ACAP
Association for Community Affiliated Plans

Responding to the Prescription Opioid Crisis

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CHAPTER 1

Executive Summary

Congress and policymakers at the state and federal levels—and health professionals in all 50 states—are currently walking a high-stakes tightrope. They are grappling on the one hand with ways to address the treatment needs of millions of Americans who live with chronic, severe pain, while at the same time combatting the nation's opioid crisis—which is diverting substantial health care resources and leading to tens of thousands of lives lost per year.

In November 2016, the U.S. Surgeon General released *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, the first report by a Surgeon General on substance overuse and substance use disorder (SUD).[1] In early December 2016, Congress passed the 21st Century Cures Act, which includes $1 billion in funding to help states address opioid misuse and overuse issues.[2] Governors, states, and policymakers are also focused on this epidemic. In July 2016, the National Governor's Association introduced an Opioid Compact for governors to sign to reinforce their continued commitment to build efforts to fight opioid addiction.[3]

Opioid misuse is a significant public health crisis in the United States which disproportionately affects poor and disabled Americans and impacts the parts of the health care system serving those populations—largely financed through the Medicaid program. ACAP-member Safety Net Health Plans have a long history of working with low-income, vulnerable populations and are now on the front lines, creating multi-faceted, comprehensive solutions to prevent and treat opioid overuse and misuse.

This qualitative analysis builds on ACAP's 2015 report, *Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative*,[4] and takes a more detailed look at innovations and best practices being developed by five ACAP member plans, including: Partnership HealthPlan of California (PHC), Inland Empire Health Plan (IEHP), Community Health Plan of Washington (CHPW), Neighborhood Health Plan of Rhode Island (Neighborhood), and University of Pittsburgh Medical Center (UPMC) *for You* Health Plan. Its aim is twofold—to explain the role of Medicaid managed care plans in addressing a public health crisis, such as the opioid epidemic, and to serve as a resource to other health plans, providers, and stakeholders looking for best practices in addressing opioid overuse and misuse.

The approaches outlined below range from managing access to opioids to encouraging providers to offer Medication Assisted Treatment (MAT), an evidence-based approach to managing opioid addiction. Lessons learned and key policy takeaways describe the essential role Medicaid managed care plans play in creating linkages to ensure individuals suffering from opioid misuse get necessary care, and the importance of addressing opioid overuse and misuse on multiple fronts—from prevention and managing access to education and treatment.

Notes

1 U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016. Available at https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf

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3 National Governors Association, "A Compact to Fight Opioid Addiction," National Governors Association. July 13, 2016. Available at https://www.nga.org/cms/Compact-to-Fight-Opioid-Addiction

4 Association for Community Affiliated Plans. 2015. *Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative*. Available at http://www.communityplans.net/research/strategies-to-reduce-prescription-drug-abuse-lessons-learned-from-the-acap-sud-collaborative/

CHAPTER 2

Introduction: Prescription Opioid Overuse and Misuse

Although the amount of pain Americans are reporting has not increased since 2000,[5,6] the number of opioids prescribed has been increasing at a startling rate. According to the U.S. Centers for Disease Control and Prevention (CDC), health care providers in the United States wrote 259 million prescriptions for opioid painkillers in 2012, or "enough for every American adult to have a bottle of pills."[7] The vast number of prescriptions for opioids is a recent phenomenon: between 1999 and 2014, the amount of prescription opioids sold in the United States nearly quadrupled.[8]

As the prescribing of these drugs has rapidly increased, so have the negative effects related to their overuse and misuse. Deaths from prescription opioids almost tripled between 1999 and 2014.[9] The estimated number of emergency department (ED) visits involving nonmedical use of opioid analgesics increased from 144,600 in 2004 to 305,900 in 2008.[10]

Medicaid is the largest source of health coverage and the biggest funder of behavioral health services in the United States.[11] By the end of 2016, Medicaid covered almost 75 million, or one in four, Americans[12]—approximately 10.7 million of whom gained access under Medicaid expansion.[13] An estimated thirty percent of the Medicaid expansion population, a previously uninsured group, lives with a mental illness, SUD, or both.[14] ACAP plans have a great deal of experience providing essential coverage to both the traditional Medicaid population and people who are newly eligible under ACA expansion.

ACAP is a trade organization that represents 60 not-for-profit Safety Net Health Plans that serve the Medicaid population as Medicaid managed care organizations. Most ACAP plans focus on serving members is a single state or locality.

Health plans which serve the Medicaid market are on the forefront of the opioid crisis. Research indicates that Medicaid enrollees are prescribed painkillers at twice the rate of non-Medicaid patients.[15] The impact of this overprescribing is significant: studies found Medicaid members to be at three to six times the risk of prescription painkiller overdose compared to non-Medicaid members.[16] Arizona, for instance, found that its Medicaid program paid for more than half of all opioid-related ED admissions in the state in 2010.[17]

Treatment is a key component of addressing the opioid crisis. Access to insurance coverage is proving essential to addressing the needs of people who suffer from opioid overuse and opioid use disorder (OUD), as cost is one of the key barriers to treatment. With the coverage expansion under the Affordable Care Act, "the share of people foregoing mental health care due to cost has fallen by about one-third for people below 400 percent of the federal poverty level" between 2010 to 2015, according to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the Department of Health and Human Services.[18]

ACAP Member Plans and the Opioid Crisis

Thirty-nine states, including Washington, D.C., turn to Medicaid managed care organizations (MCOs) to manage some or all of their Medicaid programs.[19] Medicaid MCOs serve nearly 2 in 3 Medicaid enrollees—63 percent.[20] ACAP-member plans highlighted in this report have historically served Medicaid and other low-income, high-need, vulnerable populations, which are more likely to be affected by prescription drug misuse. With this experience managing care for these populations, ACAP-member plans offer an important perspective for addressing the opioid crisis and identifying best practices and takeaways for other plans, stakeholders, and state and federal policymakers.

ACAP has made a priority of working with its member plans to facilitate the development and exchange of innovations and best practices for the prevention and treatment of prescription opioid overuse and OUD. Under a grant from the Open Society Foundation, ACAP and its member plans have been engaged in an ongoing effort to develop and collaborate on innovative approaches to reduce and prevent prescription drug overuse, including opioid painkillers. In 2013, ACAP organized a collaborative of 13 of its member plans to develop and implement programs targeting prescription drug misuse among the plans' enrollees.

This qualitative analysis builds upon ACAP's 2015 report, *Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative*, and takes a detailed look at specific components of program innovations and best practices being developed by five ACAP-member plans. In mid-2016, ACAP queried member plans seeking updated information on their innovations, progress, and challenges in preventing and treating prescription opioid overuse and OUD. In-depth interviews were conducted with five of these plans to get more detailed information about their programs' successes and ongoing challenges.

The interviews focused on plan efforts around prevention and detection of potential overuse or misuse of prescription opioids; member engagement and treatment when an issue is identified; provider engagement; tools to support prevention and treatment; and common policy and operational challenges. Table 1 provides a brief overview of the plans included in this report.

Table 1. ACAP Plans Highlighted in this Study

Plan	Medicaid Enrollment	Medicaid Service Area	Other Lines of Business
Partnership HealthPlan of California (PHC)	560,000[21]	14 counties in Northern California	
Inland Empire Health Plan (IEHP)	1,200,000[22]	2 counties in Southern California	Medicare-Medicaid Plan (MMP), Managed Long-Term Services and Supports (MLTSS)
Community Health Plan of Washington (CHPW)	315,000[23]	State of Washington	Individual Market, Dual Eligible Special Need Plan (D-SNP)
Neighborhood Health Plan of Rhode Island (Neighborhood)	185,000[24]	State of Rhode Island	Marketplace, MLTSS, MMP
UPMC Health Plan (UPMC For You)	404,077	40 counties in Western Pennsylvania	Marketplace, D-SNP, MLTSS, Medicare, Commercial, Behavioral Health (Community Care)

Notes

5 Chang H, Daubresse M, Kruszewski S, et al. Prevalence and treatment of pain in emergency departments in the United States, 2000 – 2010. Amer J of Emergency Med 2014; 32(5): 421-31

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10 Nora D. Volkow, M.D., NIH National Institute on Drug Abuse, "America's Addiction to Opioids: Heroin and Prescription Drug Abuse," Testimony to the U.S. Senate Caucus on International Narcotics Control, May 2014. Available at https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse

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15 Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003-2012. Morb Mortal; Wkly Rep 2015; 64:377-380. Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. Morb Mortal Wkly Rep. 2009; 58:1171-1175.

