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KATE BROWN
Governor

Opioid Epidemic Task Force Meeting #8

July 16, 2018

1:00am – 3:00pm

Location: DCBS; Labor & Industries Building; 350 Winter Street NE, Room F, Salem, OR 97301;

1) Welcome

DCBS report was commissioned as part of our legislative package HB 4143 in 2018. Will help shape what the Task Force does in 2019.

Ferraris and Williamson on the phone

2) Updates from the Governor's Office

Holly Heiberg from OHA reported to Jeff that there is 70% of those who have a DEA license/registration # have signed up for the PDMP. This came out of legislation for mandatory registration for licensed practitioners or prescribers. May not hit 100% because not everyone is a prescriber.

Governor will be the chair of the Housing and Human Services Committee for the National Governor's Association (NGA). She was previously the vice-chair. She will be attending a joint plenary session with the Homeland Security and Public Safety Committee. Governor Brown and Minnesota governor Dayton will host the panel "An Evolving Crisis, Combatting the Next Wave of Addiction." This is about the intersection of public safety and public health as it relates to the opioid crisis.

Timeline for legislation. Today's meeting is important so we may hone in on what we are going to be doing for our 2019 legislative concept. There is a placeholder with LC.

3) **HB 4143 Report from DCBS on Barriers to Accessing Treatment and Recovery Services; Rick Blackwell – Policy Manager for the Division of Financial Regulations, DCBS**

Will be issuing a version 1.1 to ensure that names, publications dates, etc. around the report are included.

4143 directed to report on barriers to treatment and recovery from substance use disorder (SUD) and then make recommendations to address those barriers. The OETF has been

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working, but needed some work that was part of 4143 to continue efforts towards potential legislation in 2019.

Essentially, the report is a giant menu of policy options for the OETF to consider as they head towards 2019 legislation. One guiding principle to consider while figuring out how to choose from the menu of options is, which of these recommendations best address the issue of SUD as a chronic condition? As we talk through the report will identify those areas that might help address that issue.

Where possible, tried to make sure that private and public payers were integrated across all boundaries no matter who is paying the bills. Wanted to make sure the report was as consistent as possible around that.

Not all recommendations will require legislation.

Forward (pg 12) brings up the issue that diabetes is managed chronically and has half the potential impact on public health as SUD, but they are treated completely different. Indicates we may want to look at SUD a bit differently.

Regarding medication assisted treatment (MAT), believes that the report needs to have establishment of the biological causes for deeming SUD as a chronic condition, and talking about the brain pathways.

The drugs that we talk about in the report are offering clinicians different tools at different stages to address SUD. We look at SUD as a concept. Which drugs are the best are going to be dependent on different circumstances in a different time.

Q/Comment: I like the idea of a formal recognition, but what effect does it actually have on reimbursement systems, or things like that?

A: Turn the policy ship in a direction towards recognizing if the care is treated something chronic and not acute, a lot of options flow from that policy choice. Those legislative findings are important.

Q/Comment: I think some of the examples that go throughout the report include coverage not just for acute episodes – i.e. overdose, but longer term recovery coverage. And how it gets integrated into the delivery system overall to support the chronicity of the illness. How setting that table can help then orient coverage, reimbursement, integration. The role as primary care providers and behavioral health homes.

Q/Comment: The idea of allowing to provided services without requiring that acute episode first. That can be an incredibly dangerous episode, including overdose. What could we actually do to affect change there? What would a policy look like that takes care of that?

Rick: That is something that we may need to bring back to the TF as a follow-up matter. We recognize that this recommendation needs to be put forward. What it looks like depends on making sure stakeholders have had a chance to look at a more specific proposal.

Q/Comment: I am concerned about mucking with the definition of (inaudible) primary care homes. If we manage to have SUD considered a chronic condition, it will automatically be

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included. In the expectations for longitudinal management of chronic conditions for patients in primary care homes. We just this past year added level 4 & 5 primary care homes. The important thing about Oregon's model and structure, is that it is from the patient's perspective. I am saying be cautious about how we use the model. If it is a chronic disorder than we should be treating it just like diabetes, which is an expectation for coordinated care management for any patients in a primary care home.

