Chief Medical Officer,
WA State Health Care Authority
Agenda – Washington

- Opioid Use in Washington
- Cross Agency Collaboration
- Provider Education
- Prescription Drug Monitoring Program
- Pharmacy Benefit Management
- Increasing Access to MAT
- Overdose Prevention
Opioids in Washington

- Rate of crime
- Publically funded treatment
- Opiate-related deaths
Cross Agency Collaboration

Collaborative Efforts
- AMDG Guidelines
- Chronic Pain Rules
- Prescription Monitoring Program
- Policy
- Statewide Plan
- Medication Assisted Treatment
Provider Education: Pain Management

• Older policy
  – Required state medical, nursing, dental, osteopathic, podiatric boards/commissions to develop rules around management of chronic, non-cancer pain

• Repealed permissive pain rules & mandated new rules addressing:
  – Opioid dosing criteria
  – Guidance on when to see pain specialty consultation
  – Guidance on tracking clinical progress via assessment tools
  – Guidance on tracking adherent use of opioids
## Updating Medical Director Guidelines

<table>
<thead>
<tr>
<th>Primary Focus</th>
<th>2010 Guidelines</th>
<th>2015 Guidelines</th>
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<tbody>
<tr>
<td>Mostly on chronic, non-cancer</td>
<td>Expands focus to include opioid use in acute, subacute &amp; perioperative pain phases &amp; in special populations</td>
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<td>pain</td>
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<tr>
<td><strong>Main Sections</strong></td>
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<tr>
<td>• Initiating, transitioning &amp;</td>
<td>• Recommendations for all pain phases: clinically meaningful improvement in function; dosing threshold; non-opioid options</td>
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<tr>
<td>maintaining patients on</td>
<td>• New section on reducing or discontinuing COAT</td>
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<tr>
<td>chronic opioid analgesic</td>
<td>• New section on recognition &amp; treatment of opioid use disorder</td>
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<tr>
<td>therapy (COAT) w/ principles</td>
<td>• New section on opioid use disorder in special populations: pregnancy, NAS, children, adolescents, older adults, cancer survivors</td>
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<tr>
<td>on safe prescribing</td>
<td>• Expanded sections on tapering &amp; opioid use disorder</td>
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<td>• Optimizing treatment for</td>
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<td>patients on &gt; 120mg/day MED</td>
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<tr>
<td>• Brief sections on getting</td>
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<td>discontinuing COAT</td>
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Prescription Drug Monitoring Program

• Data Sharing with Medicaid
  – WA State Department of Health is authorizes under RCW 70.225 to provide prescription data from PDMP to the Health Care Authority (HCA) for Medicaid recipients
  – Monthly updates based on matching records to a recipient file that HCA provides
Prescription Drug Monitoring Program: Patient Review & Coordination Program

- Aimed at over-utilizing clients
- Client & provider education, coordination of care
- Minimize medically unnecessary services & drug misuse
- Assist providers in managing PRC clients by providing resource information
- Narcotic Review Program: focused on chronic non-cancer pain
- Targets clients on highest MED and applies authorization as indicated
Prescription Drug Monitoring Program: What did we look at?

- High (120mg+) MED dose
- Opiates combined with benzodiazepine &/or muscle relaxants
- Previous opioid-related adverse event with current prescription
- Pill volume for chronic, non-cancer pain
- Clients paying cash
  - Clients cross reference
  - ID pharmacies
## Interventions

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<tr>
<th>Intervention</th>
<th>Data</th>
<th>Action</th>
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| Pharmacy     | • FFS & MCO clients that do not have a rejected claim on file for same prescription  
• FFS who have a rejected claim for the same prescription before the cash purchase | • 1783 incidents of cash pay were targeted  
• Top 13 pharmacies were notified                                                                                                                                                                    |
| Prescriber   | • Diagnosis of opioid adverse events  
• At least 1 ep. of poisoning  
• At least 1 Rx>120 mg morphine equiv. dose  
• ED poisoning ep., AND  
• Received at least 1 opioid Rx in last quarter of 2014                                                                                                                                  | • 88 Medicaid prescribers were identified to receive a letter of concern                                                                                                                                 |
| MCO          | • High risk previous overdose clients (see previous specifications)  
• Cash pay clients  
• PRC client’s PMP record                                                                                                                                         | • All contracted Medicaid managed care organizations received PMP data                                                                                                                                 |
Pharmacy Benefit Management