16 Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003-2012. Morb Mortal; Wkly Rep 2015; 64:377-380. Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. Morb Mortal Wkly Rep. 2009; 58:1171-1175.

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18 ASPE Issue Brief, "Continuing Progress on the Opioid Epidemic: The Role of the Affordable Care Act," January 11, 2017. Available at: https://aspe.hhs.gov/sites/default/files/pdf/255456/ACAOpioid.pdf

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CHAPTER 3

ACAP Plans' Strategies to Address the Opioid Crisis

ACAP plans understand that prescription opioid misuse and OUD is a multifaceted problem, demanding a multifaceted approach. This report highlights components of comprehensive strategies used by plans to prevent and respond to opioid overuse and misuse among members (see Figure 1), including:

A. Strategies to Prevent Opioid Overuse and Opioid Use Disorder and to Manage Access to Opioids

B. Alternative Approaches to Pain Management

C. Identifying Members and Providers for Interventions

D. Member Engagement and Management of Opioid Overuse and Opioid Use Disorder

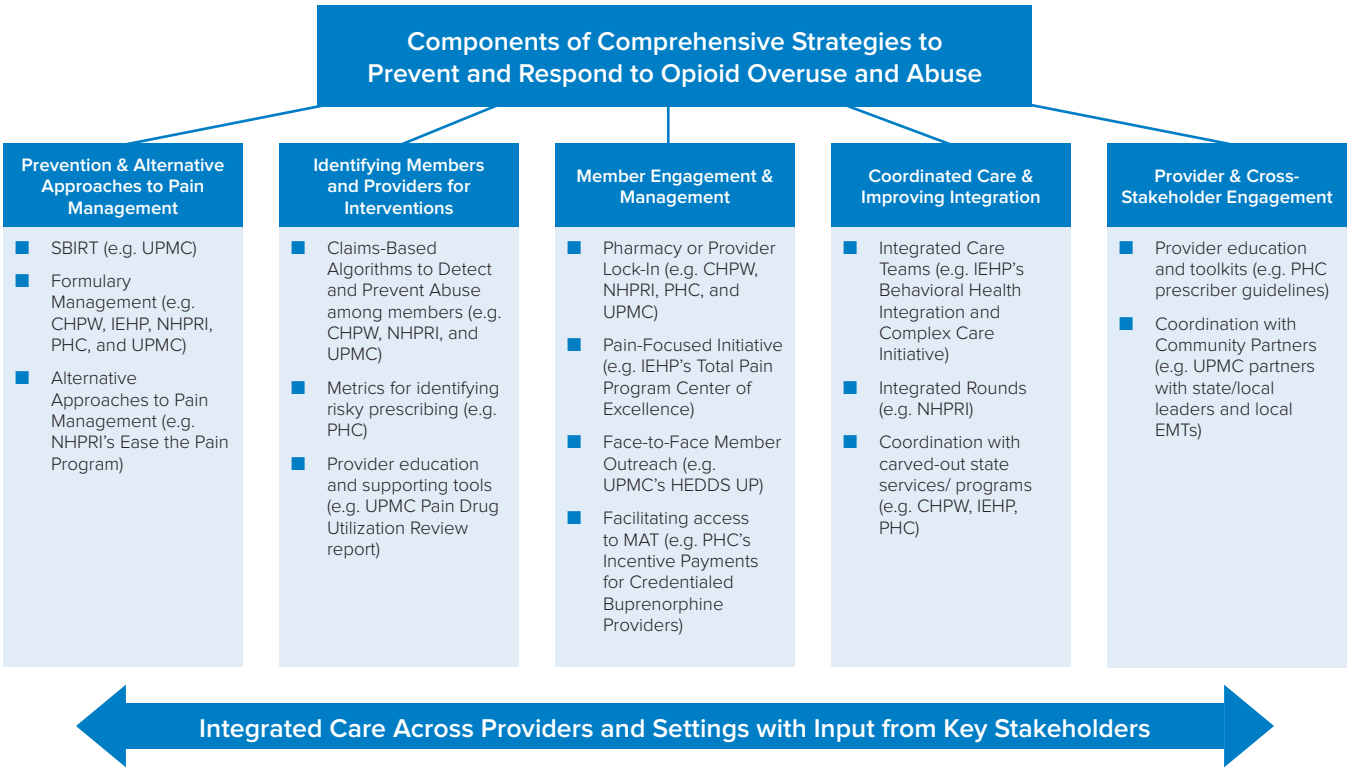
E. Facilitating Access to Medication-Assisted Treatment (MAT)

F. Provider Engagement Strategies for Addressing Opioid Overuse and Opioid Use Disorder

G. Improving Integration of Physical Health and Behavioral Health Care Services and Treatment

H. Multi-Stakeholder Engagement

Figure 1.



Note: Figure 1 includes examples of plans' strategies to prevent and respond to opioid overuse and abuse. It does not provide a comprehensive list of strategies used by the five plans highlighted in this report.

While each strategy will be explored individually in this report, early outcomes data show that plans implementing multifaceted approaches to prevent and treat opioid overuse have seen promising results. For example, with implementation of their "Managing Pain Safely" initiative, **PHC** reported a 76 percent decrease in unsafe opioid doses, a 66 percent decrease in the number of members with opioid prescriptions, and a 78 percent decrease in the rate of prescription opioid escalations between January 2014 and December 31, 2016.

A. Strategies to Prevent Opioid Overuse and Opioid Use Disorder and to Manage Access to Opioids

ACAP-member Safety Net Health Plans serving Medicaid and other vulnerable populations have developed comprehensive strategies to treat and engage with members with varying health needs and at different points across the health care continuum. This experience has been critical to the development of opioid use disorder prevention and deterrence efforts as well as approaches to target members at-risk of overusing or abusing prescription opioids.

Interviewed health plans described several roles they play in preventing overuse and misuse:

- Encouraging providers to screen patients for SUDs and to begin conversations with patients about their substance use, including opioids;
- Helping to decrease the number of opioids inappropriately prescribed, thus decreasing the number of opioids available in the system;
- Limiting permitted dosages of prescription opioids to prevent overuse or misuse;
- Limiting the ability of multiple providers to write concurrent opioid prescriptions; and,
- Ensuring access to life-saving drugs like Naloxone to prevent overdoses.

1. SBIRT: Screening, Brief Intervention, and Referral to Treatment—or SBIRT—is an evidence-based practice used by medical professionals to identify, reduce, and prevent overuse, misuse, and dependence on alcohol and illicit drugs, including opioids.[25] Using a validated screening tool, providers ask patients a set of questions about their substance use. The patient's score dictates the provider response. For patients demonstrating a moderate risk of developing a SUD, providers conduct a brief intervention. For patients identified as having developed a SUD, the provider refers the member to treatment. Some ACAP plans train providers on SBIRT, encourage its adoption through incentive payments, and provide additional support to individuals identified as at-risk or in need of treatment.

UPMC, for example, participates in a three-year collaborative aimed at increasing the identification of youth at risk for SUD by using SBIRT in primary care offices.[26] The collaborative, funded by the Conrad N. Hilton Foundation, consists of seven health plans, each of which will pilot an SBIRT training project aimed at raising the awareness of SUD among youth. The project is led by the Center for Health Care Strategies in partnership with ACAP. The project will fortify providers' abilities to screen, intervene, and refer to treatment as needed. As the health plans develop their pilot projects, they will regularly share progress with fellow collaborative participants in an effort to speed development of effective SBIRT programs. Upon completion of its work, the Collaborative will develop a toolkit that will identify best practices and challenges in establishing effective SBIRT programs aimed at youth.

The provider sites selected by UPMC to train on SBIRT already have behavioral health services embedded on site. This assures that members identified as at risk or referred to treatment will get a "warm hand-off" to a behavioral health professional. After completing training, sites will receive continued support from UPMC through monthly calls and technical assistance. Throughout 2017, all members of the Collaborative will measure the impact their training programs have on increasing the utilization of SBIRT and identifying members who are at risk of SUD.

2. Formulary Management: A change in prescribing patterns over the past 20 years has greatly increased access to opioid medications. Interviewed plans described formulary management as one of their strongest tools to curb overprescribing and overuse of opioids.

All five plans interviewed explained that effective formulary policies must take into account unique clinical situations and allow for access to opioids and other pain-relieving medications where appropriate, while also protecting against overuse and misuse.