Q/Comment: I think the primary care homes standards advisory committee is expected to reconvene. I think looking to them for what is the right set of standards as we think about this a chronic illness. So it is not specific about what it is, but how would you as an advisory committee consider this as integration within the PCPH, given the understanding of a chronic illness.

Q/Comment: I want to make sure that we don't sound like we are forcing them to do something dramatically different. In part, because, if we are trying to destigmatize SUD by framing it as a chronic condition, like any other where you want to intervene before an acute episode – analogous to not waiting until someone has a hypoglycemic crisis before you treat them for diabetes. Calling it out separately could mitigate the impact of that effort.

Q/Comment: Rick said that not everything in the report will necessarily lead to a legislative concept. There are many other policies with the OHA and DCBS having the ability to influence things. Will there be an opportunity for legislative concept that assures that the private insurance industry is pulled along on the same standard?

Rick: If there are ways to support that policy direction without legislation, rulemaking of another method we could use through the department, certainly. If that is something where it doesn't appear that DCBS could make sure there is that kind of parity between payers, then legislation would be appropriate.

Q/Comment: Sorting as we go through – OHA can implement is one column, DCBS can implement is another column, needs leg fix is a third column and needs budget fix . . . there is obviously overlap between those four columns. It may be useful for us to sort the recommendations among those categories.

Q/Comments: Do call anywhere in here where there are other states that have figured out some mechanisms to deal with some of the issues of the ERISA market for insurance?

Rick: I don't know that anyone has solved the ERISA among other states. Going to NAIC in Boston in August.

Q/Comment: Would be grateful if you would explore that while you are there. One thing we ought to consider is the possibility of convening a business round-table with some of the larger employers that do self-insure, to have a frank conversation with them about the challenges. 25% of the state is covered through ERISA. 25% Medicaid, 25% traditional, individual or small group, 25% ERISA, 25% Medicare. That means 1 in 4 Oregonians, no matter what DCBS does, wouldn't have access to appropriate treatment.

Rick: To foreshadow one of our recommendations was for us to actively engage with DOL to see what we can do around ERISA, but there are other ways to get around the issue of ERISA as a preemptive.

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Q/Comment: I think that engaging the community rather than the businesses and say look, this is having a significant impact on your bottom line. We know that substance abuse is not confined to any one socio-economic demographic. We have got to be aggressive about bringing all the relevant groups to the table.

Q/Comment: The way they did it in New York a few years ago, they said all insurers must use consistent standards for SUD, then said what those standards were.

Q/Comment: I think we should make an assumption that almost anything is going to need some legislative work. What is solely the purview of the legislature as opposed to the agencies coming to legislature and saying we need you to do this for us? Let's assume the legislative column is mostly for the stuff that nobody else can do, and that there will be other things that filter into that column.

Rick: Next section is looking at the existing structures for reimbursement for SUD.

Q/Comment: Is everyone aware that we have just completed a mental health parity report and that we are in the middle of following up with coordinated care organizations on that report?

Dr. Hargunani: The first state level analysis of the evaluation looking at any concerns regarding mental health parity within the Oregon Health Plan has been posted, and by the fall we will have posted challenges in working on remediation of any identified concerns that will be worked on throughout the rest of this year.

Holly Heiberg: We made a one-pager fact sheet and we can send that out to everyone.

Q/Comment: There are concerns that there is another layer with a mental health practitioner getting on level of reimbursement for traditional mental health disorder and a lower level of payment for addiction treatment disorder. Some say that it isn't a legislative fix that is needed, it is something within OHA called a fee-for-service schedule. That feels like something that is doable.

Q/Comment: There are two rates of reimbursement for the same service by the same credentialed person.

Q/Comment: Not just parity between disciplines, but parity between the same kinds of folks who want services.

Q/Comment: The mental health parity evaluation would not get specifically at that. It is looking at any place where there are limitations on mental health and substance use benefits that are more stringent than medical or surgical benefits. In terms of the analysis under way, it would be outside the scope of that analysis.