• Changes to Methadone Access
  – Has been on the Medicaid Preferred Drug List & did not require prior authorization
  – As of October 2015, methadone requires prior authorization approved by WA State Pharmacy & Therapeutics Committee
    • Must have tried and failed 2 other long-acting opioids
    • Maximum starting dose restrictions
  – Future removal from Medicaid Preferred Drug List is likely
### Increasing Access to MAT: Changes to Medicaid Guidelines

<table>
<thead>
<tr>
<th>Buprenorphine monotherapy</th>
<th>Covered only for pregnant women who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate/severe opioid use disorder</th>
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<tbody>
<tr>
<td>Buprenorphine/ Naloxone</td>
<td>Covered for all non-pregnant individuals age 16 or older who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate/severe opioid use disorder</td>
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<tr>
<td>Treatment Facilities</td>
<td>Treatment in a DSHS approved facility is encouraged, but not required for initiating MAT with buprenorphine</td>
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Overdose Prevention

• May 2015, ESHB 1671 Passed
  – Allows health care practitioners to prescribe, administer, distribute opioid OD reversal medication directly or via a collaborative drug agreement or standing order to anyone who might witness an overdose. Adds to prior legislation.
  – Liability Protection
    • Persons possessing & administering these drugs are protected if acting in good faith & with reasonable care
    • Prescribers protected if issued as part of legitimate medical purpose & as part of usual professional practice
  – Increasing Access to Help
    • Persons administering drug must encourage person with OD to seek care
    • Persons seeking care for someone with OD, person experiencing OD are protected from possession charges
Overdose Prevention, continued

Naloxone Distribution as of April 2015

Naloxone distributed to bystanders or carried by police

Community outreach
Jail
Medical provider
Medical van
Pharmacy
College staff
Police
State Experience: Oregon
Removing the Preferred Status of Methadone for Pain in Oregon’s Pharmacy Program
Lisa Millet, MHS
Injury & Violence Prevention Manager,
Public Health Division, Oregon Health Authority
Agenda - Oregon

- Epidemiologic Investigation to Understand How Methadone Contributed to Mortality in Oregon
- Oregon Health Authority’s State Pharmacy Director Actions
- Summary
Epidemiologic Investigation: Working Group Objectives

• Matt Laidler, MPH, Injury Prevention Epidemiologist created a special report for an agency wide Prescription Opioid Overdose Prevention workgroup

• Working group objectives
  – What are the magnitude and trends in sales, morbidity and mortality?
  – What are the relative rates by drug and drug type?
Drug poisoning mortality: rate and frequency by year and select drug type, Oregon, 1999-2008

Oregon Public Health Division-Injury Prevention Program

*2008 mortality data are preliminary; drug death categories are not necessarily mutually exclusive—deaths may involve multiple drugs. Includes unintentional and undetermined drug poisonings. Data source: Oregon Center for Health Statistics mortality data file.
Epidemiologic Investigation, part 2

Retail distribution of methadone in Oregon and poisoning mortality rate associated with methadone in Oregon, 1999-2006

- Grams sold/100,000 population
- Methadone death rate

Note: grams sold on left axis, death rate on right axis

Source: US Dept. of Justice, Drug Enforcement Administration, Office of Diversion Control, Automation of Reports and Consolidated Orders System (ARCOS); Oregon Center for Health Statistics mortality data files. Includes unintentional and undetermined intent deaths.
Epidemiologic Investigation, part 3

Drug Poisoning mortality: the role of methadone, Oregon, 1999-2008

2008 data are preliminary. Categories are not mutually exclusive - many deaths simultaneously involve several types of drugs. Includes only deaths with an X40-X44 & Y10-Y14 ICD-10 code for underlying cause of death (unintentional and undetermined intent).
Epidemiologic Investigation: Report Findings

• Methadone contributed to much of the increase in overdose deaths

• Methadone
  – Very low cost opioid compared to alternatives
  – Pharmacological properties of the drug may increase the risk of adverse outcomes—including death
  – Drug often stays in the blood stream longer than the pain relieving effects
  – Drug’s half-life partially depends on the individual taking the drug, so treatment must be adapted to each patient
Removing Methadone from Preferred Status on the Medicaid Formulary