All interviewed plans employ prior authorization (PA) for at least some, if not all, new opioid prescriptions or refills. Other formulary policies used include quantity limits on the Morphine Equivalent Dose (MED) per day that can be prescribed. While the CDC recently recommended that no more than 90 Morphine Milligram Equivalents (MME)/day should be prescribed,[27] Medicare requires plans to monitor and report on individuals who are on doses of more than 120 MED for more than 90 consecutive days and whose prescriptions are linked to more than 3 prescribers and more than 3 pharmacies.[28] This variation in limitations extended to plans' formulary policies. Specifically, plans MED/day limitations range from 120-200mg. While the word "limitation" may be used, all plans have a way for providers and members to override these policies as appropriate.

In January 2014, **PHC** launched "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse." This initiative was based on an evaluation of national best practices and local input. The internal framework for the initiative was built using quality improvement practices and the Model for Improvement methodology. The program's stated aim was to improve the health of PHC members by December 31, 2016 through ensuring that prescribed opioids are "for appropriate indications, at safe doses, and in conjunction with other treatment modalities" as measured by a decrease in:

- Total opioid prescriptions per member per month;
- Initial opioid prescriptions per member per month;
- Proportion of opioid users with escalating dose; and
- Proportion of opioid users on greater than 120 mg MED.

One of the internal workgroups at PHC was specifically tasked with "identification of interventions that can improve internal/external prescription processes to reduce opioid overuse."[29] As a result, over the last several years, a number of formulary changes were made, including:

- Stricter quantity limits and refill-too-soon edits;
- Removal of some drugs and drug formulations from the formulary, while adding others;
- Additional documentation for certain cases; and
- A requirement for a taper plan for all patients on high-dose opioids who did not have a justification for continuing a stable dose, documenting the proposed process and steps to be utilized to decrease opioid dosage.[30]

Multiple plans singled out Oxycontin as a commonly misused drug. **UPMC** has taken the drug off its formulary completely—after its removal, the plan found that 13 percent of the members previously using the drug stopped taking it and did not switch to another prescription opioid. It's unknown whether these members stopped using opioids completely or were no longer receiving them through the traditional medical system.[31] UPMC has also imposed formulary limitations in an attempt to curb opioid use by members who have been treated for overuse or OUD. For example, if a member has been prescribed buprenorphine within the past 120 days, they cannot fill a new opioid prescription without a clinical rationale from the prescribing physician.

Neighborhood utilizes a daily MME dose limit for all its short-acting and long acting opioids, when prescribed for non-cancer pain. The limit was instituted in 2009, reduced again in 2013, and is now under review for further reduction to align with the CDC's 2016 Guideline for Prescribing Opioids for Chronic Pain. The plan reports that the staggered and progressive reduction in MME limits per day has been effective in sustainably decreasing opioid utilization by their membership, while minimizing disruptions in access to needed services by members and prescribers. To help educate network providers about opioid prescribing guidelines and to support their adherence to the new limits, the plan also conducted provider training and one-on-one consultations.

Additionally, in response to Rhode Island's increasing incidence of prescription opioid misuse and overdose, Neighborhood implemented a step-therapy policy for non-formulary, long-acting pain medications, like Oxycontin. For a member to access these drugs, there must be documentation and claims-based evidence of an adequate (in terms of dose and duration) trial of two formulary long-acting agents (e.g. extended-release morphine tablets and fentanyl patches).[32] Additionally, documentation is required demonstrating how the formulary agents resulted in side effects beyond those that are common or failed to provide clinically meaningful improvement in the member's health. Neighborhood reports that in the three years following this change, Oxycontin utilization decreased by more than 70 percent.

Neighborhood also participates in a state-based collaborative, working with other plans, to develop

standardized formulary initiatives to improve opioid safety and to decrease risk of addiction. As part of these efforts, in early 2017 the plan implemented prior authorization for all long-acting opioids—including formulary agents such as methadone and morphine—to ensure that members who are prescribed these drugs meet chronic pain criteria and have appropriate tolerance. Effective July 2017, all plans in the state will limit the quantity and dosage of opioid prescription for members presumed to be naïve to the class (defined as having a negative claims history for opioids in the preceding 60 days).

B. Alternative Approaches to Pain Management

Efforts to address prescription opioid overuse and misuse must also ensure that individuals who do suffer from chronic pain have access to effective and appropriate treatment. The CDC, in their guidelines for primary care physicians, emphasized the importance of non-opioid alternative approaches to pain management. As part of plans' comprehensive efforts to address opioid misuse, many cover alternative approaches to pain management.

Health plans interviewed described the need to provide non-opioid, evidence-based forms of treatment alongside their formulary management strategies. Many health plans have expanded benefits or decreased administrative barriers to pain management benefits that show promise, such as chiropractic and acupuncture services and self-management resources. Some plans have gone so far as to work with providers to create pain management "centers of excellence"—sites that specialize in holistic pain management using multi-disciplinary approaches and adopting best practices with proven outcomes.

Examples of Alternative Pain Management Modalities Covered by Plans

- Physical therapy,
- Chiropractic services,
- Acupuncture,
- Podiatry,
- Osteopathic manipulation therapy, and
- Self-management resources (i.e. mindfulness-based stress reduction)

Neighborhood's Ease the Pain program targets members affected by chronic pain and provides access to alternative pain management treatment not typically covered by Medicaid – including chiropractic care, acupuncture, and therapeutic massage. Holistic nurse care management is also foundational to the program, focusing on the development of healthy and effective ways to cope with pain, strengthening self-management skills, and coordinating care. Ease the Pain incorporates evidence-based clinical guidelines for the use of alternative modalities of pain management into the integrated care treatment program.[33] The plan uses diagnostic codes and claims data to identify potential enrollees who, within a three-month window of review, have certain pain-related diagnoses as well as a higher number of opioid prescriptions and doctors' visits. Working with their behavioral health partner to encourage use of alternative modalities rather than drugs to manage pain, the plan employs peers to provide community outreach to members identified at risk.

Once enrolled in the program, members are managed by an integrated care team—including a nurse case manager trained in holistic pain management or a peer support specialist. The care management team reaches out to the member and works to coordinate their needs across providers. As part of care coordination, the plan leverages internal co-managed care rounds—which include physical health and behavioral health providers—to assess a member's conditions, determine care needs, and develop a comprehensive care management strategy. Typical enrollment in the program is for one year, but it can be extended based on a member's needs.

The Ease the Pain program run by Neighborhood was originally initiated by the state of Rhode Island in 2010 as part of its Communities of Care initiative, which targets members with four or more ED visits within a 12-month period. As part of the program, Neighborhood has conducted provider trainings and released guidance to educate providers about opioid prescribing. Building on learnings and promising outcomes from its Ease the Pain program, the plan is working with the state and providers to pilot expansion of this approach to qualifying members beyond those in the Communities of Care initiative.

As part of a comprehensive pain management strategy under development, **IEHP** has designed a strategy that aims to incorporate providers and resources across departments and care settings, including complex care management and pharmacy management strategies targeting members with pain. A major component of

this strategy is the creation of in-network centers of excellence for members who suffer from chronic pain or who use high levels of opioids. As the name implies, the centers for excellence will provide patient-centered, state-of-the-art, evidence-based care. Their approach will be multidisciplinary and holistic.

Members will be identified and referred to the pain-specific center of excellence through several pathways. They may be referred directly from a provider or pharmacist, through an over-the-phone or in-home assessment, or through an analysis of claims data that examines ED utilization, pharmacy data, and certain diagnostic codes to target members who may suffer from chronic pain and be at risk for OUD[34].

As of January 2017, IEHP had launched one pain-specific center of excellence, and was working on plans to develop centers of excellence programs in each of the seven regions where the plan operates. IEHP is still finalizing the population for the center of excellence programs, but is currently targeting members at highest risk which they have initially defined as members who have:

- Prescription(s) for Morphine Equivalent Dose (MED) of greater than 120mg/day;
- Prescription(s) for MED of 45-119 mg/day combined with a prescription for Benzodiazepines; an opioid, Benzodiazepine, and Carisoprodol; or anti-depressants;
- Three or more ED visits related to chronic pain;
- Two or more hospital visits for chronic pain; or
- A spinal intervention procedure.[35]

IEHP is also considering incorporating several evidence-based interventions and promising practices related to integrating medical care, behavioral health, self-management, and functional restoration into its pain management program. The plan is considering including integrated care teams that incorporate a pain specialist, licensed behavioral health professionals, and a psychiatrist. IEHP is also evaluating the inclusion of several service delivery model components, such as on-site Medication-Assisted Treatment (MAT) and substance use counseling, medication management programs that are coordinated with a pharmacy home, and the capability to coordinate directly with inpatient and outpatient Substance Use Treatment programs. Inclusion of comprehensive services such as office-based care, access to surgical intervention, and a comprehensive bundle of alternative therapies are also being considered. The plan is building a program evaluation approach into the design of its centers of excellence model. The center of excellence currently in operation regularly sends member outcomes reports.[36] Eventually, all centers of excellence will be evaluated on patient outcomes, prescription, services and referrals utilization, cost, and program engagement. The plan has convened a total pain care committee to guide development of the strategy.