Q/Comment: It gets to workforce issues. Because, if people aren't being reimbursed adequately, to provide the service depending on payer or analogous service. It's like saying a Gastroenterologist should get paid more to do a colonoscopy than a family physician should.

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Q/Comment: Another thing that happens with discrepancy, you see it in primary care service providers, hospitals are acquiring all of the direct service providers because hospitals get paid through Medicare/Medicaid and a premium compared to the direct provider. We are seeing the market shift as all of those direct providers get absorbed by the hospital complex in cities here in rural Oregon. You'll see the same thing happen wherever the discrepancy is – whoever gets paid the most will become the market leader. It is an interesting dynamic because we want to pay sufficiently and appropriately for the service the service, but at the same time we don't want to disrupt the natural market and the flow of who gets access to those services.

Q/Comment: I think it is going to be important as we move forward that we are clear when we talk about mental health, behavioral health and alcohol and drug treatment, that we are clear about what is included and not included. Sometimes people are talking about behavioral health and mental health and head injuries – but not substance use. It is going to be important that we be disciplined that way. We have pay inequities and it effects the industry's ability to sustain itself, to have a workforce.

Rick: The delivery of care, provider network. Network adequacy is a big issue on the commercial insurance side.

Q/Comment: Rep. Nathanson and I passed HB 3261 in the 2017 session that set up this new fund to set up more workforce training programs at the direction of the Health Policy Board and the Healthcare Workforce Committee. As we get into these workforce issues, we ought to be thinking about coordinating with the Health Policy Board and the Workforce Committee on using some of those funds specifically to target enhanced training opportunities for providers who could meet some of these needs. Especially those who will serve in rural or underserved areas. That is a pretty substantial fund of money and it is going to get bigger in the next biennium so we should be aware of that as an opportunity.

Q/Comment: Do you think you will need a legislative tweak for that or can you do it all by rule?

Rick: We will take a look and see if we can do it all by rule. If not, we will get back to you.

Q/Comment: We can change that definition in statute about network adequacy.

Q/Comment: With regard to time and distance applies to all of the rural sides of Oregon. There was an item in the report that mentioned something about Medicare only funded payments for “mental health institutions” that had 16 or more beds It's not only time and distance, but it is also some kind of available quantity or space or facility size because there is nothing with 16 slots anywhere on the east side. I don't really know in terms of time, distance, access, a lot of facilities on the east side are extremely small. That's coming from a federal level funding source. I don't know if those kind of caveats need to be addressed as well.

Hargunani: I think what you are referring to represented in the report is related to our inability to draw down Medicaid leveraged funding for those IMD residential entities with 16 beds or more. That is being focused on through a waiver approach that we are working on. I think your point is well stated about there being broader access issues across the state that don't even get to that 16 bed limit. I think there is some interconnection there. I think

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expanded access is addressed through some of these upcoming recommendations, but needs to be highlighted in this report.

Q/Comment: We should be thinking about telehealth too. Making sure that we've got the legislative language correct. We did some changes back in 2015 or 17 about paying for telehealth services. Telehealth is a great way to provide some of these services.

Q/Comment: Two of the critical drugs, Naloxone and Buprenorphine. There is no price competition of any kind going on. The price has become the price on people's lives.

Q/Comment: Sen. Linthicum and I both serve on the Task Force on Fair Pricing of Pharmaceuticals. Naloxone got Rep. Noble's attention because as a former police chief, he knew how much it cost to outfit his officers with Naloxone. We are starting to have some innovative conversations. There are some big hospital systems that are starting about creating their own non-profit, generic drug companies to make their own generic drugs. I think Oregon should be looking at joining into that. Making treatment more accessible means making the drugs more accessible.

Q/Comment: OHA had presented some ideas about bulk purchasing.

Q/Comment: Our pharmacy director has been participating on a National Governor's Association committee focused on opportunities around reducing pharmaceutical costs, particularly around public health crisis. There aren't any quick answers, but there are some strategies that are coming forward that we are actively looking at as a state. The report from the NGA workgroup will be coming out publically within the next month.

Q/Comment: Does the Governor's declared emergency fit in as one of those strategies?