• Push from State Pharmacy Director, Tom Burns
  – Presented the epidemiologic data to the OHA’s Prescription Opioid Overdose Prevention working group
    • Highlighting that methadone accounted for nearly 50% of prescription drug overdoses
    • Persons with a history of mental illness and substance use were over-represented in overdose deaths
  – Discussed high mortality among persons taking methadone for chronic pain with Pharmacy & Therapeutics Committee (Oregon Medicaid)
    • State Pharmacy Director asked the committee to remove methadone’s preferred status
    • Committee voted to remove preferred status
    • Change went into effect in January 2014
Oregon Health Authority’s State Pharmacy Director Actions

Annual Rates of Overdose Mortality, Prescription Opioids and Heroin, Oregon, 2000-2014

- Prescription Opioid Overdose Mortality Rate
- Heroin Overdose Mortality Rate

Crude Rate per 100,000

Summary - Oregon

- Improved outcomes for patients, communities, provide a return on investments made to address the problem
- This is a winnable battle
  - Saves lives
  - Improves patient safety
  - Improves community safety
  - Creates a bridge to recovery and better health outcomes

Partnerships focused on simultaneous implementation of key strategies
Polling Question - Oregon

• Has your state implemented any of the following restrictions on methadone? Select all that apply.
  – Removed from PDL
  – Introduced new clinical criteria
  – Prior authorization requirement
  – Step therapy/quantity limits
  – Other restriction(s)
  – No change- full access remains
Discussion and Questions - Oregon
State Experience: New York

Robert Kent, JD
Chief Counsel, Office of Counsel and Internal Controls, Office of Alcoholism & Substance Abuse Services (OASAS)
Agenda – New York

• Legislative Changes to the Prescription Drug Monitoring Program
• Changes in Prescribing Behavior
• Keys to Success
• Other State Initiatives
Early PMP Usage

• In February 2010, Bureau of Narcotic Enforcement implemented a prescription monitoring program (PMP)
  – Provided secure online access to patients’ recent controlled substance prescription histories

• Available to practitioners only
  – Available 24 hours a day, 7 days a week
  – Underused

• Between February 16, 2010 & June 16, 2013
  – 5,087 practitioners (of a population of over 100,000 practitioners) conducted only 465,639 searches
Implementation of I-STOP Act

- On August 27, 2013, the updated PMP and the mandatory duty to consult was officially implemented
- Internet System for Tracking Over-Prescribing (I-STOP) Act

Since then...

- Over 34 million PMP searches performed
- On more than 11 million patients
- By over 98,000 searchers
Change in Prescribing Behavior

- 8.7% decrease in total prescriptions
- 10.4% decrease in patients with a prescription
- 10.3% decrease in total quantity dispensed
- Largest decreases were for codeine 5 (-24%), hydrocodone (-17.7%), codeine 3 (-14.3%)
- Increases for fentanyl (3.5%), morphine (2.2%), oxycodone (0.2%)
Results: “Doctor Shopping”

Doctor Shopping decreased by 75% in the first year of the mandated use of the PMP.

82% decrease between 4th Quarter 2012 and 4th Quarter 2014.
Keys to Success

• **Mandatory** for all prescriptions
• Provider friendly
  – Investment in usable interface
  – Allow designated assistant to check PMP
• Education and outreach to providers
Next Steps – New York

- Interstate data sharing with other PMPs
- EHR integration
- Expanded data analytics
- Opioid prescriber education
Other State Initiatives

- State Parity Law
- Removal of ‘Fail First’ Requirements
- Standardized use of criteria to determine level of care for Medicaid beneficiaries
State Experience: West Virginia
James Becker, MD
Medical Director, WV Bureau for Medical Services

Rahul Gupta, MD, MPH, FACP
Commissioner, State Health Officer, WV Department of Health and Human Resources, Bureau for Public Health
Agenda - West Virginia

• Identifying the Problem in West Virginia
• Medicaid and DHHR Action Steps
  – Methadone & Non-Methadone Treatment Options
  – Prescription Drug Monitoring Program
  – Best Practice Prescribing
• Other State Partnership Initiatives with Medicaid
  – Statewide Helpline
  – Naloxone
  – Needle Exchange
Identifying the Problem in
West Virginia: Illicit Drug Use

• Approximately 8.4% of WV residents report past-month illicit drug use
  – National average is 8.82%
  – Illicit drugs include street and prescription drugs used for nonmedical purposes

• Between 2009-2010, WV was one of the top 10 states for drug use
  – Illicit drug dependence, 12 or older
  – Past-year nonmedical pain reliever use, ages 18-25
  – Past-month illicit drug use (excluding marijuana), 12 and older

Source: Substance Abuse and Mental Health Services Administration. State Estimates of Substance Use from the 2009-2010 National Survey on Drug Use and Health.
Identifying the Problem in West Virginia: Overdose Rate