C. Identifying Members and Providers for Interventions

To be effective, comprehensive approaches to curb opioid overuse and misuse must engage the right members and the right providers. Health plans rely largely on claims data to identify members who may be at risk for opioid overuse or OUD—this includes data submitted by a provider and prescription drug fills charged to the health plan.

Non-pharmacy provider data pose a challenge; there is typically a delay of three to four months from the date a member receives services to receipt of the claim by the plan. This lag complicates efforts to respond swiftly to concerns regarding utilization patterns. However, plans receive pharmacy claims much more quickly. While pharmacy claims data paint an incomplete picture of members' health care utilization, plans can intervene more quickly when warranted. In some cases, plans also have access to state ED databases, which are updated in real time and can be analyzed to identify members accessing the ED for opioid-related reasons.

Health plans use these data sources and provider referrals to identify members who are abusing opioids or are at risk of doing so. They can also identify providers with risky prescribing practices. Accurate identification of members—and providers—is a crucial step in the development of a plan's member and provider outreach and engagement strategies.[37]

1. Metrics for Identifying At-Risk Members:
Interviewed plans identified metrics which they use to signal the need for targeted engagement with members or providers. These metrics may focus on prescription and utilization measures or use algorithms that combine multiple sources of data to detect troublesome patterns in prescribing and drug use.

CHPW's pharmacy department generates reports every 90 days to help identify members who may have a high risk of opioid misuse or OUD. The reports incorporate the plan's pharmacy and medical claims data. These reports examine the number of opioid-related metrics including: prescriptions filled; pharmacies used; prescribers, specifically those who prescribed controlled substances; and office visits and ED visits per member. The plan also incorporates data from the state's Emergency Department Information Exchange (EDIE) system—a voluntary system that hospitals can choose to use to document a patient's emergency room visits—when member information is available.

CHPW's pharmacy department staff reviews the case of each member flagged as at-risk to determine whether their prescription and service utilization warrants an intervention, taking into account the context of the member's health status. For example, higher utilization of these services are anticipated for an individual with a diagnosis of cancer. The plan then performs targeted outreach and engagement to both members identified as at-risk and their primary care provider, and employs care coordination and enrollment into a more advanced intervention, such as a pharmacy or provider lock-in program.

Plans also discussed how they incorporate these metrics into more advanced algorithms that identify members with opioid misuse issues or at high risk of developing them. For example, **UPMC** implemented a pilot program that used an algorithm to identify patients who exhibit warning signs of opioid abuse or inappropriate pain management. The "Triple Threat Pilot," targeted members with concurrent prescriptions of benzodiazepine, a muscle relaxant, and a narcotic for more than 30 days for program interventions. The plan reached out to the member's primary prescribing provider to initiate the development of a care plan and re-evaluation of the member's prescriptions. UPMC plans to implement a permanent "Triple Threat" Program and a "Double Threat" Program that would identify and target members if they are concurrently prescribed an opioid and benzodiazepine.

UPMC also monitors member ED use and repeat ED-administered CT scans, as it has found that both utilization patterns have proven to be an indicator of opioid overuse or misuse among members. For members with these types of utilization patterns, the plan may reach out to the member's providers to educate them about the member's utilization profiles in an effort to improve management of their care. Members may also be referred to pain management services or medication-assisted therapy (MAT) as appropriate.

Table 2 provides an overview of select algorithms used by plans to identify high-risk members for targeted engagement or interventions discussed in other parts of this report.

Metrics of Prescription and Health Services Used to Identify "At-Risk" Members and Providers

- Daily Morphine Equivalent Dosage (MED)
- Number of pharmacies and number of prescribers for opioid prescriptions
- Number of opioids prescribed for more than 90 days
- Number of ED visits and services received at the ED

Table 2. Advanced Algorithms to Detect Prescription Opioid Overuse and Misuse for Targeted Engagement

Plan	Examples of Plan Algorithm
CHPW	■ Diagnosis for poisoning, more than 2 ED visits, history of forgery of a controlled substance prescription, inconsistent urine analysis for a controlled substance
Neighborhood	■ 7 or more narcotic or benzodiazepine fills, 3 or more prescribers, and 3 or more pharmacies over the course of 3 months for 2 consecutive quarters *(Pharmacy Home Program)* ■ 3 or more ED visits, 6 or more pharmacies, 4 or more Primary Care Providers (PCPs), 3 or more outpatient behavioral health specialists, or received controlled substances from 4 or more providers in a 180-day period.[38] *(Communities of Care)*
UPMC *For You*	■ Prescription for a benzodiazepine, a muscle relaxant, and a narcotic for more than 30 days. **(***Triple Threat Pilot)* ■ Prescription for a benzodiazepine and opioid for more than 30 days. **(***Double Threat Pilot)* ■ 5 or more ED visits within the previous 6 months and one opioid prescription. **(***HEDDS UP Program***)**

2. Metrics Used to Identify Inappropriate Prescribing Patterns: As discussed previously, the number of opioid prescriptions written for non-cancer pain has increased significantly over the last 15 years. Recognizing this trend, plans also use metrics to monitor providers for targeted engagement and education related to prescribing and treatment.

PHC, for example, regularly generates and shares information on patient dose and dose patterns with provider sites. The plan's Medical Director has performed direct outreach to sites that have at least 15 members on high-dose opioids (> 120 mg MED) in an effort to gain a better understanding of prescribing patterns and determine, for instance, whether the sites have individuals in need of palliative care.[39] Once providers or provider sites with potentially problematic prescribing patterns have been identified, PHC provides a range of education opportunities and tools to support safe and appropriate prescribing. These tools are further discussed in the *Provider Engagement Strategies for Addressing Opioid Overuse and Opioid Use Disorder* section.

D. Member Engagement and Management of Opioid Overuse and Opioid Use Disorder

ACAP-member Safety Net Health Plans profiled in this report have developed a range of approaches and programs to engage with members, coordinate care, and facilitate access to appropriate treatment across the care continuum. These engagement and care management strategies are the core of plans' multi-pronged efforts, but must be paired with the other strategies identified in this report to be effective. For example, several plans identified the need for improved transitions between settings of care as a challenge that they are working to address, including the need to provide a smooth transition in care for individuals who were previously jail-involved.

The range of approaches described by plans included targeted outreach by care managers to members identified as at-risk for or overusing opioids, the development of integrated, coordinated care rounds that involve physical health and behavioral health providers at the plan level, and programs using integrated clinics with physical health and behavioral health providers or co-located care teams.

UPMC, for example, started its "HEDDS UP Program" *(High ED Drug-Seeking Utilization Protocol)* as a pilot in 2014 and expanded it plan-wide a year later. The program identifies members who have at least one opioid prescription and who have visited the ED five or more times within the previous six months. Once identified, the plan notifies the members' providers of the overutilization and potential for misuse. Additional outreach and engagement by nurse care managers is performed for the members who have the highest frequency of ED visits, numbers of opioid prescriptions, prescribers, and dispensing pharmacies. Once contact is made, members are screened for additional needs (e.g. referral to pain management, MAT, behavioral health) using a standardized assessment selected based on the member's condition (e.g. chronic pain or behavioral health diagnosis). To evaluate the impact of this program, the plan monitors referrals to services and ongoing utilization of ED or prescription opioids to assess if the member has received appropriate services and if there is a positive impact on utilization patterns.

To increase engagement with hard-to-reach members identified for the "HEDDS UP Program," UPMC started working with and funding local Emergency Medical Technician (EMT) staff. EMT staff make outreach calls to schedule home visits, but if unsuccessful proceed to knock on doors with cold calls. If not at home, a flier is left behind describing the different types of resources and support they can provide, along with their contact number. Because these EMT providers are community-based, the plan hopes they will have more success making contact with hard-to-reach members than office-based providers or plan-level staff. While this effort is new, it aims to increase longer-term engagement with high-risk members and to help them connect to and navigate medical needs (e.g. MAT and behavioral health referrals) and other supports (e.g. housing support).