Jeff: It was a declared public health crisis, not an emergency. It is more to bring awareness to the issue rather than kicking the whole emergency declaration framework into play the same way other emergency declarations do.

Q/Comment: If by going that next step, it would make some of the things Sen. Steiner-Hayward was talking about more likely.

Jeff: There is a very strict statutory framework that kicks in to gear when you do an emergency declaration. Perhaps we should have a larger conversation with this group and add it to the agenda to work through those steps and see if it is something we think is appropriate or not. There are other states that have done it and it has worked very well for them.

Q/Comment: There is a large amount of analysis happening right now – a third party consultant helping bring forward (inaudible) of what the opportunities and challenges are with requiring any kind of alignment across preferred drug lists between CCOs and fee for service. This is an exploration underway that would be presented to the Health Policy Board in August. It is not specific to MAT, but could be inclusive of.

Rick: Section on Utilization Management

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Q/Comment: You were talking earlier about a percentage of insurers who carry one medicine? I think you were talking about insurers who will pay for one medicine and saying we are adequately covered because (inaudible) will cover our medicine. It has something to do with the idea of step care, but only one medicine isn't much of a step.

Rick: The report noted that treatment medications were covered.

Q/Comment: Entangled in the discussion is whether there are any established standards of care for addiction treatment. In the metro area, there is a group that has basically finalized something for that. If you refer to a provider that doesn't offer MAT, you've got your network, you've got everything you need, but they are not actually offering what most people would consider a standard of care treatment. I find it shocking that there are no insurers in this state that don't use step therapy. I think they are lying to you or answering truthfully but not honestly. They are answering your question, but it doesn't actually get to the point of, are they providing access to modern addiction treatment? 100% is a big number and it would be shocking if that were true.

Q/Comment: Do we want to have standards of care for substance use? Again, I think we need to have a robust discussion about what is the standard?

Q/Comment: Also the training, the treatments that are offered and formulations (inaudible).

Q/Comment: Once you have the standard, who offers it, who pays for it What is the gold standard? What is it that we are trying to get everyone to consider?

Q/Comment: On the topic of the barriers, specifically the authorizations – I think including in the legislative potential, we don't have to formulate it here because there is a second group on it, but potentially the TF supporting efforts in plea-deal reforms to not allow plea deals to include barriers to treatment. In terms of looking holistically where we are authorizing treatment, reducing barriers and steps to that initial care, the work that is happening in terms of plea-deal reform to make sure that the plea deals did not include prohibitions on treatment early release could be helpful. Instead of authorizing, we would say you aren't "allowed to."

Q/Comment: Internally, as OHA was discussing what to put forward into this report, this was an area we saw where we could make a big difference very quickly within the organization.

Rick: Rural disparity

Q/Comment: Where does that fall? Is that DCBS or OHA or a combination.

Rick: It's a workforce issue primarily. It could also be an issue with reimbursement and that might be a DCBS issue.

Q/Comment: I'm looking at the recommendation about developing a comprehensive list. Is that you? Is it McElveen? They are working on developing an index of providers.

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Rick: The recommendation says payers should develop this list, including if they are able to accept Medicaid, so that might imply (inaudible). The recommendation just says “payers.” Nothing specific about which payers should be offering it.

Q/Comment: I know about the list and looking where the treatment providers are and where the beds are, etc., but I don’t know the status of that.

Q/Comment: The problem is there is a PDF, a very dated list. So I think the spirit of 3440 was we need a modern, up to date thing that is accessible on the web where people can look at a particular county. What is your menu, what do they accept, what are their hours, etc.

Q/Comment: There weren’t necessarily dollars attached to developing that website. We all worked together to make sure that bill passed at that point in session. Afterwards, we looked around and asked, how can we couple this with other grants and other opportunities in order to build this and what people really want out of this? That work is moving forward. I think at some point, Nichole Corban, who has been spearheading that for OHA could come in and talk about that. We meet once a month internally, and I am waiting for it to get through the approval process.

Q/Comment: Executive summary, page 9 – “a user friendly, comprehensive list,” that feels like the spirit, the idea that you could look stuff up.

Q/Comment: Everyone has had a little different idea of what that should be, and we want to make it as robust as we can.

