Frequently Asked Questions about Florida's Opioid STR Grant

1. Are there any administrative dollars for the MEs?

A. No.

2. Is there funding available for outreach and awareness to advise the community about the availability of services and where services are available (assuming there is available capacity)?

A. Targeted outreach that aims to identify and link individuals with opioid use disorders to medication-assisted treatment providers is permitted.

3. What are the data reporting requirements?

A. Treatment providers are required to use OCA MSOPM when completing service records for events that are funded by the Opioid STR grant. Service records should also have accurate, eligible covered service codes included. The Department will extract records from SAMHIS and the monthly ME invoice to comply with data reporting requirements. Please note that SAMHSA may add reporting requirements at a later date.

4. Can Opioid STR funds be used to purchase residential or inpatient detox beds?

A. No. The only treatment services authorized are identified in the Chart 8 for OCA MSOPM.

5. According to the application, "grant funds will be used to pay for methadone and buprenorphine maintenance treatment for indigent, uninsured, and underinsured individuals in need, which may include screening and assessment, lab work, cost of the medication, medication administration, therapy, peer support, and other services or supports to assist the individual's recovery." Exactly what other services and supports can be paid for using the methadone and buprenorphine maintenance?

A. Individuals with opioid use disorders who are receiving methadone, buprenorphine, or naltrexone can also have the following services paid for using Opioid STR funds:

- Aftercare
- Assessment
- Case management
- Day care
- Day treatment
- Incidental expenses (housing/rental assistance and direct payments to participants are disallowed)
- In-home and onsite
- Medical services
- Medication-assisted treatment
- Outpatient
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
- Recovery support
- Outpatient detoxification
- Supported employment
- Supportive housing/living
- Crisis support/emergency

6. Why isn't Vivitrol (naltrexone) lumped together with the methadone/buprenorphine allocation?

A. The Florida Alcohol and Drug Abuse Association (FADAA) will be managing the Vivitrol services and the associated allocation through their existing program. Funding for methadone and buprenorphine maintenance treatment, and oral naltrexone, will be administered by the Managing Entities.

7. Can Opioid STR funds go to programs that deny individuals access to their services because they are using pharmacotherapy for opioid use disorder supplied through a valid prescription?

A. No. Opioid STR funds cannot go to any providers that exclude individuals who are taking medications like methadone, buprenorphine, or naltrexone as prescribed.

8. Is it okay for a provider to admit someone on buprenorphine and then encourage them to taper off and get on Vivitrol instead?

A. No. Persons served may be provided choices consistent with the prescriber's recommendation. More specifically, the Funding Opportunity Announcement states:

> Funds may not be expended through the grant or a subaward by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine.) Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider. In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Grantees must assure that clients will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

Furthermore, according to the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use:

- The choice of available treatment options for addiction involving opioid use should be a shared decision between the clinician and the patient.
- There is no recommended time limit for treatment with buprenorphine.
- Patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly.

9. What can Opioid STR treatment funds be used for?

A. OCA MSOPM can be used to pay for oral naltrexone, and methadone and buprenorphine maintenance treatment. Indigent, uninsured, and underinsured individuals with opioid use disorders who are receiving Vivitrol, methadone or buprenorphine maintenance treatment can also have the following services paid for using Opioid STR funds:

- Aftercare
- Assessment
- Case management
- Day care
- Day treatment
- Incidental expenses (excluding housing/rental assistance and direct payments to participants)

- In-home and onsite
- Medical services
- Medication-assisted treatment (methadone maintenance, buprenorphine maintenance, and oral naltrexone)
- Outpatient
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
- Recovery support
- Outpatient detoxification
- Supported employment
- Supportive housing/living
- Crisis support/emergency

Funds may be used to offset deductibles and co-pays for individuals with opioid use disorders who are receiving medication-assisted treatment. Oral naltrexone, but not the injectable Vivitrol, can be paid for using OCA MSOPM. The Vivitrol funds administered through FADAA will pay for screening, assessment, and medication administration.

10. What are prohibited/unallowable uses of Opioid STR funds?

A. Funds may not be expended by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine, or naltrexone). In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Grantees must assure that clients will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription. Additionally, Opioid STR funds may not be used for the following purposes:

- To provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).
- To make direct payments to individuals to induce them to enter prevention or treatment services.
- To make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals.
- To pay for the purchase or construction of any building or structure to house any part of the program.
- To pay for housing.
- To pay for inpatient, residential, and any other covered services that are not listed in the Chart 8 for OCA MSOPM.
- To supplant (or replace) existing funds for services.

11. Is there flexibility in the financing of these services outside of fee for service? Can the Managing Entity negotiate a case rate for OUD services?

A. Managing Entities may use any payment mechanism outlined in s. 65E-14.019, F.A.C. (fee-for service rate, case rate, capitation rate, or cost reimbursement).