Additionally, UPMC has developed an intensive care management program focused on members exhibiting drug-seeking behaviors, as well as their families. Care managers are trained in motivational interviewing and engage and guide members toward more coordinated care or recovery, depending on their needs. A telephonic substance use program assists members with managing their substance use issues and supports them in their early recovery by providing coaching. UPMC also supports Patient Navigators for individuals with SUDs in five UPMC hospitals.

In addition to helping members who have identified opioid or other substance use issues, the plan also accepts referrals for members who may not have a diagnosed SUD and who may not have had any

treatment, but are questioning whether or not they have a substance use problem. With these members, UPMC care management staff explore the potential of addiction, address treatment options, and connect members to appropriate services and treatment. Additionally, the plan promotes a focus on the family in its initiatives and has provided or facilitated education programs addressing the needs of families and children affected by OUD.

IEHP's Behavioral Health Integration and Complex Care Initiative (BHICCI)[40] was built upon the goal of partnering with a range of specialties to develop innovative approaches to engaging with and caring for complex patients, including a specific focus on providing integrated complex care management or using health homes.[41] Through this initiative, IEHP has partnered with providers at 30 sites that include community clinics, public hospitals, SUD treatment centers, an adult day health care center, and county departments of behavioral health. The program targets complex members with two of more chronic conditions, one of which must be a mental health condition or SUD. Once identified, the plan performs targeted outreach. For patients with more severe behavioral health conditions—often a population carved out of managed care—the provider team helps to refer them to the appropriate county-run services. As part of this initiative, IEHP provides funding directly to the participating providers to support the hiring of a three-person care team: a nurse care manager, a behavioral health provider, and a care coordinator. The plan further supports these sites through ongoing training, education, and tools to help provider teams to maximize their ability to provide integrated, whole-person care to patients.

Recognizing the benefits of improved integration of physical and behavioral services, including the integration of mental health and SUD services, **Neighborhood** has instituted weekly, co-managed care rounds. These rounds include Neighborhood's medical staff and behavioral health staff from the plan's behavioral health subcontractor, Beacon Health Options, who collaborate to manage and treat members with complex needs. Through the co-managed care rounds, medical and behavioral health practitioners jointly review the cases of select complex members and work to develop a member engagement strategy and care plan. In addition, Neighborhood has established an integrated care team focused on SUD, which performs biweekly co-managed care reviews. These reviews look closely at patient engagement, transitions in care and barriers to care.

Neighborhood's Health at Home program is also geared towards individuals with complex needs. While SUD is not a catalyst for enrollment in the program, the plan has found that for many of the members served, SUD is often a driving clinical need.

Another common approach plans employ to manage care and access across providers and settings are pharmacy or provider "lock-in" programs. Four of the five plans interviewed for this report (**CHPW, Neighborhood, PHC,** and **UPMC** *For You*) have instituted pharmacy or provider "lock-in" programs targeting members identified by an analysis of claims data as receiving potentially inappropriate opioid prescriptions. The goal of these programs is to better manage member access to opioids and to improve care by requiring the member to limit prescribing to a specific provider or dispensing to a designated pharmacy for a set amount of time. These designated providers and pharmacies are responsible for working with the plan to manage the member's care.

Table 3 details the criteria used by health plans to identify high-risk members that are evaluated for participation in the lock-in program. For example, **Neighborhood** has developed a "Pharmacy Home" program for high-risk members that looks at the number of narcotic or benzodiazepine prescriptions, the number of prescribers and the number of pharmacies used. The plan selected these criteria believing that for some members (e.g. those on a long-acting opioid) six prescription fills within three months would be appropriate, but a higher amount could indicate overuse or misuse. Once members are identified, Neighborhood's pharmacy department reviews each member's utilization and selects the most appropriate pharmacy to offer for lock-in, also referred to as the member's "Pharmacy Home." Once the pharmacy home is assigned, the plan notifies the member and the member's primary care provider by mail that they will be enrolled in the "Pharmacy Home" program and that the member may choose the pharmacy to which they will be assigned. The member is required to use the selected pharmacy for all controlled substances prescriptions for two years. To date, very few members have appealed the lock-in. The plan reports it has seen a reduction in the number of pharmacies used, decreased narcotics utilization, and decreased ED utilization among participants.

Table 3. Approach to Identifying High-Risk Members for Lock-in			
Plan	**Approach to Identifying High-Risk Members for Lock-in**	**Pharmacy Lock-In**	**Prescriber Lock-In**
CHPW	Diagnosis for poisoning (overdose), history of forgery of a controlled substance prescription, inconsistent urine analysis for a controlled substance	X	X
Neighborhood	7 or more narcotic or benzodiazepine fills, by 3 or more prescribers, at 3 or more different pharmacies over the course of 3 months for 2 consecutive quarters	X	X
PHC	PCP/prescribing physician or pharmacist refers members with high-risk behavior to health plan for review for lock-in program.	X	X
UPMC	More than 3 separate opioid prescriptions in a 3-month period, or 3 or more prescribers and more than 8 filled opioid prescriptions in a quarter.[42]	X	X

CHPW's pharmacy and provider lock-in program builds upon criteria and requirements established by the state law. Washington state law identifies conditions or utilization patterns signifying at-risk and overutilization behaviors when they occur in a period of ninety consecutive calendar days in the past twelve months. Overutilization examples may include, but are not limited to, receiving services or prescriptions from four or more different providers, having prescriptions filled by four or more different pharmacies, receiving 10 or more prescriptions, or receiving similar services on the same day from different practices or clinics.[43] Building off the state's requirements, CHPW has developed an internal set of identifiers to screen for additional members that may benefit from the support provided through the lock-in program. At-risk criteria include a diagnosis for poisoning (overdose), history of forgery of a controlled substance prescription or inconsistent urine analysis results for a controlled substance.

The plan also takes into account referrals from providers, pharmacists, and law enforcement. Once identified, pharmacy staff review the member's case to assess whether these utilization patterns are warranted within the context of the member's health status, or signify overuse and misuse. Members approved for lock-in are enrolled for two years before their case can be re-reviewed. For these members, a letter is sent to providers encouraging them to ensure that they review the state's Prescription Drug Monitoring Program database with their patient's prescription history before prescribing controlled substances. As a precautionary measure to address potential overdoses, providers are also encouraged to prescribe Naloxone to these members. The plan has seen a decrease in ED and medical service utilization and costs by members enrolled in the lock-in program.

CHPW also noted that for members with high ED utilization—who may be using the ED for pain or seeking an opioid prescription—simply sending them a letter recommending that they see their primary care provider instead has decreased ED utilization among these members by about 50 percent. Plan staff viewed sending a letter as an effective tool in curbing ED utilization in advance of enrolling a member into a lock-in program.

E. Facilitating Access to Medication-Assisted Treatment (MAT)

All Safety Net Health Plans interviewed for this report identified MAT as a key component of treating members with SUD. MAT involves the use of medications (typically methadone, buprenorphine, and naltrexone) to manage addiction. This intervention is commonly paired with counseling or other behavioral therapies to treat the underlying causes of addiction.[44] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), this clinically effective approach has historically been underused.[45] Many of the ACAP plans interviewed for this report reiterated the importance of MAT in treating members with OUD. But

some reported challenges with MAT provider shortages, or other barriers to access.

PHC reported that increasing access to MAT providers is a priority, but that finding credentialed providers can be a challenge.[46] As a result, PHC is partnering with community coalitions to identify new or existing MAT providers who accept outside referrals. PHC also instituted incentive payments for credentialed buprenorphine providers to increase access to MAT for members.

Neighborhood is also committed to providing members with timely access to MAT (e.g. Suboxone) through its formulary and pharmacy operations. The plan worked to reduced barriers by early adoption of simple PA criteria, systematic prioritization of buprenorphine-based MAT requests (for same or next day review), and authorization—without review—of requests made by known addiction treatment providers. Additionally, in June 2016, the plan eliminated PA requirements for Suboxone tablets up to the manufacturers' maximum recommended dosage for treating addiction and removed "fail first" criteria for Vivitrol, making it available as a first-line treatment. The plan notes that these strategies have resulted in increased access for members and reduced administrative burden to prescribers.

UPMC is working to increase its capability to treat OUD and increase the availability of buprenorphine in medical practices and licensed addiction programs through several efforts, including financial and clinical support for community-based primary care practices and addiction treatment providers. Other treatment initiatives include similar support to specialty programs focused on women with addictions who are pregnant. The plan has also developed a Special Credentialing Policy and process for buprenorphine providers who want to be recognized and promoted within the network for meeting quality standards related to the use of MAT. The goal of this credentialing program is to improve the care, quality, and patient experience for members with SUD who require treatment with MAT.