Q/Comment: At the last meeting white board session, I think I added addiction resource connection center that knows where there is capacity, that is linked into the state’s drug and alcohol help line as well as to other connection points like ERs and primary care providers and law enforcement. When somebody bumps into somebody they can call the help line and say, I’ve got a 32 year old male, single with an addiction problem, where should I go?

Jeff: We had “treatment connection center.”

Q/Comment: I think it links in. You probably don’t need legislation to do it. You could probably do it under the auspices of the drug and alcohol help line contract.

Q/Comment: The bigger point is to leverage existing infrastructure, with Lines for Life or 211, we’ve got infrastructure that is already doing work like this and they are more appropriate for keeping information up to date than having OHA be responsible for that. It is better to outsource that work.

Q/Comment: Rick’s report talks about having the payers do it, which is an interesting alternative. Is it public and private payers together? Are they going to fund it and build it?

Rick: A lot of the commercial carriers already post their networks of their providers on their website. I think private payers are already doing some of that.

Q/Comment: I thought when we introduced this, we weren’t talking about how to access data. We don’t have enough providers to put on that list.

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Q/Comment: There is an app called “Scholly” that is designed to help students find scholarships. They track all the scholarship characteristics and a student can enter their own characteristics and find scholarships that they may be eligible for. There is a cool entrepreneurial opportunity here to think about leveraging modern technology because it would also empower people. We ought to be thinking about ways to leverage private sector stuff, and if we can get somebody to develop it, it is going to be sellable to almost any state.

Q/Comment: The trick is you have to make the providers buy into it.

Q/Comment: And we have to figure out how to link with the commercial insurers. Making it not just something that providers use, but that individuals can use easily in a platform that most people carry in their pockets regardless of where they live in the state.

Q/Comment: Perhaps the providers have to do it to remain accredited. Something, so it is not a burden on a state agency.

Q/Comment: There was an article in the NE Journal of Medicine last week about barriers to Buprenorphine (inaudible). Buprenorphine is a safe drug that is hard to overdose on, but it is expensive. Opioids are easy to prescribe, but there are a lot of restrictions and it intimidates people. That’s always going to be there at the federal level, and it’s always going to be a barrier to disseminating Buprenorphine (inaudible).

Rick: Some of the federal legislation that we noted in the back of the report, including HR6, does have some ability for providers to treat more patients without

Jeff: That is something that may go in my column of to do. The Governor in her capacity of the vice-chair of NGA’s HHS, put forward a letter backing that and other pieces of legislation that are out there. I can work with Blumenauer and Merkley’s office to make certain we are championing that effort.

a. DOC Perspective on the Report – Craig Prins, Inspector General

We wanted to be in this report. We appreciate the opportunity to talk about the barriers. Unfortunately, they are budgetary barrier. We want to partner for solutions with you all if we can. One of the things, on page 44, had a needs assessment done, lays out clearly that gap we have in resources for those in our custody with sever substance abuse problems. About 55% of our 14,800 inmates would use it and we have capacity for about 4%.

One of the recommendations is to seek technical assistance. Dawnelle has already been doing that with the National Institute of Corrections (NIC), Bureau of Justice assistance. They have offered to pay for travel for pharmacy to go back to Mass and RI, two systems who are using MAT. Going in October. We want to see how other states are dealing with this.

We have a DOC policy option package – DOC Policy Option Package 124, would provide a package for MAT. It also includes mail scanners. One of the new scanners can scan mail before it is opened, so we are hoping that we can clear more mail. Right now, if it looks suspicious we hold it and try to have one of our investigations teams look at it. Package also includes body scanners. Jails in Yamhill and Washington County are using body scanning

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equipment at intake to see if people have drugs secreted in their body. Part of the package is renewing our K-9 drug detection teams.

Q/Comment: If you have got someone who is going through a major life stress, that's not the time that you get them to quit smoking. Somebody going into corrections custody with the idea that they will be required to go cold turkey, without MAT or appropriate resources, we don't offer treatment until someone is pre-released. We should be helping them at the get-go, because that would get them more years of controlling their chronic illness before discharge and before reentry. There are some compelling arguments for front loading treatment in the system so people are not dealing with all the stress of not having their usual coping mechanism while they are adjusting to being in custody.