12. In what category are drug screens billed?

A. Drug screens can be billed under medical services or incidentals. Drug screens can also be bundled into the rates that are negotiated for other covered services.

13. How is limited targeted outreach being defined?

A. It is outreach designed to identify and link individuals with opioid use disorders into medication-assisted treatment.

14. What are the outcomes for these funds? How will the feds measure our efforts at meeting the STR grant outcomes?

A. Service records linked to OCA MSOPM will be extracted from SAMHIS to satisfy federal reporting requirements.

15. How will patients receiving services with STR funds be tracked?

A. Providers need to ensure that service records are linked to OCA MSOPM and use accurate, eligible covered service codes.

16. What are the procedures to ensure these funds are not supplanting?

A. Providers and Managing Entities are responsible for ensuring that Opioid STR funds supplement and not supplant (or replace) existing funds for prevention, treatment, and recovery support services.

17. What are recommended procedures for purchasing buprenorphine for patients and tracking the costs of the medication?

A. We encourage the MEs to share effective procedures for purchasing medications and tracking the costs.

18. Who will oversee the clinical positions and peer specialists to support the CPI workforce interface with ME, providers and ER staff?

A. The DCF Regional Offices.

19. Is there any prohibition in using these funds to create a bridge between the ER and treatment?

A. Outreach designed to identify and link individuals with opioid use disorders into medication-assisted treatment is an authorized covered service.

20. Can private, for-profit providers assist in the activities outlined in the STR grant?

Q. The Department reached out to SAMHSA for additional clarification regarding the permissibility of funding for-profit entities. A response is pending.

21. Can individuals who are not members of the listed priority populations be served under this grant?

A. Opioid STR-funded treatment and recovery support services can be provided to indigent, uninsured, and underinsured individuals with opioid use disorders. Preference in admissions should be granted to individuals with the following characteristics in the order presented:

1. Pregnant women who are injecting opioids
2. Pregnant women
3. Caretakers involved with child welfare
4. Caretakers of children ages 0-5
5. Individuals re-entering the community from incarceration.

Individuals who do not fall into one of the five categories listed above can still receive Opioid STR funded services as long as they are indigent, uninsured, and underinsured individuals with opioid use disorders

22. Are there plans to provide prevention services through the STR grant?

A. There are two prevention components in Florida's proposal: overdose prevention through naloxone distribution and school-based life skills training in high-need rural counties.

23. Why is school-based life skills training being directed to rural communities?

A. Research demonstrates that rurality is a unique and important risk factor for prescription opioid misuse. Using 2008 data from the National Survey on Drug Use and Health (NSDUH), researchers compared adolescents who reside in urban/large metropolitan areas to those in rural/non-metropolitan areas. They found that adolescents in rural/non-metropolitan areas are significantly more likely to have ever misused prescription pain relievers, even after controlling for sociodemographics, health, and other drug use. More recently, researchers using 2011 and 2012 NSDUH data found that adolescents in rural areas have 35% greater odds of past-year prescription opioid misuse compared to adolescents in large urban areas, even after controlling for multiple risk and protective factors. The same pattern is observable using 2012-2014 Managing-Entity-level NSDUH estimates of the prevalence of nonmedical pain reliever use. Across all age groups, the BBCBC region, with more rural counties than any other region, has the highest prevalence of nonmedical pain reliever use. In contrast, the SFBHN region, which is home to the most populous metropolitan area in Florida, has the lowest prevalence of nonmedical pain reliever use.

In discussing rurality as a main risk factor, researchers emphasize that high prescription opioid misuse among rural adolescents is particularly concerning "because of inadequate treatment services in rural areas already overwhelmed with increasing treatment demand, long distances to providers, and transportation barriers that are burdensome for accessing regular opioid outpatient treatment." Furthermore, research shows that the drug overdose burden is 45% higher in rural areas than it is in urban areas and that rural communities are disproportionately affected by underutilization of the opioid overdose reversal agent called naloxone.

Finally, rigorous evaluation research tells us that prescription drug misuse among rural students is preventable. Randomized controlled trials of school-based life skills training in rural communities demonstrate significant reductions in prescription opioid misuse.

24. Can Opioid STR funds be used to purchase the myStrength mobile app?

A. We are posing this question to SAMHSA and a response is pending.

25. Can funds be used to pay for oral naltrexone, as opposed to the injectable Vivitrol that is paid for through FADAA?

A. We are posing this question to SAMHSA and a response is pending.

26. How are patients receiving VIVITROL from FADAA and clinical/support services from a provider through the ME going to be counted to ensure there is no duplication of count?

A. We are working on a solution to this issue.

27. Can providers use a spreadsheet to track expenditures until the OCA is added in SAMHIS and reconcile later?

A. The OCA was added to SAMHIS on May 11th. If providers need time to add the OCA to their systems, a spreadsheet may be used initially, if the ME approves. No spreadsheets can be submitted to headquarters though. All data must be reconciled into SAMHIS no later than July 31, 2017.