Naloxone to Reverse Overdoses: PHC has taken steps to increase access to Naloxone and designed a program that involves prescribing Naloxone in conjunction with opioids for patients identified by providers as at high-risk of opioid misuse. Unfortunately, the nasal spray version of Naloxone was originally not on the State's drug formulary—and the drug was carved out and managed by the state's Medicaid fee-for-service program. To increase access to Naloxone and make the drug easier to use, the plan began to provide nasal atomizers to provider sites treating members in conjunction with a Naloxone toolkit that includes best practices and guidelines to help educate providers about prescribing Naloxone. Fortunately, the State has since added the nasal spray to its formulary.

UPMC also covers and promotes overdose education and the use of Naloxone products to prevent overdoses. The plan has provided substantial financial assistance to first responders to distribute naloxone kits and, in October 2016, the plan provided information about naloxone to thousands of providers in the community.

F. Provider Engagement Strategies for Addressing Opioid Overuse and Opioid Use Disorder

Partnering with and supporting providers is essential to effective treatment of members at risk of misusing or overusing opioids. All plans emphasized that strategies to ensure that providers—across multiple settings of care—have the necessary information, skill set, tools, and incentives are essential to a plan's comprehensive strategy to prevent and treat OUD. Plans have developed a range of educational materials, tools, and payment arrangements designed to improve health care outcomes while decreasing costs.

1. Provider Education, Toolkits and Guidelines: Plans have developed a range of provider support initiatives and toolkits. These include educational resources on prescribing practices and alternative modalities for pain management, as well as toolkits that help providers to identify at-risk patients, make referrals, select treatment options, and coordinate care.

Recognizing the roles of different providers in treating patients for pain, **PHC** developed opioid prescribing guidelines for primary care providers, emergency departments, pharmacists, and dentists. The plan promotes tools to support provider prescribing decisions, including a dose calculator and a "taper toolkit" to help reduce a patient's reliance on opioids.[47] In addition to connecting providers to training videos—some of which provide continuing medical education credits—PHC partners with UC Davis to fund the Extension for Community Health Care Outcomes project (Project ECHO), which provides skills training to providers related to caring for patients with chronic pain. A multidisciplinary team of specialists support

participating primary care clinicians through weekly peer-to-peer video conferences.[48] Two-thirds of surveyed clinics and providers participating in PHC's Project ECHO indicated they were working to taper patients off high-dose opioids. Half of surveyed clinicians reported they were less likely to prescribe opioids after the program.[49]

PHC also instituted tools and approaches to facilitate direct collaboration among providers—or between providers and plan staff—to support treatment decisions for complex patients. This includes staff specifically trained in pain management who support provider and member decisions about care as part of PHC's Outreach and Understanding Can Help (OUCH) program. The program targets members who contact the plan for issues identified by the member as related to "chronic pain" or "withdrawal." These members are referred to care coordination and a case manager who works across providers to ensure appropriate connections for the member. Additionally, a nurse case manager from PHC's care coordination team helps to further educate the member about safe opioid use and chronic pain control.

UPMC supports providers caring for high-risk members in numerous ways. The plan generates several reports—including its Pain Drug Utilization Review report and Opioid/Behavioral Health Medication Polypharmacy Drug Utilization Review report —which are used to identify members at risk of overuse or OUD (e.g. members on high-dose opioids, multiple prescriptions, or frequent ED or doctors' visits). These reports are shared with providers every month or quarter, depending on the report, and are geared toward helping them understand member utilization patterns and incorporate this information into care planning. The plan also has a program that aims to support provider decision-making about care and treatment for members, including those with high ED utilization and prescription opioids.

In addition, UPMC performs targeted outreach to providers with a disproportionate share of members with high MEDs and is supporting care managers at practice sites to help providers implement MAT services. It has also created targeted resources to support providers in screening and referrals. Finally, the plan has built SUD screening tools into its electronic medical record system to encourage providers to screen in both inpatient and outpatient settings and pays providers for substance use screening.

The plan also provides educational opportunities to providers and has offered a number of webinars and on-site presentations on substance use screening and treatment. UPMC also identifies educational and training needs by soliciting input from clinical staff in UPMC and Health Plan programs, and the community via surveys and requests. In response to provider- and staff-identified needs, the plan has offered case consultations and educational and training programs on assessment and treatment of OUD and other SUDs. The plan has also disseminated relevant information and education through monthly or bi-monthly updates reaching more than 13,000 and 20,000 providers, respectively.

In March 2016, the CDC issued its groundbreaking guidelines for physicians on prescribing opioids for treating patients who are not receiving cancer treatment, palliative, or end-of-life care. The guidelines urged physicians to try non-narcotic treatment methods before offering patients prescription opioids.[50] The CDC also noted that "efforts to improve treatment of pain failed to adequately take into account opioids' addictiveness… and lack of documented effectiveness in the treatment of chronic pain…It has become increasingly clear that opioids carry substantial risks and uncertain benefits, especially as compared with other treatments for chronic pain."[51] The CDC guidelines include 12 recommendations and emphasize the use of non-opioid treatments for chronic pain when appropriate, use of the lowest effective dose when opioids are prescribed, and continuous monitoring of patients who are prescribed opioids.[52]

With the release of these new, national guidelines, more plans are disseminating the CDC guidelines to providers or working to align internal guidelines with these newly developed recommendations. For example, in Washington State, **CHPW** is working closely with the state's Managed Medicaid and Health Care Authority to draft and issue guidelines related to prescribing practices and treatment for acute pain. These guidelines will build upon current guidelines, including the recent guidelines from the CDC.[53]

CHPW also works to connect providers to supportive resources provided by the University of Washington, such as its Medicine Pain Consult services, which offers over-the-phone clinical advice to providers who see patients with complex or high-dose regimens of pain medication. The plan also encourages providers to participate in the University of Washington's Psychiatric and Addictions Case Conference services, which is a weekly videoconference targeting providers who treat patients with behavioral health needs. The series includes presentations and discussions of complex cases with the goal of helping providers build knowledge and skills to better treat patients with

behavioral health issues, including addiction. The plan also works with its community health centers to convene pharmacists for educational purposes.

2. Promoting Value-Based Payment Arrangements: Although still early in development, a number of plans interviewed for this report indicated that they are exploring the use of value-based payment arrangements or other payment incentive models to encourage appropriate prescribing of opioids and pain management services, as well as increasing access to MAT prescribers.

PHC has implemented several payment arrangements targeting provider or provider organizations in its Quality Improvement Program (QIP), which includes pay-for-performance incentives related to treatment and care for members with opioid misuse issues. The program includes incentive payments to providers who agree to become a MAT prescriber, and incentives for providers who agree to host peer-led support groups, including those related to pain management and SUD (e.g. Suboxone Patient Support Group, Pain Self-Management).[54] PHC is working to expand its QIP and noted that with funding from California Healthcare Foundation, it is partnering with two clinics to design a program and payment plan that supports integration of behavioral health and SUD services at primary care provider sites.[55]

Additionally, Medicaid agencies in Pennsylvania and Washington have set targets for moving Medicaid payments into value-based payment arrangements. As a result, **UPMC** and **CHPW** are working to meet the targets by developing and implementing value-based payment arrangements that focus on delivery system reform and improved outcomes, including for members with mental health conditions and SUD, which are tied to adherence to quality metrics.

G. Improving Integration of Physical Health and Behavioral Health Care Services and Treatment

A lack of coordination between physical and behavioral health providers, including limited coordination between mental health and substance use treatment providers, contributes to higher costs and poorer outcomes. Plans are working hard to address these challenges by integrating care through different approaches such as co-managed care rounds, co-located physical health and behavioral health providers, and "centers of excellence" that include comprehensive care management and a range of services. These approaches have shown promise in improving care coordination and management, but challenges persist where plans are not responsible for managing all of a member's care and benefits.

For example, **IEHP**, which operates in California, reported that identifying and then engaging with members with behavioral health needs such as opioid overuse issues and OUD can be challenging because it requires coordination across a range of providers (primary care, behavioral health, and specialists), entities (including the county if the individual has severe mental illness), settings of care, and other services when necessary. These challenges are more acute in California because services for members with severe mental illness are carved out and managed by the county health department, while services for members with mild to moderate mental illness are covered and managed by the plan. This dynamic can result in significant challenges in engaging members—and their providers—and effectively coordinating care and treatment. The plan also reported challenges in getting timely information on ED visits—members utilizing high levels of ED services have a higher incidence of behavioral health needs and may need more intensive engagement and care management. To address this, IEHP is exploring ways to better communicate with EDs to ensure members get appropriate referrals and treatment and that the plan can help coordinate their care beyond the ED.