Our situation in corrections is actually a bit similar to the community when you start treating it as chronic vs acute. If you treat someone at the beginning of a 10 year incarceration cycle, continuing care and resources, is also an added expense. While we would love to do that, it is a resource issue.

Q/Comment: A lot of people spend all of their time incarcerated in jails, not DOC. Can we include something going forward that at least provides an incentive, if not a requirement for county jails to do appropriate assessments and standard care treatment?

Jeff: Does Mass or RI prioritize in their budget process offering the services or are they seeking outside grant funded opportunities?

Craig: Will follow up with National Institute of Corrections.

4) Debrief of OETF Trip to British Columbia

Q/Comment: Would like to have the TF spend time about what they are doing there and how it compares to Oregon. We talked about the advantage of declaring an emergency and how that facilitated them to move past where they were stuck. There is a lot of talk about meeting patients where they are at, which is very important. I was surprised they didn't try a little harder to utilize meeting patients where they are at and then moving them into a safer place. Buprenorphine didn't come up a lot. I personally think it is a really important tool, I've had a lot of experience with it and I wasn't hearing much about it. I think Vancouver skipped over it and went straight to Methadone and safe injection sites.

Q/Comment: The real focus is on harm reduction. That is the term we used a lot when we were talking about cannabis legalization, passing measure 91. It is the approach that many European countries and BC are taking. We know that just say no doesn't work. We know that pull yourself up by your bootstraps and grow a spine doesn't work. There is a fine line between enabling and harm reduction and we want to be careful not to cross that line. On the other hand, it is kind of like abstinence only sex education – it doesn't work and we know it doesn't work, it doesn't cut our pregnancy rate, increases our STI rate, doesn't keep kids from having sex. Having things like safe injection facilities, safe consumption facilities – prescription heroine program. On the other hand, it is a controlled dose and we know it's pure, we know its strength and know it isn't contaminated with Fentanyl. I think we need to be having conversations about how we have a really open mind about our options.

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Q/Comment: If we really want to decrease deaths, we should make safe, clean, appropriate dose opiates available to people. The overdoses are from taking the wrong dose, with the exception of some suicides. The medical complications, which are very expensive, are from unclean drugs. If that was actually our goal, it would be to provide that.

Q/Comment: There are challenges under federal law. There is a reason why we don't have any overdose prevention facilities. Facilities range from simply providing safe space, to a more medically controlled, to actually prescribing. The one that looks the least problematic to me under federal law would be basically just a facility, whether it was medically managed or not. The primary problem we have in the US is similar to the problem they had to overcome in Canada, which is the "crack house statute." Literal reading of that statute indicates that there is possibly an exception to that if it is approached from two angles: You would need specific state authorization to exercise the states plenary public health authority. You have to look at it from a public health perspective. Then you would need to authorize, by state, a research pilot project. I think you have a straight faced argument why the crack house statute might not apply. I am not sure about the mechanisms for actually getting someone to say that officially. I know Seattle has pushed pretty far, the city of New York has pushed pretty far, but I am truly not familiar with federal processes to get a judge to say whether this theory works. There might be room for conversation around this.

5) Meeting Scheduling and Closing Remarks.

Q/Comment: Wondering about today's work, ask our agency partners to tee up for us a summary in some form so we can figure out how to advise the governor on what we think the priorities ought to be out of that. How to take the recommendations and distill them in a way . . . maybe we don't have a role in that? Maybe that is you guys?

Jeff: Next meeting is where we will take the previous white boarding exercise, then take a look at this and try to create a synthesis and look at what our 2019 plan is going to be. Come prepared to discuss any and all the recommendations that we have already discussed. Which ones are at the top of the list for all of you?

Q/Comment: One of the points that was made was we can't do everything in 2019, and we should be laying out a 4-6 year plan. I don't want people thinking that it is now or never. I think we should be focusing on what does the trajectory look like? What are some of the early victories we can gain? How do we gain momentum? Where do we want to be three biennia from now? What is our pathway to get there?