2007: Per 100,000 drug poisoning death rate is 12.7 nationally & 22.4 in WV

2013: WV’s per 100,000 drug poisoning death rate is 32.2

2013: WV far surpasses second-highest state, KY, whose rate is 23.7 per 100,000

2013: WV drug poisoning death rate) is 2.3 times higher than national rate of 13.8

WV has the highest rate of all-drug overdose deaths in the US

West Virginia Action Steps

- Full Implementation of PDMP
- Medicaid Efforts through DUR, Medical/Pharmacy Units
- Community Involvement
- MAT Coverage: Buprenorphine, Naltrexone
- WV Governor’s Substance Abuse Task Force
- Boards of Medicine & of Pharmacy Adopt Best Practice Educational Efforts
WV Medicaid Coverage of Methadone

• Not Covered for Methadone Maintenance
• Approved only for the treatment of refractory neuropathy & some cancer pain
• Prior authorization required as of January 1, 2014
• Not covered for treatment of drug addiction
• Non-methadone treatment options for opioid addiction
  – WV Medicaid does cover Suboxone, Subutex, Vivitrol
  – All drugs require a prior authorization
  – Strict management including counseling requirement
Non-Methadone MAT

**Therapy/Visit Requirements**
- ☐ 4 hours of therapy/month
- ☐ 1 hour individual therapy is required of the 4 hours requirement
- ☐ 2 urine drug screens/month

**Initial Dose Requirements**
- ☐ Maximum is 24mg/day for 60 day period
- ☐ Prior Authorization is available in exceptional cases

**Maintenance Dose Requirements**
- ☐ Maximum is 16mg/day
- ☐ Tablet splitting for lower doses is required when appropriate
WV Prescription Drug Monitoring Program

- WV Board of Pharmacy collaborates with Medicaid to allow access to prescription database for drug utilization review

- Review of appeals takes place to analyze of use by payment type (i.e. Medicaid, cash, private insurance)

- WV Board of Pharmacy sends letters to providers of individuals filling prescriptions in multiple locations & when patients are admitted to the ER
Best Practice Prescribing

• Medicaid DUR Initiatives
• State legislative requirements for Continuing Medical Education Programs
  – WV State Code 30-1-7a, Legislative Rules 11CSR6 & 11CSR1B
  – Successful completion of training provides 3 hours of AMA Category 1 CME
    • Required for license renewal criteria for all Board of Medicine licenses
  – Progress: 38 Continuing Medical Education trainings on Approved Best Practice and Drug Diversion Training have taken place in WV since 2013
    • Trainings for physicians
    • Approved by WV Board of Medicine
Other State Partnership Initiatives with Medicaid

First Response
- 24-hour, year-round call center with in-person call takers
- No one is placed on hold
- Immediate in-call crisis support linkage
- Support timely access to services

Local Support
- Expanded community outreach to support callers
- Single point of contact to learn about & access statewide SUD treatment resources

Mitigate Service Gaps
- Identify service gaps
- Provide data collection & analysis aimed at highlighting outcome measures & supporting providers’ data-driven decision-making
Other State Partnership Initiatives with Medicaid, continued

- Medicaid provides free naloxone syringes for inhalation and injection without prior authorization or quantity limits
- Increase in family members of opiate dependent individuals wanting access so they can store naloxone in their homes
- As of 5/27/15, law requires all first responders (EMTs, firefighters, police) to carry Naloxone
- As of 11/12/15, WV Board of Education allows Brooke Co. schools to stock a overdose resuscitation drugs
Polling Question - West Virginia

• Has your state implemented any of the following activities to improve access to Naloxone? Select all that apply
  – Included on PDL
  – Community training in OD prevention/response
  – Co-prescribing w/ opioid analgesic
  – Available w/o prescription
  – Other
  – No current initiatives for Naloxone
Discussion and Questions - West Virginia
Polling Question - Conclusion

• Would your state be interested in having a post-webinar discussion with the speakers to address any additional questions or reflections on today’s webinar?
  – Yes
  – No
Resources

- **State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose: A Report for the National Association of Medicaid Directors.** Mercer.

- **Opioid Overdose Toolkit.** Substance Abuse and Mental Health Services Administration.

- **National Alliance for Model State Drug Laws Website**
Resources, continued


- *Best Practices for Prescription Monitoring Programs*, Prescription Monitoring Program Center of Excellence, Brandeis University
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