UPMC is involved in multiple clinical, prevention, educational, research, administrative and community activities to integrate physical and behavioral health care services and treatment. Activities include technical assistance to network practices that offer MAT and value-based payments that help to support on-site care coordination for members with OUD. In addition, the plan facilitates coordination between prescribers and providers of concurrent behavioral health treatment.

Washington state is currently working to integrate most behavioral health services (except for services provided at state psychiatric hospitals) into Medicaid managed care contracts. Prior to April 2016, only services for mild to moderate behavioral health conditions were carved in. The state is phasing in integration across its nine regions and **CHPW** is offering an integrated plan in the first pilot region. As part of this effort, the plan surveyed providers to see what types of training or education were needed. As a result of the survey, the plan has done training

around MAT and is working to identify other needed resources. The state aims for all regions to have implemented fully-integrated managed care by 2020.

H. Multi-Stakeholder Engagement

Plans and other stakeholders agree that addressing the growing opioid epidemic requires collaboration and engagement across multiple stakeholders including managed care plans, pharmacies, physical and mental health providers, and social and community support services. These multi-stakeholder relationships are key to implementing the member and provider engagement efforts discussed above. All of the plans interviewed for this report have convened, or are participating in, community-oriented workgroups to address the rising use of opioids. Additionally, a number of plans have developed public partnerships with other leaders on this issue and reinforced the importance of these efforts to their prevention and treatment strategies.

UPMC, for example, has convened a workgroup of addiction specialists, pain specialists, psychiatrists, pharmacists, and primary care physicians to obtain recommendations on how the plan can better support providers treating members with chronic pain or an SUD. As part of this internal collaboration, the plan developed a pain management toolkit for providers and held meetings to educate providers about how best to address SUD. Currently, the plan is working to assess pain management interventions across the plan and the UPMC health system with the intention of creating a comprehensive compendium of interventions for use by plan staff and providers. The plan has also partnered with state and local agencies, state legislative leaders, a regional U.S. Attorney's office, and other stakeholders to raise awareness of the opioid crisis. Events have included multiple regional conferences, participation in regional groups that are developing community plans to address the opioid crisis, and community trainings on how to use Naloxone.

PHC established a number of internal workgroups (pharmacy, provider network, community initiatives, member services, care coordination, utilization management, policy and communication, and data management) to inform development and implementation of the strategies included in its Managing Pain Safely initiative.[56] The plan has found this cross-department collaboration to be especially important when making a benefit change that requires education across multiple providers and care settings: for instance, when a change is made to the formulary that may impact prescribing patterns, such as new prior authorization requirements.

CHPW participates in an opioid-focused group led by Washington State's Health Care Authority to lend the plan's perspective to the State's work on issues surrounding opioids, such as the development of state-specific opioid prescribing guidelines. As discussed above, the plan also encourages providers to participate in a weekly addiction case conference series run by University of Washington. The series allows for providers to share best practices related to care for complex patients, including patients with SUD.

Notes

25 SAMHSA. "SBIRT: Screening, Brief Intervention, and Referral to Treatment." Available at: http://www.integration.samhsa.gov/clinical-practice/SBIRT

26 The project, led by the Center for Health Care Strategies in partnership with ACAP and made possible by the Conrad N. Hilton Foundation, consists of seven health plans, each of which will pilot an SBIRT training project aimed at raising the awareness of substance use disorder among youth. The seven plans participating in the project are: BMC HealthNet, Passport Health Plan, Prestige Health Choice, Texas Children's Health Plan, UPMC for You, Virginia Premier and YourCare Health Plan.

27 Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

28 CMS, "Medicare Part D Overutilization Monitoring System (OMS) Summary," November, 3, 2015. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-11-03.html

29 PHC, "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse, Partnership HealthPlan of California's Approach to Reduce Opioid Misuse and Abuse" Available at: http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/MPS_MultipleInterventionstoDramaticallyReduceOpioidOveruse.pdf

30 Ibid

31 ACHP, "Ensuring Safe and Appropriate Prescription Painkiller Use: UPMC Health Plan," 2012. Available at http://www.achp.org/wp-content/uploads/UPMC-Health-Plan-long-opioid-profile-copyedited.pdf

32 Neighborhood, "Neighborhood Improves Access to Treatment for Opioid Addiction and Dependency." July 21, 2016 Available at https://www.nhpri.org/AboutUs/CompanyProfile/NeighborhoodImprovesAccesstoTreatment.aspx

33 Ease the Pain is a subset of a state-mandated program by Neighborhood, Communities of Care (CoC). Members are enrolled in COC if they 4 or more ED visits within a 12-month period. Ease the pain targets a subgroup of these members. Avaliable at https://www.nhpri.org/Providers/ClinicalResources/EasethePain.aspx

34 IEHP uses NCQA's CCM algorithm, which includes a pain management component.

35 IEHP, *IEHP Total Pain Care COE Program Guidelines.* Updates as of 1/26/2017.

36 Outcomes include, for example, PHQ-9 screening results.

37 It is important to note that data analysis techniques, including monitoring utilization and prescribing patterns are also used by plans to detect suspected fraudulent practices—either initiated by the member or the provider. Most plans partner with states on this issue and are taking necessary steps to identify and address fraud, when appropriate.

38 Neighborhood, "Communities of Care Provider Fact Sheet." Available at https://www.nhpri.org/Portals/0/Uploads/Documents/CoCProviderFactSheet.pdf

39 PHC, "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse," Available at http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/MPS_MultipleInterventionstoDramaticallyReduceOpioidOveruse.pdf

40 The Initiative is currently scheduled to end in 2018. IEHP, "Behavioral Health Integration and Complex Care Initiative." Available at http://bhintegration.com/

41 The ACA established the optional Medicaid State Plan option for states to create Health Homes. Health Homes are intended to provide holistic, comprehensive care to Medicaid beneficiaries with chronic conditions through coordinating primary, acute, behavioral health, and long-term services and supports.

42 ACHP, "Ensuring Safe and Appropriate Prescription Pain Killer Use." Available at http://www.achp.org/wp-content/uploads/UPMC-Health-Plan-long-opioid-profile-copyedited.pdf

43 Washington State Legislature, "WAC 182-501-0135." Available at http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0135

44 SAMHSA, "Medication-Assisted Treatment of Opioid Use Disorder." Available at http://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf.

45 SAMHSA, "Medication and Counseling Treatment." Available at https://www.samhsa.gov/medication-assisted-treatment/treatment.

46 SAMHSA, "Legislation, Regulations, and Guidelines." Available at https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines (Under the Drug Addiction Treatment Act of 2000 (DATA 2000) only physicians that meet certain qualifications are able to treat opioid dependency with FDA-approved narcotic medications approved by the Food and Drug Administration (FDA)—including buprenorphine—outside of Opioid Treatment Program setting).

47 PHC, "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse." Available at http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/MPS_MultipleInterventionstoDramaticallyReduceOpioidOveruse.pdf

48 UC Davis Health, "UC Davis ECHO Pain Manager." Available at https://www.ucdmc.ucdavis.edu/advancingpainrelief/Projects/ECHO.html

49 Ibid

50 CDC, *CDC Guideline for Prescribing Opioids for Chronic Pain.* Available at https://www.cdc.gov/drugoverdose/prescribing/guideline.html

51 Friedan, T et al., *Reducing the Risks of Relief — The CDC Opioid-Prescribing Guideline*, *NEJM*, 374;16, 1501-1504. April 2016. Available at http://www.nejm.org/doi/full/10.1056/NEJMp1515917#t=article

52 Ibid

53 Guidelines reviewed by the state and plan include: CDC, AMDG, and Canadian Guidelines, ATS

54 UOS Measure Incentive payments for providers administering buprenorphine range from $4,000 to $7,500 depending on the region. Payment to provider sites for hosting peer-led-support groups range from $5,000 to $13,000 depending on the region.

55 PHC, "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse." Available at http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/MPS_MultipleInterventionstoDramaticallyReduceOpioidOveruse.pdf.

56 PHC, "Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse." Available at http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/MPS_MultipleInterventionstoDramaticallyReduceOpioidOveruse.pdf

CHAPTER 4

Policy Considerations

While more broad-based policies are explored by state and federal policymakers, several policy challenges can hinder plans' ability to fully coordinate and manage care.

1. Ensure Access to Care and Coverage: As noted in the report, treatment is a key component of addressing the opioid crisis. Access to coverage and comprehensive, integrated physical and behavioral health care is proving essential to addressing the needs of those suffering from mental illness, SUD, or both, as cost is one of the key barriers to treatment. Curtailment of coverage would have an adverse impact on access to treatment.

2. Continue to Improve Integration of Services: Many states continue to "carve out" certain populations, benefits, or services from MCO contracts and pay for them through Medicaid FFS or a separate behavioral health vendor. As of 2014, only 9 of the 35 states and the District of Columbia that provided physical health services through Medicaid managed care programs had integrated all behavioral health benefits into their MCOs' benefit packages. The remaining 26 states carved out some or all behavioral health services (e.g., certain classes of drugs, specialty services)—or rely on Medicaid fee-for-service.[57] Where carve-outs exist, ACAP member plans are working diligently to develop ways to better coordinate with other stakeholders to assure members access to needed benefits, services, and treatments. However, carve-out policies do add a level of complexity to providing care coordination for members who receive services managed or paid for by separate entities, be it a behavioral health plan, a state, or a county agency.

3. Address 42 CFR Part 2: Rules at 42 CFR Part 2 address confidentiality of substance treatment records held by "Part 2" providers.[58] Confidentiality protections under 42 CFR Part 2 are more restrictive than the Health Insurance Portability and Accountability Act (HIPAA), as they prevent disclosure of patient information by the Part 2 program unless the program has individual and specified patient consent, a qualified service organization agreement with the entity it plans to share the information with for limited purposes, or another exception is met, such as a medical emergency. Additionally, consent must be obtained for a Part 2 program to submit a claim to a patient's health insurance plan.

As a result, these restrictions impede a plan's ability to identify members with SUD, refer them to appropriate providers and services, develop a comprehensive treatment plan, and coordinate care across providers and care settings. This can create a significant threat to patient safety, as detailed in ACAP's report, *The Impact of 42 CFR Part 2 on Care Coordination by Health Plans for Members with Substance Use Disorders*.[59]

The Department of Health and Human Services recently adopted a final rule to update the disclosure requirements included in 42 CFR Part 2 within the context of the current health care delivery system and its increasing emphasis on integrated systems of care.[60] However, these changes do not address the issues identified by health plans especially as it relates to care coordination and care management, integral components of managed care.

4. Ensure Access to MAT: Treatment incorporating MAT and use of buprenorphine or naltrexone are viewed as appropriate and necessary components of treatment strategies, but plans have expressed concerns about access to these services for members that are beyond their control. There are known shortages of providers who offer these treatments—some plans have reported that when they identify members who are candidates for MAT, they cannot get them into treatment. While the federal government has taken some steps to increase the number of MAT providers and the number of individuals they may treat, policymakers should do more to increase access to MAT services such as developing incentives for physicians, including primary care providers, to become certified to provide MAT.

The shortage of MAT prescribers contributes to a second issue: some Buprenorphine prescribers will only see patients on a cash basis. This does not necessarily mean that inappropriate prescribing is occurring, but it poses access challenges to people with low incomes. In addition, when members pay in cash, no claims are submitted to the health plan and plans have no way to know whether and when these services are rendered. This can create challenges for plans because SUD delivery system reform efforts, including quality evaluation, are dependent on the availability of accurate and comprehensive data.

Notes

57 Detty, Andrew, "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment, Commonwealth," Manatt, Phelps & Phillips, LLP, August 2014.

58 "To be a "program" that falls under 42 CFR Part 2, an individual or entity must be federally assisted and hold itself out as providing, and provide, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). A program is "federally assisted" if it is: 1) authorized, licensed, certified, or registered by the federal government; 2) receives federal funds in any form, even if the funds do not directly pay for the alcohol or drug abuse services; or; 3) is assisted by the Internal Revenue Service through a grant of tax exempt status or allowance of tax deductions for contributions; or 4) is authorized to conduct business by the federal government (e.g., certified as a Medicare provider, authorized to conduct methadone maintenance treatment, or registered with the Drug Enforcement Agency (DEA) to dispense a controlled substance used in the treatment of alcohol or drug abuse); or 5) is conducted directly by the federal government." H. Westley Clark, M.D., J.D., M.P.H., CAS, "Applying the Substance Abuse Confidentiality Regulations to Behavioral Health Primary Care Providers," Substance Abuse Mental Health Services Administration, March 2012. Available at: www.integration.samhsa.gov/March_2012_-_42_CFR.ppt

59 ACAP, "The Impact of 42 CFR Part 2 on Care Coordination by Health Plans for Members with Substance Use Disorder." Available at http://www.communityplans.net/Portals/0/Fact%20Sheets/The%20Impact%20of%2042%20CFR%20Part%202%20on%20Care%20Coordination.pdf

60 Office of Information and Regulatory Affairs, Confidentiality of Substance Use Disorder Patient Records, 42 CFR 2. Fall 2016. Available at https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201610&RIN=0930-AA21

CHAPTER 5

Conclusion

The strategies and programs highlighted in this report provide important takeaways for other plans, providers, and state and federal policymakers grappling with the opioid crisis. Interviews with plans and a review of their efforts further reinforces that the most successful strategies to address the opioid crisis require a multi-pronged approach that includes evidence-based and innovative prevention and integrated care and treatment.

Takeaways from the interviews conducted with plans are identified below:

Preventing Overuse and Misuse and Alternative Approaches to Pain Management

- Evidence-based screening tools such as SBIRT are valuable in helping plans and providers to understand members' care needs and to take appropriate action; these tools can play a critical role in prevention and treatment for patients with a range of physical, behavioral, and social service needs.
- Formulary management is an essential component of managing access to opioids, while taking into account a patient's unique clinical situations. Early data show positive impacts of formulary management[61], but evaluation should continue.
- Alternative approaches to pain management—including chiropractic and acupuncture services as well as more comprehensive centers of excellence—have proven promising in helping to manage pain and may play an essential role in opioid overuse prevention and treatment strategies.

Identifying Members and Providers for Interventions

- Metrics (e.g., ED utilization or number of opioid prescriptions) and algorithms developed by plans using claims data are useful tools to identify high-risk members requiring prevention and treatment interventions.
- Metrics used to monitor providers can help ensure providers treating members with opioid misuse or overuse issues receive targeted engagement and education related to decision-making around prescribing and treatment.

Engaging and Managing Members and Facilitating Access to MAT

- Initiatives focused on individuals with chronic pain or who are at-risk of opioid overuse—such as pain-focused initiatives or pharmacy or provider lock-in programs—can be effective in providing targeted prevention and treatment to high-risk individuals.
- Efforts to coordinate care across providers and settings—such as co-located, integrated care teams or integrated rounds that include physical and behavioral health providers—can improve member engagement as well as development and execution of appropriate treatment and care plans.
- Treatments incorporating MAT and use of Naloxone to reverse overdose are viewed as promising and necessary components of treatment strategies; however, plans have experienced barriers to integrating these into existing programs and are working to address this through innovative clinical and financial incentives.

Engaging and Supporting Providers

- Guidelines, toolkits and educational opportunities for providers regarding appropriate prescribing of opioids, referral and treatment options, and innovations in pain management are critical features of plans' efforts to prevent and treat opioid overuse and misuse.
- Incorporating value-based payment arrangements or other incentive models can be effective in encouraging providers to make evidence-based decisions about prescribing and pain management treatment and increasing member access to high-quality providers and services.

Improving Integrated Care and Treatment

- Strategies facilitating integration across physical and behavioral health services and providers—such as co-managed care rounds, co-located physical health and behavioral health providers and "centers of excellence"—are a key component of plans' efforts and have proven promising in improving care coordination and management for members with opioid misuse or overuse issues.

- Policy challenges related to carve-outs and confidentially restrictions (under Part 2) can prevent plans from fully coordinating and managing care; health plans, policymakers and other stakeholders should continue to work to address these barriers where they exist.

Developing Multi-Stakeholder Strategies

- Multi-stakeholder engagement strategies involving plans, providers, patients, families and communities, are critical to advancing the prevention and treatment of opioid overuse and OUD and appropriate pain management.

- Strong partnerships between plans, states and other stakeholders are necessary to fully address the multi-faceted nature of the opioid crisis.

Notes

61 Neighborhood, "Neighborhood Improves Access to Treatment for Opioid Addiction and Dependency." July 21, 2016. Available at https://www.nhpri.org/AboutUs/CompanyProfile/NeighborhoodImprovesAccesstoTreatment.aspx.

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